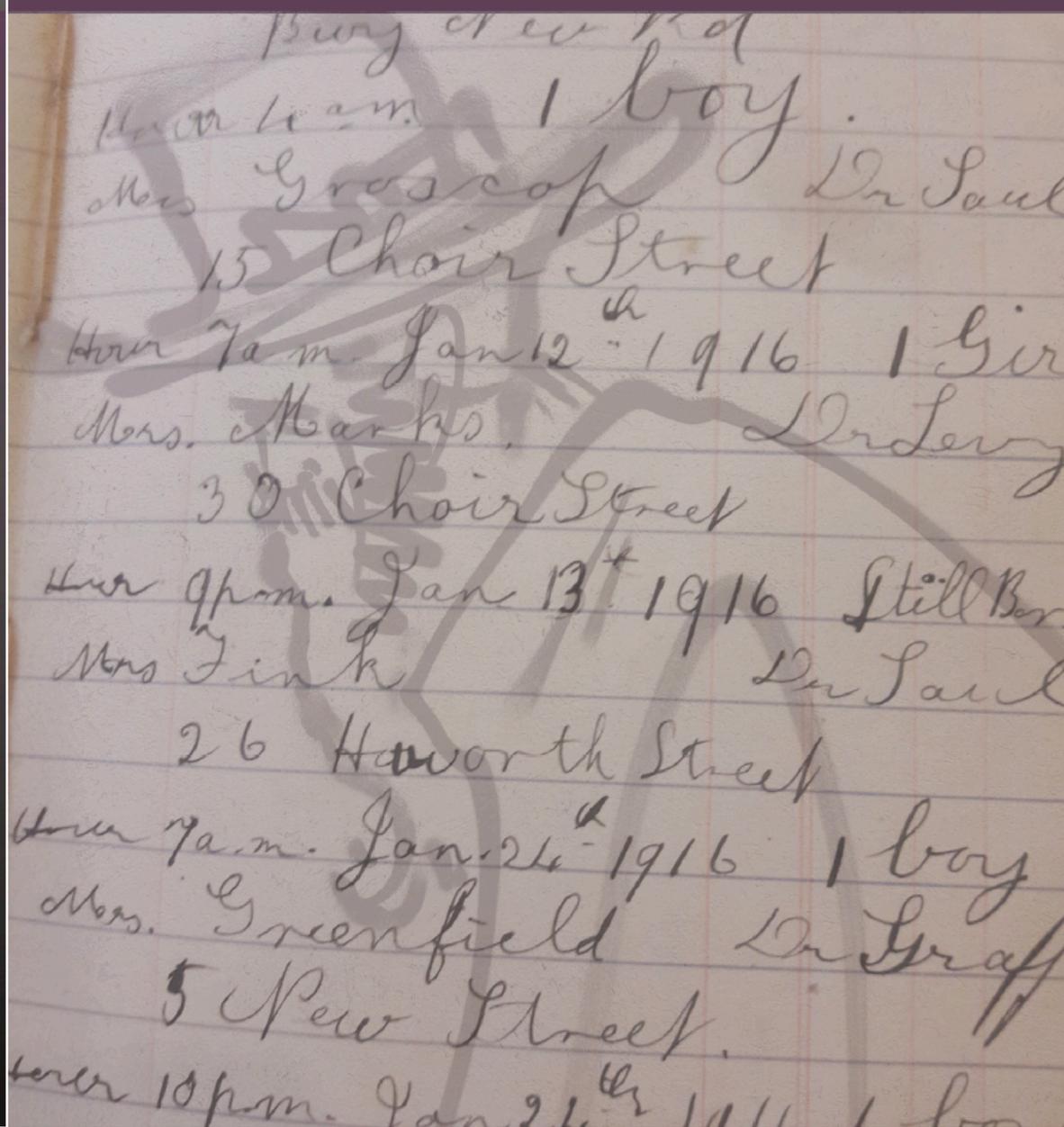


Making Bodies Kosher

The Politics of Reproduction among
Haredi Jews in England



Ben Kasstan

MAKING BODIES KOSHER

Fertility, Reproduction and Sexuality

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THE POLITICS OF REPRODUCTION AMONG
HAREDI JEWS IN ENGLAND

Ben Kasstan



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In memory of my grandparents, Esther and Raymond A. Kasstan,
and with gratitude to my parents.

Grandchildren are the crowns of their elders and the glory of
children is their parents.

—[*Tanakh*] Proverbs 17: 6

For Christina.

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Chapter 2 draws on a previous publication reworked and expanded in this book, 'Haredi (Material) Cultures of Health at the "Hard to Reach" Margins of the State', published in *The Material Culture of Failure: When Things Do Wrong* (Bloomsbury, 2017).

NOTES ON TEXT AND TRANSLITERATION

Hebrew and Yiddish words are transliterated throughout this book unless I am referring to a direct quotation. There are nuanced differences in the pronunciation of Hebrew between Jews of Ashkenazi, Sephardi and Mizrahi origin in the UK. Direct quotations in Hebrew or Yiddish are transliterated in the relevant pronunciations made of participants. These typically consisted of vernacular Ashkenazi pronunciations, which was the dominant linguistic variety of Jewish Manchester, at times among Sephardim as well. Embedding the dominant and vernacular pronunciation in this book does not imply greater authenticity over Sephardi and Mizrahi pronunciations of Hebrew. For clarity, transliterations appear with both Ashkenazi and Sephardi pronunciations in endnotes. The glossary lists both styles of transliteration for frequently used Hebrew as well as Yiddish references.

ABBREVIATIONS

the Board	Manchester Jewish Board of Guardians for the Relief of the Jewish Poor
BSTs	Birth spacing technologies
CRS	Congenital rubella syndrome
DPT	Diphtheria, tetanus and pertussis vaccine
EMT	Emergency Medical Technician
GMC	General Medical Council
GP	General Practitioner
MJLVA	Manchester Jewish Ladies Visiting Association
MMR	Measles, mumps and rubella vaccine
NCT	National Childbirth Trust
NHS	National Health Service
Sem	Seminary
VPDs	Vaccine-preventable diseases
VBAC	Vaginal birth after caesarean section

INTRODUCTION

A vineyard surrounded by a fence is better than one without a fence. Do not, however, make the fence higher than what it is intended to protect; for then, if it should fall, it would crush the plants.

—Avot d’Rav Natan

Mrs Abrams is highly prized in Manchester for supporting local women to birth according to the heightened standards of bodily governance that define them as Haredi Jews – a minority that is commonly regarded as ‘ultra-Orthodox’ and ‘hard to reach’ in the UK, claims which are critiqued in this book. She is frequently told by women ‘you don’t understand how nice it is to have a Jewish midwife who understands you’, which is reflected in the warm smiles and greetings she receives while we sit in the neighbourhood’s busy café. Mrs Abrams makes herself constantly available for local birthing women, but the value of her role extends to more serious issues that can involve contestations around the interpretations of bodily care upheld by practitioners of authoritative knowledge¹ in biomedicine and Haredi Judaism:

When they go over their due date, *halachically* [according to Jewish law] you shouldn’t and the doctors will still pressurise, ‘we’ve got to induce you, you’re over your due date’. But the woman will ask the rabbi and if he says no, she won’t do it. You’re never comprising health, if it’s medically something, everybody understands. I think [her role] it’s to advocate where they are coming from. (Mrs Abrams)

Such dilemmas around birth introduce how healthcare constitutes a borderland through which multiple, and at times opposing, understandings of bodily governance and care come into contact for Haredi Jews in England. *Making Bodies Kosher* explores how Haredi Jews navigate maternity and infant care, and respond to biomedical interventions that are seen to contest local understandings of how a Jewish body should be protected. Jews are as much a ‘people of the body’ as of the book, and a focus on care surrounding birth and babies illustrates how bodies are ‘organ-ized’ in processes of social reproduction (cf. Eilberg-Schwartz 1992: 8). To be made kosher is a reflection on what is considered acceptable and safe to be incorporated, and this ethnography addresses the conducts of a minority group who intend to protect their social life and continuity against threats which are feared to destabilise boundaries built in relation to the external world.² The following chapters explore Haredi cultures of parturition and bodily protection historically, politically and relationally, as any ‘attempt to understand reproduction in isolation from its broader context is a barren exercise’ (Tremayne 2001:22).

The book analyses the social politics of parturition and bodily protection among Haredi Jews in Manchester using the paradigm of immunity and immunitary reactions. My approach addresses the multiple ways in which a Jewish minority continuously attempts to manage encounters with the external world by focusing on the body as a terrain of intervention – especially in the context of maternity and infant care. In doing this, I advance a broader body of work which explores how immunity has been conceptualised as a creative and crucial system of protection that negotiates socially-constructed boundaries of the self and difference (see Esposito 2015; Haraway 1991; Martin 1990, 1994; Napier 2016). Understanding bodily and collective protection in terms of immunity frames the biomedical as well as socio-political aspirations of the Haredi minority and the state in ways that are constant over time.³ Esposito’s (2015) paradigm of ‘*immunitas*’ is mobilised in this book as a major body of theoretical inspiration to critically engage with the social construction of immunities and protection. It provides a framework to critique how émigré Jews were perceived as so-called ‘alien’ bodies in need of assimilation and prophylaxis during the nineteenth and twentieth centuries,⁴ the way in which the Haredi lifeworld is now preserved by strategies of self-protection from the external world, and the current perceptions of childhood vaccinations in Haredi families – who are otherwise represented as having a low uptake in public health discourse.⁵

Research Context: The Vineyard as Seen from Each Side of the Fence

Haredi Jews are a rapidly growing minority with among the highest total fertility rates in England, which are estimated to be over three times that of the general population (Staetsky and Boyd 2015). Yet the health and bodily care needs of Haredi Jews remain poorly understood by Public Health England – the body that is mandated to ‘protect and improve the nation’s health’.⁶ Public Health England produces authoritative knowledge on health and bodily care, and thus formulates expectations of the ideal and ‘compliant’ citizen.⁷ International public health discourse frames Haredi Jews as being ‘non-compliant’ or ‘resistant’ to its services, but, as I make clear in the following chapters, the minority itself feels that the state is unable to understand their needs or be trusted to meet those needs.⁸ Opposing pursuits of bodily protection emerge as a key issue in the relations between the Haredi minority and the state in this ethnography.

From the perspective of the state, the immunisation of the population against untoward threats is to be engineered through biomedical surveillance and interventions that require bodily compliance. Areas of maternity and infant care demonstrate how individuals are intimately bound up in population health and welfare, especially vaccinations, which are one of the most effective strategies to arrest the spread of certain infectious diseases. Maintaining a degree of *immunity* from the outside world is, at the same time, the most effective strategy to protect and preserve the Haredi lifeworld from socially constructed contagions, such as external systems of knowledge and information (including those pertaining to the body). The Haredi preference to avoid (potentially dangerous) encounters with, and exposure to, the outside world consequently affects perceptions of healthcare services. Family health can be viewed with particular caution among rabbinical and lay authorities because the biological and cultural perpetuation of the collective is seen to be at stake.⁹ The Haredi minority can therefore be understood as claiming *immunity* from the obligation bestowed to the broader population (cf. Esposito 2012; 2010; 2008); an obligation that the state articulates as being necessary for the protection of all, through the biomedical construction of immunity.

An antonymic fault can then be seen from each perspective of the minority and the state, to appreciate each other’s quest to preserve

individual and collective life. In the words of Mrs Shaked, a local Jewish woman, there is 'a lack of understanding from the outside, and probably a lack of understanding from the inside out'. The perceptions of healthcare services held by Haredi Jews in Manchester therefore stem from a broader relation between the inside and the outside, or the minority and the state. In combining an archival and ethnographic approach, *Making Bodies Kosher* demonstrates how the protection of health and bodily care forms an enduring area of contestation between an ethno-religious group and the state.

The entanglement of culture, faith and health are addressed in this book by critically engaging with the construction of a so-called 'ultra-Orthodox Jewish community' in public health discourse, and reflecting on the nuanced socio-religious differences that this term tends to obscure.¹⁰ Archival documents from the nineteenth and early twentieth centuries adjoin ethnographic research to illustrate the complex relations that have emerged *within* Jewish Manchester, but also between it and the external world. The interplay between culture, faith and health illuminates how a diverse and fragmented minority group remains entangled in competing struggles of integration and insulation, which is otherwise masked by the representations of an idealised and 'imagined community' (cf. Anderson 2006).

The conditions in which Haredi Jews are today portrayed as being 'hard to reach' are discussed in the context of minority–state relations, and healthcare is placed in the broader strategy of dissimulation and self-protection that Haredi Jews pursue.¹¹ Rather than outright evasion of state services – as the 'hard to reach' label implies – Haredi religious and lay authorities in Jewish Manchester prefer to negotiate and mediate the delivery of healthcare services to the settlement.¹² When possible, state services become a point of intervention on the part of Haredi Jews in an attempt to make them 'comply' with the governance of the body, as dictated by authoritative interpretations of the Judaic cosmology, which could otherwise threaten the preservation of collective life.

How the Haredi Jews of Manchester negotiate health and bodily protection is reflected in the local cultures of maternity and infant care that have emerged from the reproductive realities and needs of a rapidly growing minority group at the margins of the state. Local Haredi Jews consider certain biomedical procedures such as caesarean sections a challenge to the custodianship of Jewish bodies which can disrupt biological and cultural perpetuation, warranting appropriate responses from experienced Haredi doulas. For this

reason I consider ‘interventions’ as a protective practice of biomedical obstetric cultures, but also Jewish birth supporters when directly intervening in local maternity wards. The cultures of maternity care in Jewish Manchester then offer a concrete example of how mainstream NHS services are acted upon by Jews in Manchester and made kosher.

Finally I discuss the complex issues and concerns that underlie responses to childhood vaccinations, which remain one of the most effective (but also controversial) public health interventions that Haredi parents in England must navigate. There is no monolithic attitude toward childhood vaccinations in Jewish Manchester despite blanket representations of Haredim forming noncompliant communities. A focus on infant care demonstrates that the responses to, or low uptake of, vaccinations in this minority group are not appropriately framed if presented as an issue of compliance. Rather than attributing low uptake of vaccinations to ‘cultural factors’ or religious ‘beliefs’, Haredi parents in Manchester selectively negotiate vaccinations primarily because of anxieties around bodily protection and safety. The reasons that underlie low uptake of vaccinations among Haredi families accord strongly with those observed in the broader non-Jewish population of England. I emphasise the need for public (health) discourse to appreciate the nuanced experience of the Haredim as being a minority group *in* the UK, which has been the site of several controversies concerning vaccination safety.

Making Bodies Kosher contributes to a body of work that explores how ethno-religious minority groups respond to (or are seen to subvert) biomedical and public health interventions that present a challenge to their collective identity or cosmology. Embodying this struggle is the lived reality of birthing and caring for the family, where the biological and cultural perpetuation of a minority can be threatened. A Jewish settlement sitting at the ‘hard to reach’ margins of the UK state then serves as a microcosm in which core and current issues in the anthropology of reproduction unravel.

Health at the ‘Hard to Reach’ Margins

An anthropological critique of public health illustrates how this particular institution forms part of a broader strategy of the state to assimilate minority groups, but also how protective responses are subsequently fielded on the part of minorities.¹³ Haredi responses to public health interventions are explored in this book in terms of the

'three bodies', as the interaction between the individual body, the social body and the body politic demonstrates the co-construction, 'production and expression of health and illness' (Scheper-Hughes and Lock 1987: 31). The individual body is a vessel of lived experience that exists in relation to, and is constructed by, the social body as well as the body politic, the latter of which is cultivated as a terrain of social and political control or 'intervention'. Rather than propagating the term 'community' (which is critiqued in Chapter One), I instead uphold the concept of a 'social body' as it more accurately reflects the way in which the body of an individual is socially constructed by, and with, the collective that it forms. Throughout this book I make reference to the body politic as being synonymous with the notion of the body of the nation, the defence and protection of which is presented as necessary for the survival of all. Scheper-Hughes and Lock's (1987) concept of the three bodies illustrates how they are entangled and mutually constituted through public health interventions, as strategies to shape and fortify the body of the nation must target individuals as well the social body that they form. More specifically, the three bodies offer a terrain in which protections and immunities are performed.

Public Health England portrays the 'ultra-Orthodox Jewish communities' as well as the so-called 'Gypsy and Traveller Communities' as being 'hard to reach'.¹⁴ Not only do public health authorities impose and ascribe the 'hard to reach' status but they also construct and assemble 'communities' out of groups that are geographically and socio-culturally diverse. In doing so public health discourse *imagines* Haredi Jews as forming a monolithic 'ultra-Orthodox Jewish community' (cf. Anderson 2006), which has the (possibly unintended) effect of blotting out ethnic and socio-political differences between sub-groups.

'Hard to reach' groups at the margins of society can be likened to being socially, economically, or politically disenfranchised – or what is also termed 'underserved'.¹⁵ Biomedicine is an institution that has the power to both marginalise and de-marginalise, to exclude and rein in, but can also be subverted by 'hard to reach groups' as a form of self-marginalisation (cf. Ecks and Sax 2005) – or in the case of the Haredim, self-protection. Representations of the Haredim as a 'hard to reach' group at the margins of the state should be placed in a broader context of a minority status produced in relation to a majority, dominant, and national population. The state can be mapped by both territorial and cultural boundaries, wherein the majority population is cast as (or imagines itself as) the national group or the

body of the nation – as is the case for the (White) English population in Britain as a whole.¹⁶

The relation between majority and minority populations is typically one of disparities in power, whereby the latter population is shaped by both its size and political submission and where the former ‘defines the terms of discourse in society ... and the cultural framework relevant for life careers’ (Eriksen 2015: 357). However, it is important to note that minority and state relations do not exist in a vacuum but are, as Mahmood has argued, historically contingent:

Even though religious minorities occupy a structurally precarious position in all modern nation-states, the particular shape this inequality takes – its modes of organization and articulation – is historically specific (2016: 11).

Embedding historical records within this ethnography narrates the continuous implications of power and domination for a minority, not only when exercised *over* Jews in England (vis-à-vis the state) – but also *among* Jews. The growth of the Haredi population currently underway can, however, be read as an internal minority status (among the Jewish population in England) that is shifting towards an internally dominant majority position.

Émigré Jews in England during the nineteenth and early twentieth centuries, as will be made clear, faced immense pressures to *integrate* at the level of the social body (where group identity is maintained alongside participation in the social structure of the majority or national culture), and to *assimilate* and become anglicised Jews (causing the disintegration of internal ethnic and cultural boundaries). Eugenics discourse in the early twentieth century regarded the success of émigré bodies, with specific reference to the Jews, as dependent on their capacity to assimilate, and thus *intermarry* (Chapter One). However, the injunction against intermarriage in the Judaic cosmology prevents assimilation into a national (non-Jewish) majority, which demonstrates how Jews – as a minority group in England – have historically had to negotiate opposing responsibilities to the Judaic cosmology and body of the nation.¹⁷

Rather than a minority status being a monolithic category, it should be understood as a lived reality that is experienced in the plural form, especially if we consider how different *minorities* in the Haredi settlement of Manchester have varying degrees of relation to – and self-protection from – the state. Haredi Jews can be described as a minority in two senses of the term, as Jews form a relatively small population in England (with an historical experience

of prejudice) but also because the Haredim comprise at least ten per cent of all Jews in the country today.

A focus on health and bodily care then directs our attention to the institutions that create, maintain, and also target minority statuses (cf. Tsing 1993: 17) – but also the ways in which these statuses become a lived reality at the margins of the state.¹⁸ Yet a view from the margins also illuminates the often creative and elaborate cultures of health that continue to manifest when the state is unable to tailor its reach to minority groups.

An anthropological focus on the body offers a foundation for understanding how the enduring contention between a minority and the biomedical or public health authority is enacted.¹⁹ With this in mind, public health interventions (and their associated implications) cannot be understood without being entrenched in an analysis of the historical and social construction of the body – or bodies – and how, for ethno-religious minority groups, the preservation of (collective) life can be at stake.

By re-defining “normative” constructions of gender, sexuality and the body, reproduction can be controlled with the intention of fortifying group boundaries and ensuring cultural domination (and also perpetuation) by promoting natality – as is the case when a population is cast as (or cast themselves as) vulnerable.²⁰ In such cases, contraception and family planning form a biomedical (and political) technique of population control, which can be viewed as a threat to the survival of (and a weapon against) the social body or that of the nation (Kaler 2000; Kanaaneh 2002; Ong 1990). The bodies of women belonging to minority groups constitute and reproduce the margins of national, ethnic and social difference (Kanaaneh 2002; Merli 2008), and can thus be located as the target of intervention (to depress their natality) for the protection of the national majority’s (collective) life. Contests over the management of (social) reproduction and family health captures how the preservation of collective life rests on the construction of what I call *antonymic immunities* as forms of bodily protection between the Haredi minority and the state.

The Social Construction of Protection

Public health involves the political management (and politicisation) of health and bodily care and in so doing formulates expectations and responsibilities of citizenship that are performed through bodily

compliance.²¹ Reproduction is emblematic of this, where standards of 'good' maternity and infant care have historically been articulated according to socio-politically constructed norms (Marks 1994). The need to re-produce ideals of a 'good' (read: compliant) mother or parent is particularly important in order to reproduce a valuable and idealised population as a whole,²² and over time state ambitions have shifted from an historical need for economic resources (or 'manpower') to responsible neoliberal citizens (see Davin 1978; Oakley 1984; Lonergan 2015). Jewish women in England were represented as the 'model mothers' of robust infants at the turn of the turn of twentieth century, a time when Britain's higher rates of infant mortality created national and imperial anxieties around quality mothers and maternity care (Marks 1994). Contemporary public (health) discourse seems to imply that Haredi Jewish women are nowadays non-compliant mothers when it comes to accepting maternity and infant health interventions, indicating how the social value of biomedical technologies can redefine expectations and values around motherhood.

Pregnancy, childbirth and infancy are stationed in the gaze of medical and public health surveillance; biomedical and political domination of reproduction casts pregnant women as incapable of being trusted with the responsibility to make bodily decisions for either themselves, their foetuses or children (Oakley 1993). Yet being a target of biomedical intervention does not equate with being a passive recipient, illustrating how the bodies of women and children can emerge as a terrain that is caught between competing worldviews.²³

The term '(non-)compliance' indicates the extent to which individuals abide by medical advice, but is a conceptual reference that is viewed with criticism as it 'denies the legitimacy of behaviours that deviate from the doctor's instructions' (Ballard 2004: 110). Thus the term compliance reflects the paternalistic way in which biomedical authorities command obedience from people and deference to its authoritative knowledge.²⁴ The paternalistic expectation to comply with routine schedules continues to circulate in public health cultures, probably because observing clinical instructions forms a central part of treatment outcomes and the overall success of disease control.²⁵

When minority groups are framed as not complying with the expectation to act as responsible citizens, particularly in the context of obstetric and child health interventions, they are accused of compromising the body of the nation's integrity and immunity.

Vaccinations are a particularly marked example of this representation, as low uptake in Haredi settlements is viewed as exposing the broader population to danger because the phenomenon known as herd or social immunity can become compromised, thus warranting public health scrutiny and intervention. Low responses to vaccination campaigns are one of the overwhelming reasons why Haredi Jews seem to be portrayed as beyond the reach of Public Health England.²⁶ In attempting to reach – or perhaps save – Haredi Jews,²⁷ public health authorities emphasise the socio-religious components which present an obstacle to intervention rather than acknowledging the historical context of marginality that might continue to be at play, or political failures in responding to biomedical misconducts (such as the measles, mumps and rubella vaccine controversy in the UK).²⁸

The conceptualisation of ethnic and religious minority groups as ‘hard to reach’ reflects a broader tendency of public health discourse to situate ‘cultural factors’ as inhibiting the uptake of (or compliance with) healthcare services (see Parker and Harper 2006: 2). In viewing ‘cultural factors’ as an obstacle to engaging with healthcare, biomedical and public health authorities lose sight of the fact that ‘culture is not something that irrationally limits science, but is the very basis for value systems on which the effectiveness of science depends’ (Napier et al. 2014: 1630).

Public health authorities often fail to recognise that the *values* of human health are constructed in relation to other kinds of *value*, which ‘intersect and enable what it means to be human, and what it means to be healthy’ (Lynch and Cohn 2017: 370). Dismissing opposition to treatment regimes as ‘cultural factors’ then overshadows, and perhaps absolves, the role of biomedical authorities in providing healthcare services that meet local-level values, expectations and needs (see Fassin 2001).

Claims that Haredi Jews are non-compliant with preventive healthcare services have not yet been explored from an anthropological perspective, and rarely consider how interpretations of health and bodily care reflect religious worldviews or social codes of conduct. Moreover, the allegation of non-compliance places an emphasis on the so-called ‘hard to reach’ minority rather than the fact that biomedical technologies and interventions ‘are enmeshed with medical, social, and political interests that have practical and moral consequences’ (Lock and Nguyen 2010: 1). The body is the site of a complex entanglement of lived experience, cosmological governance, and politics, the ethnographic enquiry of which shows

how perceptions of health services are constructed and responded to in their given contexts.

Public health interventions form a salient strategy of what Foucault (2006) termed 'governmentality', meaning the various forms of 'discipline' that are applied to co-opt subjects into being 'governable' – at the level of the individual and the population – by exercising power over life. The control of bodies by the state is enacted through the diffusion of surveillance into areas of everyday life, such as the public health authority and biomedical 'disciplines' (described as 'biopower'). Exercising discipline and control at the level of the population is what Foucault (2006) described as 'biopolitics', with interventions often paved by the production of statistics or epidemiology.²⁹

I use Foucault's theoretical approach as a general frame of analysis regarding historical and contemporary public health strategies and the way in which minority groups are targeted for assimilation, which is particularly evident when juxtaposing the experience of émigré Jews during the nineteenth and early twentieth centuries, and Haredi Jews, in present-day Manchester. More specifically, I reflect on the work of Esposito (2015) to critically engage with health interventions as a strategy to preserve collective life.

Esposito (2015) has advanced the paradigm of biopolitics by focusing on the dual biological and legal significance of immunity, which has become the mainstay of social, political and economic existence. Immunising the body against biological and social-constructions of contagion has emerged as the premier strategy to preserve life and protect from danger. The rigorous pursuit of immunity can, however, have the consequence of negating life itself in the form of an autoimmune response – or the self-implosion of the body (Esposito 2015). Esposito's point is that the relation between politics and life is dependent on the way in which 'life lends itself to being preserved as such by political immunization' (2015: 113). Immunity is a form of the politicisation of biology, which sees a shift in the emphasis from the body as 'the object of biopolitics' to the precise way 'that object is grasped' (2015: 112).

Non-compliance can then be interpreted as a failure to fulfil an obligation to biomedical or public health authorities, and thus a self-exclusion, exemption, disincorporation or *immunitas* from a debt to the common or body of the nation (cf. Esposito 2008, 2010, 2015). Esposito makes clear that *immunitas* is a dispensation and position of being 'freed from communal obligations or [one] who enjoys an originary autonomy or successive freeing from

a previously contracted debt' (Campbell 2008: xi). In advancing Esposito's perspective, the hard to reach label can be conceived as an accusation, as minority groups such as the Haredim are portrayed as evading mainstream healthcare services and interventions – and thus exempt themselves from a responsibility to the state.

The individual body is positioned as the level at which the immunitary strategy of politics is enacted, tasking itself with preserving life and delaying death to the furthest possible point, and is increasingly mediated by technology. For this reason, Esposito regards the immunitary paradigm as the cornerstone of modern socio-political systems, a notion that is applied throughout this book to analyse how public health interventions mark an entanglement and alignment between the individual and social bodies and that of the nation. The power of immunity emerges as a mechanism to preserve life, and is simultaneously appropriated and resisted by the Haredi Jews of Manchester. Whilst social immunisation is deployed for the preservation of individual bodies and the Haredi social body as a whole, social immunisation can also be taken as a form of self-protection, which, on the other hand, can result in an attempt to be 'exempt' from an obligation to the body of the nation.

Immunitary reactions occur at the threshold in which the internal and external meet (Esposito 2008; 2015), which, in this ethnography, describes the areas in which Haredi Jews and the state engage with each other. Immunity forms part of an enduring attempt of the state to assimilate foreign bodies as well as to immunise the body of the nation against the threat of biological (and social) contagion, whilst also manifesting as an attempt of the social body to maintain a degree of *immunity* from the external world. These contrasting attempts to preserve collective life demonstrate how antonymic immunities are at play.

Healthcare is emblematic of this struggle to preserve individual life as well as the life of the social body, presenting a compromise to the social body's attempt to protect itself by maintaining its relation to the external world. When the sense of social order is perceived to be under threat, the conducts relating to self- and social control intensify (Douglas 2002). Self-protection is a strategy to defend the Haredi cosmology against contagion from the external world, but also from internal differences. The imagery of 'a vineyard surrounded by a fence' reflects the increasingly fortified and resistant reactions that have the potential for an autoimmune response – and thus an internal threat to the Haredi way of life. As Esposito (2015) puts it, the barriers (or fences) which are intended to protect life

from external threats can come to present a graver risk than they are intended to prevent.

Who Are the Haredim?

Haredi Jews form a growing population with considerable internal socio-religious diversities. Whilst Haredi settlements are dispersed across the world, the largest are situated in Israel, the United States and England. The Haredi population in England has continued to grow primarily because of high fertility rates, and for this key reason they are forecast to constitute the majority of Jews in the UK by the middle of the twenty-first century (Staetsky and Boyd 2015). The dominant, integrated, and anglicised Jews will, as already mentioned, constitute a minority of the Jewish population in the UK. Such an intra-group change is an eventuality that will present both continuities and discontinuities with the past narrative of Jewish dynamics in Manchester and England during the nineteenth and twentieth centuries.

The broader Jewish population in England is apprehensive of the anticipated changes caused by future generations of 'black hats and Jewish babies',³⁰ and they often direct criticism (and taunts) towards the Haredim. Much concern centres on the Haredi preference to limit their exposure to the broader Jewish and non-Jewish world. The Haredim's aversion to secular education and professional employment, as well as the general resistance to (or cautious use of) the Internet and secular media, are a few examples of how Haredi Jews disconnect themselves from broader society. To many (non-Haredi) Ashkenazi Jews,³¹ the Haredim can be viewed as 'ultra-Orthodox' or even 'extremist' Jews whose way of life is reminiscent of the *shtetls* in Eastern and Central Europe;³² a lifeworld that was left behind long ago by their émigré ancestors. Haredi Jews in the UK have been the target of unwelcome political and media attention as of recent, particularly regarding standards of secular education in Haredi schools, claims that so-called 'British values' are being refuted, cases of sexual and domestic abuse, harassment and intimidation of those who leave the fold, resistance to acknowledging and accepting gender and sexual diversity and controversies surrounding conjugal roles. The unwanted limelight brought by these examples signifies how experiences of marginality do not equate with being marginal in terms of public discourse and scrutiny (cf. Ecks and Sax 2005; Nijhawan 2005).

It is important to critically engage with the ‘ultra-Orthodox’ category that is imposed on Haredi Jews, especially in public (health) discourse, as it is an inaccurate description for several reasons.³³ The ‘ultra-Orthodox’ label implies a gradation of religiosity where one group is considered to be ‘ultra’ observant compared with other Jews, when the issue at hand is not the degree of observance but rather conceptual or cosmological differences in the essence of Judaism between groups or denominations (Watzman 1994: xi).

In Haredi worldviews there is nothing ‘ultra-Orthodox’ about living a life of Torah Judaism, which, in theory, is conducted in accordance with religious prayer and observance of the codex of law known as *halachah* (Figures 0.1 and 0.2), but also the customs (*min-hagim*) and stringencies (*chumrot*) that determine how elements of religious law and responsibilities are practiced. Despite nuanced differences in the conducts of these pious Jews, they generally regard themselves as the legitimate, authentic and authoritative bearers of Judaism. Haredi is the term that these religious practitioners often prefer to apply to themselves, which is drawn from the *Tanakh* (Hebrew Bible) and means ‘those who tremble at God’s word’ (Isaiah 66:5). Its current usage became common in the second half of the twentieth century – particularly to separate a wing of Judaism that differed in worldview and practice from what was previously considered ‘Orthodox’ (Baumel 2003).

The Haredim can be distinguished from Orthodox (and to a greater extent ‘modern Orthodox’) Jews by virtue of the latter group’s attempt to reconcile Judaism and *halachic* observance alongside mainstream society, employment and educational opportunities. Haredi Jews can be told apart by the aforementioned preference to be self-insulating, but also in terms of their socio-religious organisation. It is generally the case that Haredi Jews in England do not follow the religious authority of the ‘Chief Rabbi of the United Hebrew Congregations of the Commonwealth’,³⁴ and instead consult their own respective *Bet Din* or rabbinical elite (as was the case in Manchester).³⁵

Ashkenazi Haredim include two major wings, which formed out of an historical and cosmological opposition in Eastern Europe between the Litvak (Litvish)³⁶ and Hassidic (Hassidish)³⁷ Jews around the time of the mid-eighteenth century. Historically speaking, Litvish Jews were regarded as *misnagdim* (also *mitnagdim*), meaning opponents (or ‘the opposition’) of *Hassidut* (Hassidish philosophies) and its approach to mysticism. Hassidish groups are also diverse and

revolve around the authority of a *rebbe* and his particular teachings, philosophies and interpretations of the Judaic cosmology.³⁸ Jews of a Litvish origin now constitute a dominant culture in the Haredi world – particularly in Israel – and elite educational institutions (*yeshivot*) reproduce this socio-religious hegemony (see Hakak 2012).³⁹ The collective term Haredim also includes stringently religious Sephardi and Mizrahi Jews who trace their origins to Spain,⁴⁰ North Africa and the Middle East, though in the case of Manchester it was not unusual for them to assimilate into the structures of Ashkenazi and, more specifically, Litvish cultural dominance. While this book models the cultural dominance of Ashkenazi Haredim in Manchester, including their vernacular pronunciations of Hebrew and Yiddish inflections, their practices should not be taken as normative or more authentic over and above those of Sephardi and Mizrahi Jews.

Haredi men are identifiable by their outfit of a black suit, white shirt and black hat that has nuanced and important variations in brand or style: this has become the standard of Haredi dress for men, also adopted amongst the marginalised Haredi minority of Sephardi and Mizrahi origin in Manchester. Conforming to (Litvish) Haredi standards of dress occurs especially when young men attend *yeshivah*, and forms part of a broader strategy to discipline and control their bodies – a necessity for their spiritual lives to flourish (see Hakak 2012: 2). Hassidish men are identifiable by variations in garb, long *peyot*,⁴¹ and an emphasis on the Yiddish rather than English language (especially amongst males). These differences between Haredi Jewish groups are important because they can present nuanced influences and implications for navigating the external world, including health and bodily care.

The social dynamics and fragmentations of Jewish Manchester are thoroughly explored in Chapter One, but it is worth briefly mentioning here that there were occasionally degrees of commonality between locals. Haredim (usually Litvish) would refer to themselves using the Yiddish word *frum* (pious), and would also use it to describe others when signalling that a basic standard of religiosity and reliability around *halachah* was (or allegedly was not) kept in common. For this reason, and to avoid participants being internally identifiable, I often use *frum* rather than specifying the groups or lineages that interlocutors belong to (unless relevant).⁴²

I take issue with previous studies that describe the Haredim as constituting a form of ‘Jewish fundamentalism’ or Jewish

'fundamentalist enclaves'; terms often used in the context of Israel (such as Aran, Stadler and Ben-Ari 2008; Stadler 2009; and Hakak 2012).⁴³ The 'fundamentalist' label is imposed on minority groups but should be used with caution, as socio-religious movements ought to be considered in their own contexts, and recycling the term presents the risk of conflating the practices of disparate groups.⁴⁴ The term 'fundamentalism' (and also 'extremism') forms part of the socially constructed pursuits of religious authenticity that, in public discourse, are typically discussed at length in the context of Islamic groups. Applying blanket terms like 'fundamentalism' to the Haredim is not conducive to understanding the complexities at play for socio-religious minority *movements* – who might exist in a fluid and relational tie with the external world (cf. Stadler 2009). It casts religious groups such as the Haredim against an imagined and polarised construction of a liberal British 'norm',⁴⁵ which is not reflected in the current climate of social conservatism and fervent nationalism made visible by the 2016 'Brexit' Referendum.⁴⁶ Whilst Haredi Jews in England are positioned as part of a global and growing 'ultra-Orthodox' movement, this book explores the importance of (and relation between) cosmology and local context when attempting to understand conducts of health and bodily care that are not in the desired manner of 'compliance'.



FIGURE 0.1 Torah Judaism, Jewish Manchester. Photograph by Thomas S.G. Farnetti. © Wellcome Collection. Published with permission.



FIGURE 0.2 *Tefillin* (phylacteries), Jewish Manchester. Photograph by Thomas S.G. Farnetti. © Wellcome Collection. Published with permission.

The Jews and Haredim of Manchester

The United Kingdom has the second largest Jewish population in Europe (after France), currently numbering approximately 271,250.⁴⁷ The vast majority of Jews live in England, and almost all Haredim live in the settlements of North London, North Manchester (Northwest England), or Gateshead (North East England). Manchester is home to the UK's second largest Jewish and Haredi settlement after London,⁴⁸ and sits in a region of historical and contemporary significance.

The Orthodox and Haredi populations straddle the bounds of two different local authorities ('councils') within Greater Manchester, but are brought together under the assemblage of 'Jewish Manchester' in this book. This term is partly used to maintain the anonymity of participants and particulars, but also to emphasise how this Jewish population overlaps and overflows across administrative boundaries.

Jewish Manchester is viewed as an increasingly attractive destination to live as it boasts a lower cost of living than London as well as an established settlement with Haredi-led services to facilitate the assimilation of new arrivals. Much of the growth experienced is due to the Haredi preference for large families and their high fertility

rates. According to some estimates just under a third of Greater Manchester's 30,000 Jews are Haredi and approximately fifty per cent of all Jewish children under the age of five are born into Haredi families.⁴⁹

This ethnography is centred around the largely Orthodox, Haredi and Hassidish neighbourhoods, but rather than being demarcated areas, they overlap considerably by virtue of the small area that Jewish Manchester encompasses. An Orthodox, state-aided Jewish school was, for instance, nestled amidst streets populated mainly by Haredi and Hassidish families, who viewed the school as unsuitable for their own children. Many neighbourhoods were not exclusively Jewish but also punctuated with Mancunian,⁵⁰ South Asian and Eastern European locals. A mosque, Polish grocery stores, non-kosher restaurants and comprehensive schools are all dispersed within and around the Jewish settlement. Despite the territorial fluidity between Jews and non-Jews in Manchester, socio-religious divisions were maintained, perhaps as an attempt to limit the potential for encounters to destabilise established conceptions of 'purity' and 'danger' (cf. Douglas 2002).

Barth (1969) has argued that ethnic groups construct and fortify the boundaries of inclusion from exclusion, in order to protect social – and not necessarily territorial – integrity. The self-protective stance of Jewish Manchester reflects Barth's analytical delineation of what is internal and what is external as necessary to the protection of the social body, provoking immunitary responses at the (potentially dangerous) points of encounter with the state (cf. Esposito 2015). However, the proposed separation of internal and external along a boundary does not reflect the propensity for exchange between Jewish Manchester and the broader non-Jewish world, which I discuss in the context of Haredi cultures of health.

A frontier area or borderland, which encompasses instead the fluidity of cultural encounters and crossings, can more accurately describe the experience of minority groups at the margins of the state. Rather than a clear demarcation between the Haredim and the state, a frontier area instead casts attention to the space where they engage with each other. In the words of Wilson and Donnan, the frontier is a zone 'where rules are disputed and authority is confronted' (2006: 116). Health and healthcare then become a frontier area in which Haredi Jews and the state, as well as competing *authorities* on health and bodily care, interact. The potential for a frontier to expose Haredi Jews to what is positioned as belonging to outside the Judaic cosmology then make it a necessary space

to police and negotiate the extent to which influence is incorporated into the Haredi social body. The frontier area that draws the Haredim and the state together is essential to my broader reflection on the theoretical paradigm of Esposito, who discusses immunitary responses as targeting the location of a constructed threat, which is 'always on the border between the inside and the outside, between the self and other, the individual and the common' (Esposito 2015: 2).

(In)Security and Antisemitism

Debates around antisemitism and Jewish (in)security in the UK intensified during the 2013–2019 period under research, and they remain a lived reality that influences the perceived need for self-protection among Haredim. Firstly it is worth mentioning that the UK has among the lowest levels of reported antisemitism in the world (Staetsky 2017: 5). That being said, reported anti-Jewish hate crimes have been reaching peak levels year-on-year (Community Security Trust 2015, 2017a, 2017b, 2018). Antisemitism remains a major source of political concern for the UK Government, which pledged to fund private security guards and apparatus in Jewish schools nationwide after a series of violent attacks and provocations against Jews in Europe.⁵¹ The UK Labour Party, under the leadership of Jeremy Corbyn, has faced major and sustained allegations of institutionalised antisemitism, to the extent that Britain's three leading Jewish newspapers claimed in July 2018 that a Corbyn-led government would pose 'an existential threat to Jewish life in this country'.⁵² Following the Pittsburgh synagogue massacre in October 2018, the Home Secretary Sajid Javid attended a high profile vigil in London co-organised by the Board of Deputies of British Jews (2018) to offer reassurance that 'the threat level for UK Jews had not changed' – though it remains at severe.

The international events of July and August 2014 provoked particular tensions for the Jews of Manchester. Worldwide demonstrations and global attention followed the Israel–Gaza conflict of July 2014, which was ignited by the kidnapping and murder of three Israeli teenagers in the Occupied Palestinian Territories in June 2014. To my consternation, news sources aired the protests and counter-protests that had been consuming Manchester's city centre. It seemed the conflict had been repositioned to King Street, right outside an Israeli cosmetics company called Kedem, which consequently dragged the nature and demographic of the field-site under media scrutiny. Images of polarised and opposing

groups – seemingly of Manchester’s Jewish minority on one side and demonstrators on the other – came to epitomise my issue with how the research context was re-presented. Jewish institutions as well as local and national media coverage portrayed a united and intertwined ‘community’ under assault, and this is an image I critically engage with in Chapter One.

Responses in Jewish Manchester to the 2014 Israel–Gaza conflict and the string of attacks committed against Jews in Europe varied between prayers of redemption or of mourning, or city centre demonstrations organised by local Israel advocacy groups (Figure 0.3).⁵³ These responses indicated how Jewish Manchester did not sit in isolation from, but in relation to, events in the broader Jewish and non-Jewish worlds. Jewish Manchester itself was not immune from hate crimes. Two local Jewish cemeteries were targeted over the course of my research, with vandals desecrating, damaging and tagging swastikas on headstones, which heightened perceptions of vulnerability (see BBC News 2014; Halliday 2016). In 2017 two popular kosher restaurants in Manchester were set ablaze, one of which was being investigated by local police forces for ‘antisemitic hate crimes’ (Sugarman 2017), and no doubt fuelled many apprehensions that Jewish Manchester would face an act of targeted terror.⁵⁴ The preference for self-protection (which has implications for the relation between the state and the Haredi minority) must be cast against this backdrop of perceived vulnerability and the local



FIGURE 0.3 ‘We say no to antisemitism’ demonstration staged in Manchester, October 2014. Photograph by the author.

anticipation of a targeted attack. Contextualising the current experiences of antisemitism and the (in)security concerns among Jews in Manchester offers a point of comparison with the historical confrontations and conflicts faced by émigré Jews, which often occurred in the context of healthcare (Chapters One and Two).

A Recent History of Jewish Immigration to England

The UK became a significant destination for Ashkenazi Jewish immigration from Eastern and Central Europe during the years 1880–1914.⁵⁵ This period saw an exodus of up to three million Jews from the European continent, approximately 150,000–250,000 of whom settled in the UK (Dee 2012; Tananbaum 2004, 2015). Up to 30,000 of these émigré Jews had arrived in the already existing Jewish settlement in Manchester by 1914 – a time marked by growing resistance to ‘alien’ and Jewish immigration in the local area and country as a whole (National Archives n.d.).⁵⁶

Whilst London has historically been the Jewish stronghold of England both in terms of size and its degree of civic life, congregations flourished in industrial and trade centres across provincial England. A Jewish presence in Manchester dates back to around 1770–1780 when the (then) growing town had become an attractive and perhaps profitable destination for peddlers, gradually developing into a permanent Jewish settlement by the end of the eighteenth century (Rubinstein, Jolles and Rubinstein 2011; Williams 1976). Industrialism and commerce were dawning in Manchester at this time, and ‘Manchester Jewry grew with Manchester’ (Williams 1976: vii).

Manchester became a hub for émigré Jews throughout the nineteenth and early twentieth centuries because it was a principal industrial centre between the European continent and Liverpool (which was then a leading transmigration port to the United States).⁵⁷ Whilst Manchester was renowned for its industrial prowess as a ‘cottonopolis’ at this time, attracting some notable Sephardi and German Jewish merchants, most of the nineteenth and twentieth century émigrés laboured in trades such as tailoring or waterproofing (Williams 1979). The economic potential of Manchester was one ‘pull factor’, but it is also the case that many émigrés were fleeing pogroms, marginalisation and conscription, from across Eastern and Central Europe, particularly in Roumania, Galicia,⁵⁸ and Tsarist Russia.

Émigré Jews came to Manchester in waves. Immigration was presented as an issue around the 1840s when the poorer Polish Jews were increasingly considered to be a 'burden' to the settled minority (see Alderman 1992; Endelman 2002; Williams 1989). The pace of immigration picked up by the 1860s, continuing into the 1870s, and then increasing exponentially with the arrival of Jewish émigrés from the Tsarist empire between the years 1881–1914, the latter of which irrevocably changed the dynamics of the overall and local Jewish population (Rubinstein, Jolles and Rubinstein 2011). Russian and Polish Jews (Ashkenazim) already formed over half the minority population by 1875 and then over two-thirds by 1881 (Williams 1985; National Archive n.d.). It is important to note that, by 1875, the Jewish settlement was not divided between the established and the émigré Jews as two opposing groups, but a nuanced gradient formed of a 'highly tessellated and exceptionally mobile social scene' (Williams 1989: 91). Rather than one 'community', Jewish Manchester was historically produced by continuous flows of immigration that caused internal oppositions and inconsonance, which continues to resonate in the present day (Chapter One).

Moves to anglicise and assimilate 'foreign Jews' in England were typically spurred by their more established and integrated co-religionists who had achieved civil rights as a minority group in the UK in 1858 (coinciding with the period of increased immigration). The period of mass immigration then manifested in increasingly intensified strategies of assimilation and anglicisation (Williams 1989). Concerned with maintaining their improved position in English society, established Jews propelled and instituted deliberate strategies of socio-religious prophylaxis in order to convert "alien" refugees into young "Englishmen" (Dee 2012: 328).⁵⁹

Jewish Manchester was no exception to having a pro-anglicisation agenda for 'foreign' Jews, which, as will be discussed in Chapter Two, was achieved through Jewish health and welfare campaigns. The elite of the English Jews, and notably those who formed the Jewish Board of Guardians for the Relief of the Jewish Poor (inaugurated in 1867), mandated themselves to integrate émigré Jews and their children. Some Haredi Jews in Manchester resisted the assimilatory pressures of their anglicised co-religionists over the course of the nineteenth and twentieth centuries, often by establishing their own services and institutions of religious authority (see Williams 2011; Wise 2007).

The 'foreign' Jews and their children who arrived from Eastern and Central Europe had largely assimilated into Manchester's

Jewish social body by the middle of the twentieth century, with the stark contrast between the elite and émigré Jews and social gradient diminished, as well as the gradual northwardly move of the Jewish settlement. The imperative of anglicising and integrating the 'foreign' social body in the nineteenth and early twentieth centuries should be viewed in the historical context of immigration seen as posing a threat to the body of the nation from within. This was especially the case for Jews in the UK, where immigration policies sought to reduce the flow of, and deport, Jewish 'aliens' at the time (Cesarani 1992).

The rise of Nazism caused the last wave of Ashkenazi Jewish immigration to the UK and Manchester during the 1930s (and to a lesser extent the post-war years), with immigration policies at this time allowing entry to 'desirable' Jews rather than being altogether exclusionary (Kushner 1989).⁶⁰ Jewish immigration during Nazism has been well discussed by Williams (2011), who has challenged the established interpretation that the Jewish narrative of immigration is a wholly successful one of integration aided by a liberal and hospitable British society.

Jewish immigration to England is a much more layered narrative than is presented in public discourse, with a history of assimilatory pressures (engineered by both the established Jewish classes as well as the broader English society) and implicit and explicit expressions of antisemitic hostility.⁶¹ The Jewish population of the UK dropped from its estimated high of 420,000 in the 1950s to the current number of below 300,000, largely because of ageing, migration, assimilation and inter-marriage (Abramson, Graham and Boyd 2011; Waterman and Kosmin 1986). The growth of the Haredi population can be viewed as a counter-balance to this historical experience of assimilative pressures and practices, with self-insulation and self-protection now serving as a survival strategy. Chapters One to Four substantiate this introductory discussion by juxtaposing archival material with ethnographic research to illustrate the historical continuities (and also discontinuities) in how health has been negotiated alongside issues of assimilation, insulation and integration for the Jews of Manchester over time.

Researching Historically-Situated Jewish Worlds

The dialogue I construct between historically situated Jewish worlds in this book captures the narrative of my research and my narrative

as a researcher. The émigré Jews who arrived in Manchester tell the story of my own great-grandparents who migrated at the turn of the twentieth century to Paris, Liverpool and Dublin; where my grandparents were born and raised as French and British Jews. My grandmother was born in 1920s Dublin under the care of a local Jewish midwife, Ada Shillman, which sparked my interest in how cultures of maternity and infant care among Jews have shifted over time. My own experience of living with the Jews of Manchester as a Jewish (or Jew-ish) ethnographer, as I go on to discuss, reflects a conceptual critique of this book in that it disrupts the idealised image of a 'community' and how this category is deployed in public (health) discourse.⁶²

Manchester became the focus of this book as it is home to a rapidly growing Jewish population, yet there is little ethnographic record tracing the on-going changes in the region's Jewish dynamics (with most attention focused on London). From 2014 to 2015 I lived on a street described by many as being in the *cholent* or *chamin* pot – a reference to a traditional dish stewed gently from Friday sundown and served on *Shabbos* or *Shabbat* afternoons.⁶³ Whilst this metaphor was made in reference to the neighbourhood's standards of piety, I instead saw how the imagery of pulses, brisket or meat, potatoes and grains sitting closely within a pot reflected the nuanced diversity and internal tensions in Jewish Manchester (Chapter One).

The home I shared with young Jewish people was a short walk from local synagogues (*shuls*),⁶⁴ kosher grocers and cafés, Jewish schools and community spaces and projects, which enabled me to become immersed in the social world of Jewish Manchester and develop a rapport with local families. I was soon invited for *Shabbat* meals and eventually earned the trust to childmind for some *frum* families, gaining close insights into processes of social reproduction and discussions around family health and childrearing. My research participants consisted of *frum* Jewish families and locals, male rabbinical authorities and *rebbetzins*,⁶⁵ and maternity carers (midwives, doulas and postnatal support). The majority of my interviews were semi-structured and conducted in English, often laced with Yiddish and Hebrew phrases. Interviews were recorded with permission and transcribed, and I made written notes when interlocutors preferred not to have their interviews recorded. The names of all participants have been changed to protect their identities.⁶⁶

Married *frum* women were my main interlocutors because family health is considered to fall in their domain. Yet it was a constant challenge to comprehend what would be (un)acceptable to women

regarding the stringencies they applied to interactions with the opposite gender and whether they would prefer to meet in a private or public setting.⁶⁷ Enquiring about intimate areas of women's health was something that I was conscious, and at times, nervous about. The maternity carers (who form the core of Chapter Three) were sensitive and patient with my questions, but also assertive, with one midwife reminding me that 'no uterus means no opinion'. My relatively young age, twenty-six at the start of fieldwork, perhaps made *frum* women more open to meeting for an interview and I imagine that this can be explained by the context in which the encounters took place. The women I interviewed were all married with children or grandchildren, and I was likely granted a status akin to 'boy' or 'youth' considering the fact that I am an unmarried man and, at the time, was engaged in full time learning at Durham University – perhaps similar to their own boys who might be studying at prestigious *yeshivot* (or in *kollelim* if they were married) away from home.

My gender was less of an issue than my soul and blood, and the conflicts I did experience were rooted in opposing definitions of who is a Jew. Orthodox and Haredi Judaism determine a Jew as being born from a Jewish mother or through a conversion performed under a 'reputable' *Bet Din*.⁶⁸ The British Liberal and Reform movements are by contrast equilineal, meaning Jewish status is transmitted through either parent. In being a patrilineal Jew and active in Liberal Judaism, I presented an anomaly for the Jews of Manchester as I was not recognised by them as Jewish but could mobilise an understanding of law and customs, as well as the Hebrew language. My positionality in Jewish Manchester was determined by my mother's womb, despite my Jewish practice and patriline, and the fluidity of my multi-ethnic and multi-national family ties.

Liminality is often constructed as being 'dangerous, inauspicious, or polluting' (Turner 2002: 368), and it frequently seemed as if I embodied the threats which Haredi Jews seek to protect themselves from – integration, assimilation and most grievous of all, intermarriage. I became entangled in a conflict of what is constructed as internal and external to the Haredi Jewish cosmology: research participants would project their social-constructions of normative Judaism against me and, in turn, that which is cast as belonging to the external (and thus non-Jewish) world was then constructed through me as a medium. At the core of this is the aforementioned issue that Haredim regard themselves as the authoritative bearers of Judaism. I found that some research participants used particular

methods to reinforce their positioning of me. One such example was *Shabbat* observance and being used as a *Shabbos goy*,⁶⁹ or being referred to as a *Sheigetz* – a highly derogatory Yiddish word for a non-Jewish male meaning ‘impure’ or ‘abominable’.⁷⁰

It is likely that some locals agreed to meet me because they assumed I was Jewish according to their exclusive definition. Whereas some Haredim accused me of being deceitful when I would later discuss my diverse family background, I instead argue that the issue rests in different conceptions of what constitutes Jewish belonging and identity. How I positioned myself as Jewish – and how I was positioned as Jew-ish or *goyish* – in Manchester became a continuous process of negotiating and navigation that was constantly in a state of flux, and was an experience that tested my own identity and perhaps those of my interlocutors too.

Understanding the shifting dynamics of Jewish Manchester required a close consultation of the rich history of Jewish immigration to the region, and my research involved delving into historical records at the Manchester Archives & Local History and listening to hours of oral histories housed in Manchester’s Jewish Museum. The majority of archival documents explored were annual reports and records of various Jewish welfare groups originating from the peak period of Ashkenazi Jewish immigration and up until watershed periods such as the establishment of the NHS in 1948. Like previous ventures of historical anthropology I have sought to examine archival ‘documents themselves as the equivalent of field notes’ (Ovesen and Trankell 2010: 3). Yet archival documents are not immune from critical-engagement, and most pertaining to Manchester’s former Jewish Quarter are written from the perspective of the Anglo-Jewish elites and clearly narrate their assimilatory agenda, with little trace of the perspectives of ‘foreign’ Jews and Jewish women (see also Williams 1979). The oral histories instead offered an invaluable narration of the émigré experiences. The purpose of placing archival documents and oral histories alongside my own ethnographic field-notes is to juxtapose historically-situated contexts and illustrate how healthcare emerges as a recurring area of intervention.

Healthcare provision in England has, of course, changed radically from the period when émigré Jews settled in a pre-welfare state to the current scope of NHS care, which is among the largest employers in the world. Thus émigrés and Haredim today also encounter remarkably different systems of healthcare. Émigré Jews in the nineteenth and early twentieth centuries often had to contend with small-scale, fee-paying and voluntary-led services that ran along

religious lines, and the poorest would have to negotiate the coercive tactics of Christian missionaries (Chapter Two), which is a therapeutic landscape that Haredi Jews do not tread through today. The proliferation of biomedical technologies has recalibrated maternal health and infant survival since the mid-twentieth century, which, on the other hand, presents contemporary Haredim with unprecedented moral dilemmas around motherhood and reproductive decision-making. While the context of care has certainly shifted across these historically-situated periods of time, my comparative approach pinpoints how healthcare remains a borderland where anxieties around integration, assimilation and protection are continuously performed.

(Re)Presentation

Many residents were concerned with the implications of my research and the way in which Jewish Manchester would be represented in this book. How (Jewish) minority groups are represented is a particularly sensitive issue as my critical reflections could be misappropriated and used to propagate antisemitic or xenophobic vitriol in Britain's post-Brexit climate. Fader has remarked on the challenge of representing Hassidic Jews in Brooklyn within 'the politics of contemporary ethnography where the "informants" are literate, politically active, and engaged in their own representation' (2009: 17; also Arkin 2014). In the UK there are established Jewish bodies that represent and re-present the minority's public image at the national and regional levels. It is also worth noting that there are Haredi-specific representative and security bodies, even though the Haredim may rely or cooperate with services from the broader Jewish population. The settlement in Manchester was not politically impotent, and there is indeed access to professional skillsets such as legal and media representation within (or within reach of) the Haredi social body. An issue I became mindful of was how representations of Haredi Jews in my research could conflict with the way in which they articulate their own representations, with the difference being that ethnography 'does not speak *for* others, but *about* them' (Comaroff and Comaroff 1992: 9 [emphasis in original]).

Locals warned me on many occasions that I had a responsibility to ensure that my research would not endanger 'the community', or fuel an exposé of Jewish Manchester. Some locals also asserted that my outsider-status meant that I would be unable to reach particularly protective parts of the settlement, signalling that my research might not be representative of all Haredi Jews in Jewish

Manchester. In both of these instances, it was clear to me that many locals were concerned with how the Haredim (as a collective) would be represented in the public domain through this book.

Several issues explored by the book offer important implications for healthcare delivery strategies, such as understanding the role of religious authorities in determining access to birth spacing technologies and health information (Chapters Two and Three). As a Jewish (or Jew-ish) ethnographer I felt a personal conflict about how to discuss such issues, which could well be misappropriated and 'used against the community', as some locals feared, perhaps also resulting in accusations that I had 'aired dirty laundry in public'. Some areas of my research also challenged my own position as an active participant in feminist struggles for gender justice as well as sexual and reproductive rights. I ultimately decided to discuss health encounters that may appear controversial as it is essential to produce a substantiated representation of the Haredim, and the diverse ways in which sensitive areas of healthcare are approached in order to avoid propagating the narrative of a homogenous 'ultra-Orthodox Jewish community' in public health discourse. As an anthropologist, however, how I wrote this book also had to be constantly balanced against the contemporary climate of xenophobia, which, as mentioned, has had significant implications for ethnic and religious minority groups in the UK.

Outline of the Chapters

Part One critically engages with a public health discourse which represents Haredi Jews as a monolithic 'ultra-Orthodox Jewish community' at the 'hard to reach' margins of the state. Whilst the social fabric of Jewish 'community' life might appear tightly-woven from the outside, in Chapter One I unravel the historical layers of dissent and difference which demonstrate how representations of a Jewish 'community' are not only a romanticised figment of the imagination but also have the effect of concealing nuanced differences of need. Historical material exposes how increasing Jewish immigration amplified social and medical racism in Manchester, creating anxieties around the positionality of the broader and established Jewish population. Chapter One goes on to set out how internal fragmentation is often caused by a multiplicity of worldviews whose interaction can be perceived as dangerous or contaminating, and addresses how aspirations of self-protection are manifested.

In Chapter Two I discuss the implications for healthcare delivery strategies that emerge from the heterogeneity of Jewish Manchester and the preference for self-protection among Haredi Jews. Rather than being 'hard to reach', healthcare is contextualised as a frontier area in which Haredi Jews and the state interact, and thus the site of 'immunitary reactions' (cf. Esposito 2015). I establish a dialogue between archival material and ethnographic research to illustrate the recurring ways in which mainstream healthcare requires negotiating in order to uphold the *halachic* guardianship of Jewish bodies – or the interpretations that are propagated by religious authorities. Health and bodily care are presented as marking a struggle of integration, insulation and assimilation for the Jewish settlement in Manchester. My aim in Chapter Two is to articulate how Jews in Manchester have specific needs as well as expectations of health and bodily care that remain poorly understood over time, which prompts institutionalised and increasingly creative responses to meet the shortfall of state services. However, the autonomy to provide culturally-specific care within the Haredi settlement can have the repercussion of obscuring and over-ruling individual needs in order to protect the social body as a whole. This chapter contrasts the 'hard to reach' label that is imposed on Haredi Jews with the emic constructions of health and bodily care to introduce how multiple expectations around healthcare exist in Jewish Manchester.

Part Two explores how maternity and infant care bring the individual body into a contest of guardianship between the biomedical and Judaic cosmologies and how certain health interventions are negotiated by Haredi Jews. Chapter Three illustrates how reproduction and maternity care are positioned in the gaze of both the biomedical and Judaic cosmologies, and more specifically as areas of intervention. This chapter focuses on the maternity care provided by pious doulas (and to a lesser extent midwives), who attempt to birth the Jewish social body within the mainstream biomedical culture and moderate the dominance of biomedically-oriented care. I frame reproductive 'interventions' as having opposing conceptualisations – being enacted by both the biomedical authority, but also the Haredi doulas, who protect the social body by negotiating potentially disruptive areas of biomedical maternity care, such as antenatal screening surveillance, caesarean sections and birth spacing technologies ('contraception').

Chapter Four cross-examines an international public health discourse that represents Haredi Jews as having a low uptake of childhood immunisations, and uses the context of Manchester to discuss

the issues that underlie responses to vaccinations. The chapter challenges the reductionist representation that the ‘ultra-Orthodox Jewish community’ has a uniform issue with ‘compliance’ by narrating the complex ways in which local Haredi mothers navigate this sensitive arena of child health. The focus of this chapter is on critiquing the representation of Haredi Jews as being opposed to vaccinations because of their ‘religious beliefs’ or ‘cultural factors’. Vaccine hesitations are informed by parental concerns of safety as well as experiences of ‘adverse reactions’, which the public health authority is viewed as failing to address. Haredi Jewish parents consequently view public health guidance with mistrust, thus echoing many studies previously conducted in the UK. The concerns observed in Jewish Manchester are not dissimilar to vaccination anxieties across the ‘general’ population of the UK, suggesting that modes of acceptance, delay and outright opposition to immunisations on the part of Haredi Jewish parents should be understood in the context of them constituting a minority group in the UK – where public controversies have previously occurred. I use this chapter to critically engage with public health discourse by reflecting on the work of Esposito (2015).

The last word or *sof davar* of this book concludes with a discussion of the opposing constructions of protection and immunities that exist for the Haredim of Manchester and the state, and which become intensified around reproduction. A view from the vineyard exposes how antonymic strategies to preserve the collective lives of the social body and that of the nation are sanctioned.

Notes

1. The term ‘authoritative knowledge’ is borrowed from Jordan (1997).
2. Kosher: acceptable or permissible according to the codex of dietary laws (*kashrus* or *kashrut*).
3. To avoid confusion, I henceforth use ‘immunity’ to refer to the biomedical construction of the term, and italicise the term to indicate the social construction of *immunity* in the Haredi context. I use ‘immunities’ (plural) to refer to opposing uses of the term. References to Esposito’s (2015) paradigm of immunity (*‘immunitas’*) are clearly made in text.
4. An ‘émigré’ is a person who has left their own country in order to settle in another, typically for political reasons. In my opinion the term émigré is more appropriate than ‘immigrant’ or ‘refugee’ to describe the broader context of Ashkenazi Jewish relocation to the UK and

Manchester over the course of the nineteenth and twentieth centuries due to persecution and socioeconomic marginalisation in Europe (see Chapter One).

5. Following past studies in the field (Greenough, Blume and Holmberg 2018) I use vaccination and immunisation interchangeably.
6. Public Health England is an 'executive agency' sponsored by the Department of Health. It is entrusted with several responsibilities regarding the health of the nation, and supporting citizens to 'protect and improve their own health' (Public Health England n.d. A). Previous studies, for instance, have remarked how there is a 'huge cultural gulf' between Haredi groups and health services in Manchester, the latter of which is apparently in need of a 'crash course in Judaism' (Wineberg and Mann 2015). It is also important to note that in critically engaging with public health and biomedicine, I do not deny the need and merits of these services.
7. In this book I use the term 'public health authority' (or authorities) interchangeably with Public Health England and international counterparts by virtue of their mandate to formulate authoritative knowledge (cf. Jordan 1997), guidelines, and schedules pertaining to maternity care and child health interventions.
8. For examples of public health discourse and studies that make reference to Haredi Jews, see Anis et al. (2009); European Centre for Disease Prevention and Control (2012); Henderson, Millett and Thorogood (2008); Lernout et al. 2009; Local Government Association and Public Health England (2013); Muhsen et al. (2012); Public Health England (n.d. B; 2016); Stein-Zamir et al. (2008); World Health Organization: Regional Office for Europe (2013, 2016).
9. Lay authorities in Haredi lifeworlds can take the form of informal 'helpers' or 'doers', known as *askonim* (vernacular) or *askanim*, as well as maternity carers (Chapters Two and Three).
10. Throughout this book the terms 'ultra-Orthodox', 'community' and 'hard to reach' appear in quotation marks to critique their common yet problematic usage, particularly in public health discourse.
11. Scott (2009) cites Benjamin and Chou (2002) for coining and applying the term 'dissimilation' in the context of social groups in the 'Malay world'. I prefer Scott's (2009: 173–174) elaboration of 'dissimilation' as 'the more or less purposeful creation of cultural distance between societies'. All references to dissimilation in this book are made in reflection of Scott's (2009) use of the term.
12. Rather than propagating the term 'community' (critiqued in Chapter One), I use 'settlement' to reflect the experience of émigré Jews settling in the UK and the aspirations of Haredim for a lifeworld that is as self-protective and autonomous as possible. My specific interpretation of the term settlement should not be conflated with use of the term settlements in other contexts.

13. Instrumental to this argument is Foucault's (2006) paradigm of 'governmentality' as well as a broader body of work focusing on power relations between the state and minorities and marginalities (such as Das and Poole 2004; Lock and Farquhar 2007; Ong 1990; Scott 1985, 2009), which offer a backdrop to most appropriately conceptualise responses to public health interventions. The paradigm of immunitary protection and reactions spearheaded by Esposito (2015) enriches my reflections on marginality and minority-state relations in the context of health and bodily care.
14. Use of the term 'hard to reach' in public health literature has attracted little critical reflection among anthropologists. I interpret the 'hard to reach' label as warranting an intervention of the body politic on the part of the public health authorities, which attempts to survey and control the individuals that constitute a social body – with the ultimate aim of assimilating differences and incorporating this social body within the body of the nation.
15. Studies have articulated how these social groups, including homeless persons in urban areas of France, can view the health authority with mistrust and thus require the careful outreach of health services in order to enable social inclusion through the institution of medicine (Sarradon-Eck, Farnarier and Hymans 2014).
16. See Jakobson (2013: 356–357) who discusses the English dominance of British historical consciousness. The reference to 'imagine' is taken from Anderson (2006).
17. See Mahmood (2016: 60), who charts the historical relation between minority rights in Europe and regional, national, and geopolitical security. She describes minority rights and religious liberties as 'strategies of secular liberal governance aimed at regulating and managing difference (religious, racial, ethnic, cultural) in a national polity'.
18. The margins of the state have been conceptualised as 'both a lived reality and a site of intervention' (Nijhawan 2005; Das and Poole 2004).
19. Lock's analysis of the body offers a useful point of departure to critically reflect on the relation between minority groups and public health interventions. In her words, 'The body, imbued with social meaning, is now historically situated, and becomes not only a signifier of belonging and order, but also an active forum for the expression of dissent and loss, thus ascribing it individual agency. These dual modes of bodily expression – belonging and dissent – are conceptualized as culturally produced and in dialectical exchange with the externalized ongoing performance of social life' (Lock 1993: 141).
20. As Ong (1990) has discussed in the context of Malaysia's Muslim population, who form a national majority.
21. See Farquhar and Lock (2007: 2), who note that 'in law it [the body] has been seen as the only possible basis for the citizen's responsibility to act and to choose'.

22. I use the term 're-present' to underscore how images are articulated again or anew for particular effect.
23. Many anthropological studies narrate how the intended beneficiaries of global public health interventions respond in unexpected ways. See, for example, Jolly (1998); Root and Browner (2001); Parker, Allen and Hastings (2008).
24. 'Concordance' has instead been suggested as an alternative term that realigns patient–practitioner relations to resemble an agreement over treatment regimes (Ballard 2004). Yet the limitations of concordance (as an agreement) are seen when there is an expectation to follow rigid or 'routine' schedules, as is the case for vaccinations. Parents who choose to negotiate acceptance of vaccinations by delaying uptake or selective acceptance are nonetheless regarded as 'non-compliant' in studies of child health in England (see for example Cassell et al. 2006: 786), which therefore demonstrates the limits of a negotiated 'concordance' in certain arenas of healthcare. In this regard, 'concordance' and 'compliance' become interchangeable.
25. See also Harper (2010), who discusses how global public health legislation may entail the use of possible sanctions in order to 'ensure' (or what might be regarded as coercing) 'compliance' with regimes to control forms of drug-resistant tuberculosis.
26. The term 'hard to reach' is also used to describe Haredi Jews in Israel in the context of vaccination coverage (Stewart-Freedman and Kovalsky 2007). Concerns about vaccination uptake among Haredi Jews are not specific to the UK, but also Israel, where apathy and hostility towards public health services 'result in a failure to vaccinate' (Anis et al. 2009). However, important differences between the Haredi contexts of Israel and England remain (Chapter Four).
27. See Abu-Lughod (2002), who critiques the emphasis placed on the socio-religious construction of gender in Afghanistan that warrants intervention and 'saving' rather than the historical or political production of context.
28. The triple antigen immunisation against measles, mumps, and rubella (MMR), see Chapter Four for a more detailed discussion.
29. In Foucault's words, 'Discipline was never more important or more valorized than at the moment when it became important to manage a population; the managing of a population not only concerns the collective mass of phenomena, the level of its aggregate effects, it also implies the management of population in its depths and its details' (2006: 141).
30. Quoted from Geoffrey Alderman ([*The Jewish Chronicle*] 2012).
31. Ashkenazi is generally a reference to 'ethnic' background for Jews of Eastern and Central European origin.
32. Small town with a large Ashkenazi Jewish population, historically in Eastern and Central Europe.

33. Some Haredi Jews may describe themselves as ultra-Orthodox, often to distinguish themselves from Jews positioned as less religiously observant (according to Haredi standards of piety).
34. Ephraim Mirvis currently holds the position of 'Chief Rabbi of the United Hebrew Congregations of the Commonwealth', which represents the anglo-Orthodox Jewish consortium (United Synagogue) and allied institutions.
35. Court of Jewish law, *Beis Din* was the vernacular in Manchester among Ashkenazi Haredim.
36. Noun, Litvak (Litvish was the vernacular adjective in Manchester) descend from Jews in the historical region of the Grand Duchy of Lithuania (which now spans several states including Lithuania, Belarus, Latvia, and parts of Poland). Litvak Jews maintained a *shtark* (strict or pious) culture of scholarship and study of religious texts, and Litvish *yeshivot* continue to form the elite and socio-religious hegemony in Israel (see, for instance, Hakak 2012). Although Litvish and Hassidish Jews constitute major branches of the Ashkenazi Haredim, there are also other sub-groups such as *Yeshivish* and *Yekke* (German origin).
37. 'Hassidish' was the vernacular term in Jewish Manchester, and is used throughout this book.
38. Hassidish groups (or 'dynasties' as they are often referred to) are typically named after the towns in Central and Eastern Europe from which they originate (e.g. Belz, Ger, and Vishnitz). Manchester was home to a range of Hassidish groups including Satmar, Belz, and Chabad Lubavitch.
39. *Yeshivah* (sing.), *yeshivot* (pl.) are institutions for the immersive study of religious text, which can begin from as early as fourteen years of age in some Haredi circles.
40. Sephardi Jews are of Spanish and Portuguese (Iberian) origin. Following the expulsion of the Jews from Spain in 1492, Sephardi Jews were broadly dispersed and were eventually the first Jews to re-settle in England. The term Mizrahi is also used by Jews who trace their origin to the Middle East, such as Iran and Iraq.
41. Side-locks that men are religiously mandated to maintain. Whereas Litvish Jews usually have discreet *peyos* (also *peyot*) that are tucked behind the ears, Hassidish Jews generally have long and dangling *peyos* but short hair.
42. In some cases I have also changed the particulars of participants to prevent them from being internally identifiable.
43. It is also important to note that some Haredi groups in Israel can be framed as 'extremist' or 'fundamentalist', in part, because they oppose Zionism and do not recognise the authority of the state of Israel – which they view as contrary to the Judaic cosmology (Chapter Four). The specific context in which Haredi Jews are portrayed as 'extremist'

- in Israel (such as opposition to Zionism) is not be transferrable to the UK context.
44. To a similar extent the representation of Haredi Jews as being 'non-liberal' (such as Fader 2009) is in danger of binding a group as one defined category, when what is true of any 'community' is its diversity. Fader (2009: 221) states that the term 'nonliberal' necessitates a juxtaposition of religious movements with socio-cultural constructions of liberalism as well as the politics of modernity – with these often being entangled amongst each other – as has been discussed and critiqued in the past (see Abu-Lughod 1998). The term 'nonliberal', for instance, has also been used to describe the position of Muslim women in what Mahmood (2005) regards as a 'politics of piety' in Egypt.
 45. The term 'liberal' has been critiqued in anthropological discourse, and Asad views it as comprised of values that are 'more contradictory and ambiguous than is sometimes acknowledged' (2011: 36).
 46. Brexit is a common reference to the United Kingdom's 2016 Referendum to withdraw from the European Union, the result of which was (at least in part) inspired by xenophobic and anti-immigrant discourse and resulted in public displays of racism towards minority groups (Kasstan 2016; Stein 2016; Sayer 2017). Record levels of hate crimes were observed across the UK in the first three months after the Brexit referendum (BBC News 2017), including anti-Jewish hate crimes (Community Security Trust 2017).
 47. See Statesky and Boyd (2015). This approximate figure is taken from analysis of the 2011 census, but should be viewed with caution as detailing religious affiliation is not compulsory in the UK census and may therefore not record the total figure of people who self-identify as Jewish.
 48. Manchester is used as a reference point and collective shorthand by Jews in the UK for what is actually a broad area spreading across different administrative areas and local authorities.
 49. Wise reported in Manchester University News (2007).
 50. Demonym of (and colloquial reference to) somebody originating from Manchester. Burman (1982) uses the term 'Jewish Mancunians' to denote differences between Manchester's populations, yet I found that the term 'Mancunian' was used explicitly in reference to non-Jews.
 51. These attacks included the unleashing of a Kalashnikov rifle at the Jewish museum of Belgium, Bruxelles, killing four people in May 2014; the siege of a Parisian kosher supermarket in January 2015 that saw multiple Jewish hostages held, four of whom were executed; and the fatal shooting of a Jewish security guard outside the Great Synagogue of Krystalgade, Copenhagen, in February 2015. In December 2017 a masked gang launched Molotov cocktails at a synagogue in Gothenburg, Sweden, days after the President of the United States officially recognised Jerusalem as the capital of Israel.

52. See *The Jewish Chronicle* (2018).
53. The 'Say no to antisemitism' demonstration (October 2014) was organised by 'The North West Friends of Israel', an Israel advocacy group.
54. Central Manchester became the focus of international attention on 22 May 2017 when a suicide bomber attacked a music concert killing twenty-two people and injuring over one hundred. Shortly after the arson of Manchester's kosher restaurants in June 2017 a mosque was torched in what was considered to be an anti-Muslim hate crime, indicating a concerning pattern of targeted arson attacks against ethnic and religious minority groups in the Manchester region.
55. In this book I focus on the historical waves of Jewish immigration to England, and Manchester during the nineteenth and early twentieth centuries, but Jewish history in England traces as far back as the medieval period. The medieval narrative is dominated by bloody massacres and accusations of blood-libels until England became the first sovereign state in Europe to expel its Jewish minority in 1290. Jews were not able to resettle in England until the seventeenth century, under the authority of Oliver Cromwell. Sephardi Jews were among the first to resettle in the UK, but now constitute a marginalised minority of the Jewish population in the UK (Chapter One).
56. The Jewish population of Manchester had numbered around 1,800 Jewish people in the 1850s, twenty-five per cent of which were of Eastern European origin (see Alderman 1992; National Archives n.d.). The majority of Jews were of German and Sephardi origin (see Archives Plus n.d.). By 1881, eighty-three per cent of Jewish heads of household in Red Bank, Manchester, were born abroad (see Vaughan and Penn 2006).
57. Immigration to Manchester reoccurred in the 1930s due to the rise of Nazism in Germany and the '*anschluss*' (Nazi annexation of Austria), (see Williams 2011).
58. Galicia has historically had a substantial Jewish population. This region in Eastern Europe was formally under the Austro-Hungarian Empire until 1914, and now sits within the borders of Poland and Ukraine.
59. Sport was used as a particular strategy to anglicise (often male) Jewish children (see Dee 2012).
60. Resistance to Jewish immigration was a political demand and agenda of the British Union of Fascists at the time, and can be situated in a broader historical narrative of antisemitism in the UK (see Chapter One where I discuss this in relation to the medical establishment). Similar to the internment of 'enemy aliens' during 1914–1918, many German (and Austrian) Jews became classed as 'enemy aliens' upon the outbreak of the Second World War irrespective of their refugee status (see Kushner and Cesarani 1992).
61. UK politicians describe the Jewish 'community' as a 'model of integration' (Board of Deputies 2016; UK Government 2012), which should be understood against a historical backdrop of social exclusion.

62. A revised version of Kasstan (2016a).
63. Ashkenazi, *cholent*; Sephardi, *chamin*. The preparation of *cholent/chamin* avoids prohibitions of cooking on *Shabbat*.
64. Yiddish, synagogues. Used vernacularly in place of synagogue, also in some local Sephardi circles.
65. Yiddish, wife of a rabbi.
66. I have not anonymised names discussed in archival records and oral histories, as this material is essentially ‘open access’ by virtue of being openly accessible to the public.
67. To interview or even meet informally alone with an unmarried woman, particularly those attending seminaries (often shortened to sem), however, would be unacceptable in the Haredi worldviews. Young Haredi Jewish women in England attend sem around the age of sixteen to eighteen for one to two years as a preparatory stage before marriage, or university for modern Orthodox girls.
68. Reference to ‘reputable’ taken from The United Synagogue (n.d.). A *giyur* or ‘conversion’ performed under one *Bet Din* is not unanimous and does not mean recognition by another *Bet Din* or denomination.
69. Goy(im), sing/pl. Literally ‘nation(s)’, the term ‘goy’ (singular masculine) or ‘goyim’ (plural) is generally used pejoratively to describe a non-Jew and their conducts (*goyish*). *Shabbos goy* means using somebody positioned as a non-Jew (by definition of *halachah*) to perform tasks that a Jewish person is prohibited from doing on *Shabbat*.
70. *Sheigetz* is derived from the Hebrew word ‘*sheketz*’.

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Part I

'COMMUNITY' HEALTH

Chapter 1

THE PURSUIT OF SELF-PROTECTION

In December 2014 I visited the Manchester Jewish Museum, which inhabits a deconsecrated Sephardi synagogue in the area that was formerly the Jewish Quarter. Sara, a volunteer guide, articulated the complexities and difficulties of the nineteenth and early twentieth centuries for émigré Jews, and she told me that the vast majority of them were destitute and settled in the area stretching off Manchester Victoria railway station. Émigré Jewish neighbourhoods sat in the shadows of the city and formed a significant part of the slum areas of Red Bank and lower Strangeways.¹ The main reason for moving to the slums was poverty and the proximity to the station, for the émigré Jews would have been travelling ‘a long way, [when] you left God knows what behind you in horror or poor circumstances’ (Sara). Whilst many of the émigré Jews were escaping pogroms and penury on the European continent, Sara emphasised how many also came ‘not in need, but in preference, because tradings were good and Manchester was *the* area to be in the world, rivalling London’.

With such close proximity to Manchester Victoria, continuous immigration meant the slum areas of Red Bank and Strangeways became ‘absolutely saturated with Jews and Jewish culture’ (Sara). This Jewish Quarter, she went on to say, sat ‘cheek by jowl’ with the wider émigré and ‘indigenous’ populations that were just as financially marginalised, often leading to tense and hostile relations. The aspiration for many Jewish families at this point was to climb from the areas within and surrounding ‘the slums’ and move well in to,

and north of, Cheetham Hill and Hightown. These areas, according to Sara, were home to what people called the ‘alrightniks’, because by then ‘you’d made it, you’d done alright for yourself [whereas] down there you had a community of people who needed food and shelter’.

Only a remnant of this ‘illustrious Jewish past’ (as Sara put it) remains, since families began to gradually move northwards into leafier and often more affluent districts – the Jewish Manchester I came to know. Traces of the bygone Jewish Quarter can still be seen in the convenience and grocery shops now owned by émigré families originating from South Asia, alluding to an enduring narrative of immigration and integration for diverse ethnic groups in this corner of England (Figures 1.1 and 1.2).

Jewish Manchester has changed considerably in size, diversity and intensity over generations, and is now home to among the fastest growing Haredi populations in the UK. Mrs Kushner, a (Litvish) Haredi local in her sixties, told me that Jewish Manchester used to be smaller and tightly woven, resembling ‘an area in Jerusalem called *bayit v’gan*.² It was just a garden in between the neighbours. Manchester was a little bit like that, everybody knew everybody’. Relations between Haredim and the broader Jewish and non-Jewish populations are nowadays marked by a mutual gap in understanding, and Sara claimed the former are ‘terribly *defensive*, so what secular people – and lets get this right – what secular people regard as hostility, is fear’ (emphasis added). Sara clearly had a stake in re-presenting a particular view of Jewish Manchester as a Museum guide, and she was careful to put across the correct image. Yet her comment signposts how the image of a garden in between the neighbours has, to paraphrase the epigraph of this book, come to resemble vineyards surrounded by (de)fences to separate what is seen to be kosher from what is not.

This ethnographic vignette offers a stepping-stone to explore the shifting social dynamics that occur over time among the Jews of Manchester, and in this chapter I look closely at how a historically self-sufficient Jewish settlement has become increasingly protective against internal diversities as well as the external world. Unravelling the socio-religious composition of Jewish Manchester illuminates how Haredim have nuanced health and wellbeing needs as well as expectations, which are often obscured by the term ‘community’ (Chapter Two).

Economic, socio-religious and ethnic multiplicity in the historic Jewish Quarter manifested in a gradation of internal marginalities

that is continuous with the present day topography of Jewish Manchester. In what follows I first narrate the implications of consecutive flows of immigration during a period of heightened social and medical racism, and the consequent attempts to incorporate émigré Jews into the established Jewish social body and integrate them into the body of the nation. I then discuss how internal dissonance in the present-day Haredi settlement rests on differences in worldviews or religious outlooks (vernacularly termed *hashkofos*),³ the coming together of which can be viewed as dangerous to local moral orders. The representation of a homogenous ‘ultra-Orthodox Jewish community’ can be understood as an imagined and amalgamated category that does not reflect the realities of Jewish Manchester.

The ways in which Manchester’s Haredi settlement attempts to meet its own socioeconomic and material needs has the effect of maintaining a degree of collective autonomy, and a reduced reliance on external services and the state. Rather than Jewish Manchester being a self-sustaining settlement per se, I argue that it has become increasingly self-protective – enabling the careful negotiation of encounters with the non-Jewish and non-Haredi worlds, and the avoidance of socially constructed contagions. Perceived threats to



FIGURE 1.1 Formerly the New Synagogue (consecrated 1889), now a South Asian enterprise. Photograph by the author.



FIGURE 1.2 Torah Street, the former Jewish Quarter. Photograph by the author.

the Haredi lifeworld requires a continuous process of response: self-protection emerges as a strategy of social *immunity* among different Haredi groups, and between the inside against the outside – thus creating a graded relation to the UK state.

The Jewish ‘Community’

Changing social dynamics in Jewish Manchester are most clearly associated with notably higher total fertility rates among Haredi families, and it is estimated that Haredi children will account for fifty per cent of all Jewish children in the UK by 2031 (Staetsky and Boyd 2015). Broader influences include inward Jewish migration from London as well as internationally, a number of ‘nouveau *frum*’ families,⁴ and those who move to Manchester to become Jewish through *giyur*.⁵ The growing prominence of the Haredim in Jewish Manchester (and England) reflects the wider demographic changes that are currently underway in Jewish populations of the United States and Israel (Staetsky and Boyd 2015; Valins 2003; Malach et al. 2016; Cohen 2016).

Shifting demographics and internal fragmentations in Manchester were already developing by the late 1970s, which was, according to Mrs Levy, ‘too awful for words’ in what she described as an era of ‘religious mania’.⁶ Mrs Kahn, a Haredi mother of nine, observed how Jewish Manchester has become more polarised as a result of the settlement’s unprecedented growth over the last twenty-five years. The rise in the number and plurality of Hassidish groups in the settlement is a noticeable example of socio-religious changes in the Jewish social body over time, as many locals told me. Mrs Kuschner recalled how ‘there were very, very, few Hassidim in Manchester years ago when my mother was a little girl’, but now, ‘even people who were not brought up Hassidish have taken on their ways and their garb for some reason’. Remarks such as these indicate how Haredi Judaism is a socio-religious *movement* that responds to broader social processes, rather than being a static construction of religious ‘extremism’ or ‘fundamentalism’ (Introduction). Mrs Gellner, a *frum* neighbour of mine, made this clear by discussing how the settlement has become:

More Haredi than it was twenty to thirty years ago and that’s a *protection*. But I think we’ve probably gone more right⁷ than we were because the world out there has gone much more to the left; the

world out there is much more permissive. Society and morals have all gone downhill and to *protect* yourself and your family, you've built up more *protective* shelter and the way to do that has gone to the right. (Emphasis added)

Similarly, Mr Dror described how:

The community has moved very much to the right over the last fifteen to twenty years, increasingly so, much more insular and much more *protective*, feeling much more threatened by the advent of the internet, by changes in society and the world outside. (Emphasis added)

The perceived need for 'protection' – or social *immunity* from external contagion – has therefore been driving the gradual push to the 'right' that Jewish Manchester has experienced. It can be inferred from Mr Dror's and Mrs Gellner's claim that changes in the standard of religious observance is an antonymic shift in response to increasingly dangerous strides that the non-Haredi world and national culture has taken towards the 'left,' requiring protection. Thus Haredi Judaism should be understood as sitting relationally (and as a continuous response) to broader political, socio-religious and technological changes in the outside world.

The flux in which *frum* Jews have become more Haredi and protective against the external world over time differs from what is described as 'denominational switching' from one conceptualisation of Judaism to another.⁸ Mr Emet (a pious Sephardi father) told me, 'I've said it once, and I'll say it again: The community here in Manchester can be more *extreme* than the Taliban' (emphasis added). For Mr Emet, the Haredi expression of Judaism in Manchester and the vernacular construction of religious authenticity is then perceived to surpass the 'extreme' of what public and media discourse otherwise regards as 'religious fundamentalism'.

The Jewish settlement in Manchester that Mr Dror and Mrs Gellner described can be understood as a protective refuge and form of dissimulation, which is the intentional pursuit of cultural (and perhaps physical) distance by upholding and maintaining conducts that constitute markers of difference in relation to the mainstream (see Scott 2009: 173–174). It forms part of a deliberate strategy and 'art of not being governed' (Scott 2009), and this form of resistance or 'counter-conduct' can then be perceived as threatening to the state's authority, integrity and perhaps even its continuity. The preference for self-protection and social *immunity* among the Haredim illustrates how minority groups can indeed choose to dissimilate or

insulate themselves (cf. Ecks and Sax 2006), but it would equally be inaccurate to represent them as living in isolation or detachment from the body of the nation.

Scott (2009) uses the example of minority groups in the Zomia region of Southeast Asia to analyse and frame minority–state relations, and remarks how such groups still exist ‘relationally and positionally’ to the state, despite dissimilating. His argument is that these quasi-autonomous bands seek to evade what he terms a ‘subject status’, rather than a relationship with the state altogether, an argument which I here use to frame the experience of Haredi Jews in Manchester.⁹ The immuno-protective stance of the Haredim then illustrates how the concept of citizenship and a subject status can be negotiated. Thus the status of an ‘ultra-Orthodox Jewish community’ as being ‘hard to reach’ (the focus of Chapter Two) can be grounded in a broader anthropological discourse of minority identity and positioning in relation to the state.

The historical quest for autonomy and self-reliance in Jewish Manchester (and increasing strides towards self-protection currently underway) should not be misconstrued as constituting a utopian ‘community’. Intra- and inter-group prejudices that have historically existed between Manchester’s Jewish and non-Jewish populations are part of the fortification that constructs an ethnic boundary, as ‘ethnic identities function as categories of inclusion/exclusion and of interaction’ (Barth 1969: 132). However, perceptions of inclusivity and exclusivity in Jewish Manchester run *within* the settlement, as much as *between* the minority and majority populations. Ethnic identities and ascriptions are not inborn or given but are socio-historically contingent, with the boundaries of ethnic contestation – both within and between groups – being a response to external events (Alexander and Alexander 2002).

The historical flows of immigration as well as the current diversity in Manchester bring a constellation of Jewish sub-groups together – with some continuing to have their legitimacy and belonging contested (such as the Sephardim, as I go on to discuss). Other Jewish groups and modalities are resisted because of the potential danger they can pose to the socio-religious and moral order of Haredi and Hassidish Judaism. The splintered composition of Jewish Manchester therefore warrants critical engagement with the term ‘community’, and echoes broader calls to ‘to stop talking of the community as a unitary subject and to analyse axes of contestation within it’ (Benjamin 2002: 8).¹⁰

The term ‘community’ is often used to describe the Jewish social body and is generally regarded in a positive light: imagined as being a place of comfort, unity and safety. A ‘community’ is, as Bauman describes, bound up in the imagination and ‘is nowadays another name for paradise lost – but one to which we dearly hope to return’ (2001: 3). The widely discussed idea of a ‘community’ in the Jewish context is therefore an ideal and idealised construction that does not reflect the lived realities of exclusivity and exclusion in Jewish Manchester, neither past nor present. References to ‘community’ as a conceptual category of intra-group relations have been problematised because of its ‘mythic value’, which can – and do – give rise to a ‘misplaced belief in “community” and the “participation” that goes with it’ (Cannon et al. 2014: 93). Thus communities ‘are to be distinguished, not by their falsity/genuineness, but by the style in which they are *imagined*’ (Anderson 2006: 6 [emphasis added]). It then becomes clear that the idea of a cohesive Jewish ‘community’ in Manchester, from its historical inception, is a romanticised figment of the imagination. Disentangling the internal fragmentations within the Haredi social body is a crucial wing of this book, and informs my broader argument that the category of an ‘ultra-Orthodox Jewish community’ is constructed in the imagination of public (health) discourse and its production of authoritative knowledge.

Implications of Immigration

The increasing numbers of émigré Jews arriving in Manchester and England in the nineteenth and early twentieth centuries meant that antisemitism became more pronounced across social, political, and medical domains. I was told by Sara, ‘there was a lot of prejudice against immigrants [in Manchester], and it wasn’t the fact that they were Jewish so much, but the place was poor’. Antisemitism was, however, a lived reality for the Jews of Manchester regardless of economic status. Sissie Laski recalled how she had first experienced antisemitism when, after marriage, she moved from London to the highly affluent area of Didsbury (South Manchester) in 1914, and was shocked to find that Jews were barred from joining social clubs.¹¹ Louis Rich, who grew up in the Jewish Quarter, also said antisemitism was rife during the first half of the twentieth century, ‘and they used to treat these immigrants – these Jewish immigrants – like *we* treat the Pakistanis now and the Hindus, with contempt, disdain’.¹² Reflections such as this indicate how prejudice towards minority

groups persists with flows of immigration over time both at the local and state level.

With the establishment of science as a dominant culture of knowledge in nineteenth century Europe, the body of the Jew was constructed as fundamentally different and pathological in medical discourse, and thus 'unworthy of being completely integrated into the social fabric of the modern state' (Gilman 1992: 223). Medical racialism and anti-'alien' discourse were mutually reinforcing: stereotypes of Jews being weaker, sicklier, or predisposed to diseases that were constructed in the medical imagination influenced political opposition towards Jewish immigration to Britain and vice versa (Reuter 2016; also Tananbaum 2015).¹³ Hostility towards the growing 'alien' Jewish minority in England tended towards articulating the implications of immigration for the body of the nation, and racialised representations featured prominently in twentieth century concerns of 'national eugenics'.

In 1926, an article published in the *Annals of Eugenics* claimed that 'alien Jewish' children in London's East End often fared worse in terms of intellectual, medical, physical and hygienic standards when compared with 'the general Gentile population', and these racialised allegations were consequently used to challenge the flow of 'alien' immigration to Britain (Pearson and Moul 1926: 51). These critics of Jewish immigration seemed to mobilise a conception of the value of intermarriage to assimilate 'difference', insinuating how *halachic* prohibitions against intermarriage might act as an indicator of the degree to which the émigré Jewish population could fully integrate into the UK – which was arguably presented as an expectation of a citizen:

From the standpoint of the immigrant racial purity may be a dominating belief, [but] from the standpoint of the national statesman the suitability of the immigrant must depend not only on what he brings to the nation, mentally and physically, but also on the possibility of his assimilation. Many of the old stock of English Jews have fully recognised this; they have intermarried ... For them Jewry is a religious faith and is something apart from the question of nationality and racial purity. From the standpoint of the host-nation, this is undoubtedly the better attitude and might very reasonably be made a criterion of the fitness of a race for immigration into a settled country. It is from this aspect of the matter that stress must be laid on the question of racial purity – the defect in racial purity may be a measure of the immigrant's capacity or willingness to amalgamate. (Pearson and Moul 1926: 18)

Claims that Jews were inferior compared with the 'native standard of fitness' were challenged, however, in articles submitted to the *British Medical Journal* by a Jewish physician, apparently on the basis that 'the *expectation of life* at all ages is higher among Jews than among Gentiles' (Feldman 1926: 167).¹⁴ While chronic poverty was a shared experience among Jewish émigrés and non-Jews in London's East End, the former actually had lower rates of infant mortality by the turn of the twentieth century (Marks 1990). Representations of Jews as being biologically inferior to the 'general Gentile population' were therefore contested, and such stereotypical and intangible portrayals might instead reflect the reality of life as a marginalised and evidently racialised minority. Stereotyping claims were not limited to the Jewish body being physically 'stunted' or deficient, and also portrayed Jews as having high birth rates (and thus a growing and racialised 'Other') – a claim which can be understood as being continuous over time when levied upon the Haredi minority in England.

Social and Medical Racism in Modernising Maternity Care

The interaction between social and medical hostility meant that antisemitism was a lived reality for émigré and Manchester-born Jewish women when accessing local maternity care in the 1920s and 1930s. The total medicalisation of pregnancy was consolidated over the course of the nineteenth and twentieth centuries and brought irreversible changes to childbearing cultures, whilst also enabling medical racism to be practiced over the bodies of Jewish women and their newborns. Incorporating pregnancy and childbirth into biomedical jurisdiction signalled a transition from what was an area of women's lived experience and practical expertise to what gradually became an area of medical authoritative knowledge (that was dominated and constructed by men) – one that can be read as an intimate strategy of biopolitics. Through medicalisation, the biomedical control of childbirth – and thus women's bodies – emerged as a key strategy of the state to manage the body of the nation and reproduce a population of quality in an era of British imperial ambitions and anxieties.¹⁵ Cultures and identities of childbirth had dramatically changed over the course of the twentieth century as midwifery became professionalised and hospital-based births overseen by physicians were established as the norm, heralding an unprecedented level of medical involvement, innovation and intervention.¹⁶ Childbearing women 'made the transition from mothers to patients' (Beier 2004: 379), and Jewish women subsequently encountered intersectional forms of bodily domination.

The numbers of Jewish women opting to birth at Manchester's main maternity hospital (Saint Mary's) had increased by the 1920s, and English-born Jews in particular had a preference for biomedical maternity care at the time.¹⁷ The shift towards hospital births in Jewish Manchester, however, occurred alongside fraught encounters between Jews and medical professionals at Saint Mary's over the *brit milah* (circumcision) of male infants.¹⁸ During the early decades of the twentieth century it was a fairly routine maternity experience for women to remain in hospital for one week to ten days postpartum.¹⁹ The *brit milah*, undertaken on the eighth day of an infant's life, would have fallen during this period of maternal convalescence. Medical professionals in 1921 had objected to the circumcision being performed in the hospital and some boys consequently had to have their *brit milah* delayed, which was contrary to the Judaic cultivation of the male infant body.²⁰ It was later claimed that the authorities at Saint Mary's did not object to the performance of the circumcision per se, but according to archival records, it was the 'crowding together on the occasion of a large number of Jews and making themselves merry'²¹ – which can be inferred as the gathering of a *minyan* for the ceremony.²² Even when taking this justification at face value the medical objections still disrupted a defining process of social reproduction, as preventing the bodily covenant of circumcision withheld a male body from being marked and sanctified as Jewish.

It is, however, in circumstances like these that we can appreciate the limitations accompanying attempts to engage with historical material from an anthropological perspective. The archival record that is available offers limited scope to grasp the lived experience of encountering the state through maternity services, and the reflections of local women. The record, for instance, describes that a conflict occurred when physicians objected to the circumcision being performed in the local hospital, but not *how* émigré or English-born Jewish mothers experienced the contest over Jewish bodies in a foreign healthcare environment and when convalescing outside the familiarity of the Jewish Quarter. The pain and difficulties of childbirth would have been intensified for émigré Jewish women in England if birthing without the support of kin relations, who may have remained in their countries of origin, and when alienated by the disciplinary and discriminatory practices of care providers (Marks 1994: 7). Opposition to the *brit milah* being performed would have been a serious issue for émigré women as they recovered on maternity wards. Such early twentieth century conflicts in maternity

care reflect the broader struggles of assimilation and integration experienced by émigré Jews in Manchester, and demonstrate how the attempt to assimilate minority populations at the margins is an example of how 'sovereign power exercised by the state is not only about territories; it is also about bodies' (Das and Poole 2004: 10). Biomedicine, when deployed as part of a process of 'internal colonialism', becomes an indispensable part of the state's attempt to reassert its authority and extend its reach from the 'centre' over the physical and conceptual 'margins' of the state – where challenges to prevailing norms are reproduced.

Louis Rich, a Manchester born Jewish doctor, recalled how emergency obstetric care was institutionally underfunded and fraught with danger in the early 1930s when he completed his medical training, indicating the relatively low status of maternal health and mortality in the scale of concerns during the modernising framework of biomedicine. This was, he recalled, an era when caesarean sections were performed without access to blood transfusion services and when physicians received limited obstetric training.²³ One tragic incident of maternal mortality to affect the Jewish settlement was the death of nineteen-year-old Molly Taylor on 12 May 1934. Sydney Taylor attributed the death of his wife to systematic failings and neglect in maternity care, and described how the event was the source of much discontent between the Jewish settlement and the local health authority at the time.²⁴ He recalled how Molly had elected and paid in advance to labour in Saint Mary's Hospital, which, as mentioned, was then known for being a specialist maternity unit in Manchester. When Molly arrived at hospital following the onset of labour she was apparently dismissed by the healthcare professionals on duty. Upon leaving she promptly gave birth on the hospital steps but, due to a shortage of beds, was redirected to Crumpsall Hospital in a 'jerky' ambulance,²⁵ characteristic of medical transport in the formative years of twentieth century Manchester.²⁶ The next day Molly died from delayed 'obstetrical shock' following a catalogue of insufficiencies in care, as Rich recalled, 'I'm guessing that by the time she got to Crumpsall she had lost so much blood, she couldn't possibly have recovered'.²⁷

Molly's death was unusual because her pregnancy and birth were not problematic, and the incident provoked staunch criticism from both the Jewish population and local women's advocacy groups (Emanuel 1982). A public inquiry was inconclusive, but the case resulted in a group of women creating a committee for the surveillance of maternity services in Manchester, as they 'were not

satisfied to delegate responsibility for their lives to what they saw as a self-interested medical profession' (Oakley 1984: 67). Sidney Taylor regarded his wife's death as a case of medical negligence. Dr Rich, who lived on the same street as the Taylors, reflected on the insufficiencies in care as an issue of entrenched racism and claimed that the reaction of the hospital authorities at the time was, 'what can you expect from these bloody Jews?' He considered this response to be symptomatic of the British medical authority at the time:

It was a very difficult atmosphere in the 1930s. The amount of anti-semitism was enormous. The British Medical Association [BMA] was the most antisemitic organisation you could possibly imagine. First of all, they objected to Jewish doctors who were trying to escape from Germany and once they got here they wouldn't let them practice. The whole atmosphere against Jews was awful. (Louis Rich)²⁸

The perceived entrenchment of antisemitism in the British medical establishment that Dr Rich remarked on ought to be seen as an extension of the prevailing socio-political climate during the early 1930s: a time when members of the British monarchy and governing elite were initially sympathetic, and in some cases appeasing, towards the rise of National Socialism in Germany.²⁹ Molly Taylor's tragic death elucidates how the medicalisation of pregnancy and childbirth during the early twentieth century intersected with prevailing norms of antisemitism for Jewish women in Manchester, causing them to encounter nuanced forms of bodily domination and discrimination.

Incorporation and Integration

Increasing social and medical expressions of antisemitism prompted a regime of assimilation and anglicisation by the established Jewish elite in the major English settlements, targetting the 'foreign' customs of the émigré Jews. The intention was to forge a syncretic Jewish and British identity, whilst being cautious of 'marrying out' and dissolving completely (see Heggie 2005; also Dee 2012b; Tananbaum 1993, 2004, 2015). Here, assimilation means to be incorporated into the established Jewish social body and dilute the degrees of difference with the non-Jewish population through anglicisation, rather than assimilate and become non-Jewish through intermarriage.

Jewish Manchester was no exception to having a pro-anglicisation agenda for 'foreign' poor Jews. The already established and integrated Jewish minority in Manchester were indeed concerned

with the consequences of representation and how the influx of émigré and 'foreign Jewish poor' could affect their own positioning and public image, who themselves sought to emulate the British middle classes (see Burman 1982: 36). Interventions were therefore seen as necessary to maintain the standing of the English Jews, who sought to project an image of a respectable and caring 'community' where the poor were supported without needing to rely on public funds (see Williams 1979). Importantly, the responsibility of self-care was also a condition of belonging for Jews as a minority 'Other' in the UK (Reuter 2016: 6). Organised Jewish welfare bodies in London and Manchester developed out of the inability and inflexibility of the Poor Law Amendment Act (1834) to meet the needs of this ethno-religious minority group (or any other) and to liaise with statutory authorities accordingly,³⁰ who feared that the provision of special arrangements might attract more poor Jewish émigrés to the country (Jones 2001: 91; see also Marks 1994; Williams 1976). The establishment of Manchester's Jewish Board of Guardians for the Relief of the Jewish Poor³¹ in 1867 (henceforth 'the Board') exemplified this, and aimed to prevent the poor appearing as a cost to the state whilst also seizing the opportunity to integrate and anglicise émigré Jews and their children.³²

The Board not only gave rise to an authoritative and representational communal body to provide welfare services and relief, but also created a degree of Jewish autonomy that limited and buffered the interaction between the Jewish population and the local authority. On the other hand, the fact that the anglicised Jewish elite had instituted the Board reinforced power relations between the earlier-established and 'foreign' Jews. The Board, for instance, worked with allied surveillance programmes that sought to improve health outcomes among Jewish neighbourhoods and maintain a positive public (health) image of the Jewish minority (Chapter Two).³³ Moreover, the Board's assimilatory strategy also traversed the broader settlement, such as Jewish schools, to enforce blanket vaccination policies (Chapter Four).

It is important to note that Manchester at this time was an industrial powerhouse but also home to some of the country's most overcrowded, squalid and insanitary living conditions.³⁴ Cyclical epidemics and outbreaks of infectious disease affected the region's working poor, and cholera continued to sweep through the city during the nineteenth century (Museum of Science and Industry n.d.), inflicting high levels of morbidity and mortality – particularly during infancy. Services and 'interventions' were instituted by

both the local authority and Jewish elite to improve, or at the very least manage, health in Manchester's most insalubrious areas – the slums which were home to a significant number of 'foreign' and marginalised Jewish poor.

By 1873–1875, up to ninety-five per cent of Jews requesting financial relief from the settled Jewish constituency and its welfare infrastructure were described as 'Foreigners', with the remaining five per cent being the 'Native Jewish Population'.³⁵ Using the term 'native' to re-present Jews (and their descendants) of the founding settlement makes clear how they positioned and defined themselves hierarchically – in relation to their 'foreign' co-religionists – as being, or having become, definitively English. Despite the influx of immigration to Manchester, the Board was keen to offset the image of the 'foreign Jewish poor'. The Board, for instance, had sought to discourage émigrés from settling in the area³⁶ yet attempted to re-present Jewish immigration positively by claiming it 'has not injuriously, but on the contrary, has beneficially affected Manchester'.³⁷ Thus émigré Jews had to navigate a multiplicity of aspirations as well as expectations pertaining to citizenship and positioning, which were held by both the broader Jewish social body and critics of (Jewish) immigration concerned with reproducing the body of the nation.

Responding to Assimilatory Pressures

Jewish piety during the nineteenth and twentieth centuries was not characterised by greater authenticity and uniformity; denominational, ideological, or social differences were as much a feature of life for Jews in the North West as elsewhere. Jewish Manchester has historically experienced great diversity and plurality, including the controversial establishment of a Reform synagogue in 1856 and the emergence of Zionism at the end of the nineteenth century. Attempts to assimilate the 'foreign' Haredi Jews were not always met submissively because of diverse and opposing constructions of Judaism and religious observance.

Many of the émigrés during the nineteenth and early twentieth centuries were indeed strictly observant (Williams 1979), or 'Haredi' by today's conceptual definition. Intra-group differences regarding standards and customs of religious observance had led some émigré Jews to form their own *shtiebel*s³⁸ and *chevrot*,³⁹ which were viewed as pursuits of 'semi-autonomy' and 'cultural isolation' by English Jews (Williams 1976: 273).⁴⁰ The smaller and exclusive *chevrot* formed by pious émigré Jews also provided material and

economic support to strictly-religious arrivals in order to counter the assimilatory pressures and hostility of the Jewish elite (Williams 2011: 218–219; also Wise 2007; Dobkin 1994). Interestingly some developed their own relief and welfare programmes, such as the Russian–Jewish Benevolent Society (established in 1905), as a conscious strategy to ‘free new immigrants from reliance on the investigative methods and anglicising objectives of the Jewish Board of Guardians’ (Williams 2011: 218–219).

The reluctance of these émigré Jews and the working poor to submit to the assimilatory dictates of the Jewish establishment can be interpreted as a tactic of evasion conducted as part of a process of dissimilation from both the state and the wider Jewish social body. The historical pursuit of dissimilation among émigrés is continuous with the Haredi context of present day Manchester (discussed later in this chapter), and exemplifies the recurrence of internal fragmentation and the preference for some Jews to maintain degrees of autonomy and social *immunity* from the broader Jewish social body as well as the external world.

Internal Marginalities and Multiplicity

Marginality is not a singular construction but manifests in many forms, each having a different relation to health (Ecks and Sax 2006). The multiple experiences and positions of marginality – or the concurrent existence of *marginalities* – is marked by intra-group gradations in socioeconomic, religious, ethnic and gender statuses. Attention to marginalities as an analytical category illustrates the historical continuities and discontinuities of internal difference and fragmentation that have emerged in Jewish Manchester over time.

The former Jewish Quarter was ordered and mapped according to a graded topography, demonstrating how marginality ensnared multiple layers of the social body rather than being defined by a singular experience as a minority group:

The social structure of Manchester Jewry resembled a pyramid: cotton traders, professionals, and solid retailers were located at the top, below them came modest shopkeepers, and at the bottom was a poor eastern European working class, mostly itinerant traders and semi-skilled manual workers. ... this class structure soon exhibited a geographical dimension. The poorest Jews inhabited the slums of Red Bank, north of Old Town. The wealthier elements had for some

twenty years been moving into middle-class suburbs mainly to the north of the city, at Cheetham Hill. (Alderman 1992: 28)

The Jewish settlement was clearly defined by implicit and explicit socio-religious and economic differences as opposed to a defined dichotomy between Jewish and non-Jewish 'communities'. The social gradient created predictable inequalities in health, with the working poor being the subject of intense surveillance mainly because of concerns that the insalubrious housing of the slums could incubate infections (Chapter Two).

Times of economic depression were recurring and 'brought the horrors of unemployment to thousands of working class homes',⁴¹ with the situation exacerbated by Manchester's 'cruel' autumnal and winter climate. Economic insecurity over the course of the nineteenth century had led to begging amongst the Jewish poor, despite the attempts of the Board to bring an end to 'indiscriminate almsgiving' and 'street mendicancy' through its relief.⁴² Begging was often seen as a cause of anxiety for the Jewish elite. Minutes belonging to the 'Society for the Relief of *Really* Deserving Distressed Foreigners' (emphasis added) in 1875 regarded the majority of foreign people living on alms as 'idle and worthless'.⁴³ Portrayals of destitute émigré Jews as 'idle and worthless' by 'natives' is comparable to representations of populations during colonial domination as lazy, primitive and repulsive by occupying authorities (cf. Comaroff and Comaroff 1992; Lock and Farquhar 2007: 307).⁴⁴ In such contexts, the 'really' deserving might be inferred to be those responding with compliance to the imposed or dominant order.

Nineteenth century Jewish Manchester was described as a 'self-sufficient community', where businesses and factories owned by the Jewish elite – such as the waterproofing industry and cap trade – provided (often seasonal) employment to the Jewish working poor living in the slums (Dobkin 1986: 36). Émigré Jews rarely sought work outside of the Jewish settlement and instead remained in Jewish-owned trades, 'preferring to labor among their own kind, in trades they already knew well, for masters who, however harsh, at least spoke their language and were sometimes willing to accommodate their religious requirements' (Endelman 2002: 134). Whilst taking employment within the Jewish Quarter enabled cultural distance with non-Jews to be maintained, accommodating religious requirements was not always the case as many Jewish locals had to sacrifice *Shabbat* observance – however difficult this may have been – in order to work and earn a living (discussed later in this chapter).

In being largely restricted to the local garment making and seasonal waterproofing trades, Margaret Langdon recalled how men at the time could be in a situation where one is 'very busy all winter, and idle, or what was rather pitifully called "you played all summer."'45 Moreover, it was not uncommon for Jewish workers in the cap or raincoat factories to return home without employment or compensation after being informed that there was 'no more work'.46 The most destitute would then request material relief from the Board.47 The cyclical nature of 'boom and bust' in the local trading continued to affect health right through to the twentieth century, as, for instance, reported levels of illness and disease in Jewish Manchester almost doubled between 1903–1904 and 1904–1905.48 Married Jewish women in Manchester usually worked and became the breadwinner only when their husbands fell ill, as a married woman in employment would indicate low social status and a man's limited ability to provide for his family (Burman 1982).49

Despite the realities of destitution, the slums generally offered a sense of camaraderie for the émigré Jews and were, in some cases, a preferable place to live compared with the suburbs – perhaps because of the majority Jewish population and the potential security this could have offered.50 Many émigrés from Tsarist Russia could attest to the lived experience of pogroms and traumatic memories of persecutory violence – such as the whipping of Jewish children by Cossacks as they rode through *shtetls* or violent antisemitic attacks by Christians,51 so a preference for living in a densely populated Jewish area is not surprising.

Dina McCormick recounted her childhood in the slums. When she complained of famishment, her mother would retort 'I don't wonder you're hungry ... I was hungry the whole nine months I carried you. There wasn't any food and hundreds lived like me'.52 A Jewish soup kitchen sat on Southall Street nourishing the destitute Jews and non-Jews of the area during Manchester's relentless wet winters that were 'a by-word of wretchedness'.53 However, the sustenance it provided to the Jewish poor also, in some cases, isolated them from people *within* the slums as well as their relatively wealthier co-religionists.

The stigma attached to using a Jewish soup kitchen owing to the particular under-class it sustained, was, for some, a lasting marker of socio-economic difference. Dina recalled how her mother would forbid the family from using the soup kitchen, and 'would sooner we died of starvation on the street than we should do such a thing'.54 As an elder, Dina reflected on the intra-group

differences and marginalities that characterised her childhood in the formative decades of the twentieth century and remarked how, at the age of seventy-two, she would continue to position Jews of the former slums. In her words, 'I still meet women that I went to school with and [who] went to that soup kitchen, and I still look down on them. Wouldn't you think I would forget it?'⁵⁵ Socioeconomic gradations were therefore not an issue of polarity between 'slum and the suburb, but within the slum itself' (Williams 1979: 48).

The slums of Red Bank and Strangeways were generally disregarded as 'a horrible, dirty, miserable place'⁵⁶ by the socially mobile and relatively wealthier Jews 'who had made it' and only encountered the slums when travelling to the town centre. The proximity of the Jewish slums to the 'centre' of Manchester affirms how marginality is relational, inferring not just a geographical position but a product of 'power relations *between* social groups' (Ecks and Sax 2006: 209).⁵⁷

Sara at the Manchester Jewish Museum informed me that 'on the Sabbath, no matter how poorly off you were, you made your meal on a Friday and you didn't cook, you didn't work you didn't do anything that disturbed the Sabbath'. *Shabbat* was, however, a working day for many Jews employed in trades because of the necessity to earn a living. Dina McCormick recalled how most, if not all, Jewish firms in the clothing trade opened on Saturdays and Jewish employees worked or were only paid for five days of labour, and it was the norm to take Jewish religious holidays off unpaid.⁵⁸ Some individuals took it upon themselves to act as 'defenders of the faith' by reprimanding those who did not, or could not, uphold the obligation to keep *Shabbat*.⁵⁹ Rather than being positioned as apostates, the conditions and pressures facing families in the slums meant that Sabbath observance took less precedence.

Dina, for instance, described how her mother would say 'God understands I'm poor, and when I'm rich, I'll keep *Shabbos* like the rich do, but when I got to work all week, I've got to do my cooking on *Shabbos* morning'.⁶⁰ The limitations on observing the Sabbath were therefore an accepted cost and reality of the time that marked the experience of marginality for the 'foreign Jewish poor', who did not have the same socio-economic leverage as their wealthier and anglicised co-religionists to refrain from labouring on the day of rest. The need to work on the Sabbath testified to the pressure of integration at the time, and for many Jews was 'a painful concession to the necessity of survival in England' (Williams 1979: 46).

The internal multiplicity and marginalities that manifested within the slums (also between it and the wealthier Jewish class) were not confined to the history of Jewish Manchester, but are recurring in the present day settlement. Adoniyahu, an unmarried modern Orthodox man in his early twenties, described how there was ‘fifty shades of grey here’, which indicated how the Haredi settlement today has much more diversity than the black and white garments that are worn uniformly by Haredi men. Manchester therefore reflects previous studies of Jewish topographies, which have been described as typically consisting of ‘religious microspaces’, where ‘what looks like a single “suburban Orthodox Jewish community” is in fact a much more complex agglomeration of many communities’ (Diamond 2008: 120). These ‘microspaces’ within Orthodox Jewish topographies tend to be exclusive as well as encompassing of intra-group diversity – and Jewish Manchester was no exception. In fact, a previous study of a Haredi Jewish neighbourhood in Manchester referred to the intra-group diversity as a situation where ‘clearly there are communities within communities, but the imagination of an idealistic overall community remains’ (Valins 2003: 167).⁶¹ The ‘ultra-Orthodox Jewish community’ should then be understood as an imagined category that obscures internal dynamics and fragmentations.

Haredi locals would tell me how Jewish Manchester is a ‘friendly community’ – and the fabric of society appeared rich and tightly woven (for those positioned as being on the ‘inside’). This image was contrasted against an outside world perceived as inhospitable to Jews, with one *frum* woman asking ‘Where does a Jew go? Where does an Orthodox Jew go? Who would want them?’

Religious events certainly brought different facets of the population together, forming a principal – but not habitual – area of interaction. The festival of *Purim* was one vibrant example of this, as the settlement transformed into a carnival with homes and institutions open to passers-by and with gifts of food (*mishloach manot*),⁶² alcohol and donations flowing across the settlement. Children attending particular schools would be in costumes to identify their collective: boys from one institution were dressed in red and white stripes from the iconic book ‘*Where’s Wally?*’, those from another dressed as penguins, and another dressed as musketeers adorned with *fleurs de lis* – illustrating how Haredi youths and children can incorporate external cultural histories and artefacts into their protective zones.

The festival of *Purim*, however, occurs just once a year and locals would allude to subtle threads of distinction and distinguishment.

Rather than a 'community' – as the Jewish population in the UK refers to itself as, and is referred to as⁶³ – I found that the field-site consisted of overlapping and multi-layered groups who sat side by side, and often in tension, with each other. Moving between Jewish groups exposed the internal dissent and dissonance, and the gradations of separation that were perceived to be necessary for the protection of the Haredi and especially the Hassidish cosmologies.

Diversity within the 'community' manifests in intricate differences in outlooks or worldviews, as I go on to discuss in this chapter, and brings a struggle of differentiating what makes somebody 'Orthodox' from being 'Haredi'. Rather than having clearly demarcated boundaries within the social body, the Haredim could be differentiated by prevailing attitudes and established norms that were not seen amongst Orthodox families (Mr Emet).⁶⁴

Mrs Gellner, who married into an established Manchester family, described the basic standard of being an Orthodox Jew as observing the laws of *kashrut* and *Shabbat*. However, there was a considerable difference between this reference-point and the chief indicator of being Haredi, at least by the standards set in Jewish Manchester. According to Mr Emet, this centred on the 'shunning of secular education. It's a big issue here, for some reason it's a massive issue'. Despite the gap between what Mrs Gellner described as the basic standard of Orthodoxy and the prevailing identifiers of being Haredi, the relatively small geography of Jewish Manchester meant that a gradation of observant families sat 'cheek by jowl', therefore distinguishing the area from the geographical breadth of Jewish and Haredi neighbourhoods in London.

The Sephardim

Dina McCormick made clear that there were obvious socio-economic differences in early twentieth century Jewish Manchester between the anglicised Jews and the 'slum Jews that we were', but also that there was an ethno-religious gradient amongst its diverse population. She said, 'there were the German Jews that looked down on everybody – and the Austrian Jews – they looked down on the Russian Jews and the Roumanian Jews and the Polish Jews'.⁶⁵ Similarly, Louis Rich recalled how Jewish Manchester was divided into 'clans', but that there was also a common 'Other' and point of difference, as he said, 'then there were the outsiders: the Sephardic Jews'.⁶⁶

The Sephardim had generally settled in Manchester from as early as 1845, arriving mostly from present-day Syria, Iraq and Turkey,

and prospered through the import and export of goods. The importance of Manchester's industrial and economic opportunities for the Jews of Aleppo during the nineteenth century is made explicit by them making reference to 'next year in Manchester' in place of Jerusalem at the *Seder* meal during Passover (Rollins 2016).⁶⁷ Some Sephardi Jews did live in proximity to the slums and factories (evidenced by the former Sephardi synagogue in Cheetham Hill), but most were cotton merchants rather than being the 'foreign poor'.⁶⁸ By virtue of their relatively privileged marginality,⁶⁹ one could argue that Sephardi Jews were just as 'alien' to the Eastern European émigrés as the local non-Jewish population. Rachel Black claimed that the ethnic marginality and socioeconomic status of Sephardim meant they were not, and could not be 'native' Jews:

They don't eat the same kind of food like we do, they have a different kind of cooking, they have a different language – and they were all rich, of course. How could they mix with the Manchester Jews? They couldn't – you know perfectly well rich people cannot mix with poor people.⁷⁰

There was more or less a 'complete and absolute separation' of Sephardim and Ashkenazim, an animosity manifested in a general resistance to mixed-marriage (though it did occasionally happen), and the maintenance of separate synagogues.⁷¹ However, the Sephardim themselves did not comprise a monolithic block and the large constituency of Jews from Aleppo were later accused of heresy and expelled from the Sephardi synagogue on Cheetham Hill Road. They went on to establish a separate settlement in a relatively more affluent area of South Manchester (Halliday 1992). The Sephardi Jews, who, whilst generally being a wealthier sub-group during the formative years of Jewish Manchester, were (and remain to this day) marginalised by Ashkenazi Haredim.

Internal prejudices continue to be directed towards the Sephardim in the present day, which illustrates the entrenched differences and internal prejudices that are harboured within the term 'community'. Local Sephardi Jews tend to be divided between the area's Moroccan and Iberian synagogues, or, as was more commonly the case amongst Haredi circles, Sephardi families assimilated into the dominant Ashkenazi and Litvish population.⁷² Mr Emet asserted that 'there's no Sephardic community, as such, let's be clear about it. There are plenty of Sephardim around, but as such, there's no identity'. Part of this issue is apparently because Jewish Manchester leans much more towards Haredi Litvish cultural dominance. For

Sephardi Jews to be accepted amongst the *frum* circles, Mr Emet told me there is a perceived feeling of needing to be ‘more Haredi than the average Ashkenazi: you have to pretend you’re not Sephardi.’ Thus local conceptions of what constitutes religious authenticity continue to be determined by the cultural dominance of Ashkenazi (Litvish) Jews, as the Sephardim are positioned ‘outside’ the Jewish social body in ways that are historically recurrent.

The dietary laws which ‘keeping kosher’ involves were, according to Sara at the Manchester Jewish Museum, historically ‘there to keep the community together’. However, the diversity in standards and stringencies applied to *kashrut* in Jewish Manchester, I later found, ran contrary to Sara’s claim that *kashrut* was a means of binding the *kehillah* (community). Local *frum* Jewish families would hold themselves to the dictates of different *kashrut* (and thus rabbinical) authorities, which supposedly vary in stringencies, creating a situation where some *hechsherim* were perceived to be more kosher and authoritative than others.⁷³

Whereas *Kedassiah* was viewed as an acceptable *hechsher* amongst Hassidish circles,⁷⁴ there were local and London-based *kashrut* authorities serving the majority of the Haredi population. However, the *hechsher* of the Sephardi *Bet Din* was generally not viewed as stringent enough for many (Litvish) Haredi mothers. In the words of one *frum* woman from France, the Sephardim are regarded as ‘not religious enough’. Kosher was then something of a relative term as families aligned to different origins or worldviews might not eat or ‘break bread’ together – thus fortifying intra-group boundaries and divisions.

A Protective ‘World within a World’

Jewish Manchester has a range of Haredi-led institutions, enterprises and services that are designed to support and sustain its growing settlement and demographic. The social infrastructure in Jewish Manchester crafts its reputation as an affordable alternative to London’s Jewish neighbourhoods. Some families rooted in Manchester considered it an ‘easier’ place to live, although those who had relocated from London would often describe Manchester as ‘provincial’. With the social infrastructure catering extensively to the needs of the Jewish settlement, dependence on broader Jewish or non-Jewish services are – with the exception of healthcare – significantly reduced. Rabbi Kaplan, for instance, explained how

Jewish Manchester sought to be a 'self-sustaining community' where locals could easily go their 'whole life' without resorting to non-Jewish shops for groceries and goods.

The internal services help to create the 'self-sustaining' settlement described by Rabbi Kaplan, yet this also has the result of *protecting* Haredi Jews from the need to encounter the outside world in areas of quotidian life. The Haredi pursuit of autonomy was made clear during a discussion with Sara, who told me how 'it wants to be self-sufficient, self-contained, and ideally for the Haredi community, its *ideal* aspiration is to live separately in peace' (emphasis added). The fortification of the settlement alluded to by Sara can be read as a conscious strategy of resilience, but is also an aspiration and vision that has not been fully achieved.

Social conducts that the non-Haredi world incorrectly interpret as being offensive are, I was frequently told, in fact defensiveness on the part of the Haredim. *Rebbetzin* Yad, who is a prominent figure in her Hassidish circle, made clear to me that, 'I'm talking about communities trying to cope but on the other hand, it's a community that is vulnerable'. Thus we see how the social body attempts to cope, but also how self-protection from external pressures can consequently leave it vulnerable to internal pressures (see Chapter Two).

The extent to which Jewish Manchester is self-containing and protective, Mrs Shaked told me, means that being Haredi is akin to living in 'a world within a world. You don't have to always go *outside*, you can run your existence *within* this *closed world*' (emphasis added). Thus the aspiration to be as autonomous as possible means that Haredi Jews can negotiate the extent to which they engage with the external world. The stringent interpretations of *halachic* observance that defines the Haredi cosmology (which was regularly criticised in public media during the period of my research) is, on the one hand, 'oppressive, but the care is immense' (Mrs Shaked). Mrs Shaked, originally from Iraq, described how Jewish Manchester is 'a very closed community that really takes care, so even if somebody is ill then food is left at their doorstep. Cooked food, given food, clothing, children are taken off their hands, looked after'. Intra-group care is described as forming part of the religious obligations of *gemilut hasadim* (acts of loving kindness) and *tzedekoh* (vernacular),⁷⁵ and is an enormous material advantage to Haredim, which also increases the autonomy of the settlement.

Mrs Shaked went on to claim that the internal systems of support apparently buffer socioeconomic deprivation in Jewish Manchester,

to the extent that it cannot be compared with the experience of deprivation in the broader non-Jewish population. The internal and informal economy is used in conjunction with welfare funds from the local authority (and central government) in order to mitigate deprivation caused by 'religious poverty' and the higher cost of *frum* living. Internal strategies to alleviate socioeconomic stress then create a position where the Haredi minority can also be called 'privileged marginals' (cf. Faubion 1993: 191) when viewed in relation to the socioeconomically deprived and minority groups in the area, which overlap with Jewish Manchester.

Intra-group provisions were not necessarily designed to replace state welfare and NHS services in an attempt to create a self-sufficient and autonomous enclave, but rather to meet the limitations of state provisions and to materialise the *mitzvah* (commandment) of *gemilut hasadim*. These took the form of remarkable intra-group charities, services as well as *gemachim*,⁷⁶ which are made available to any Jewish person in the settlement cutting across internal divisions. Certain charities would, for instance, collect money to deliver weekly food supplies and parcels to needy families in order to prepare meals for *Shabbat*. The services perform a unique role in catering to the needs of the religious constituency for whom outside agencies that are positioned as non-Jewish or not *frum* would be considered as inappropriate by many of the Haredi locals I met. The services available include a library, swimming pool, mental health counsellors and therapists, educational needs facilities, family and children's centre, financial advisor, legal advisor, service to absorb new arrivals, hospital visitation groups, burial carers and birth supporters (Chapter Three). Moreover, certain Haredi organisations perform a key role in lobbying local authorities for resources, as well as acting as gatekeepers of the social body.

The *gemachim* consist of a continuously growing portfolio of resources that are freely available, or for a nominal charge to cover the expenditures incurred. These include baby clothes and equipment, laundry services, wedding dresses, foods and supplements which are considered to be health promoting and medicines, to name a few. Whilst these services are available to all Jews in the area, I was told they are mainly managed by Haredi Jews. The extensive range of services and *gemachim* highlights the immense investment in care and *chesed* (compassion) to support vulnerable and deprived Jewish locals. According to *Rebbetzin* Yad, 'the amount of good, of care, that is built into our community lifestyle is actually a tremendous assistance to the health service'.⁷⁷ Similarly Haredim

in the London Borough of Hackney can draw on a particularly significant and abundant range of *gemachim* for infant and children's provisions, and parallels the staggering number of Jewish families receiving government child benefits in the area (Abramson, Graham and Boyd 2011). Intra-group and government welfare provisions are therefore synthesised as a combined strategy to alleviate the specific experience of 'religious poverty'.

The *gemachim* can also alleviate the higher cost of *frum* living that growing Haredi families face. Mrs Shaked surmised that 'what is declared is certainly not income that is actually earned in one year'. She based her judgment on the reasoning that welfare benefits alone could not meet the challenges and demands that a religious cost of living entails, especially with a larger than average family. These additional costs include the imperative of subsidising the religious studies programme for (multiple) children attending state-aided Orthodox schools or private Haredi school fees, *yeshivah* and seminary fees, synagogue membership fees, donating ten percent of a monthly income to *tzedokoh*, the inflated price of kosher food, and the string of religious events in the Jewish calendar. The higher cost of Haredi living then gives rise to what she called a 'black market economy', where cash transactions underlie the buying, renting and selling of goods and property, which are 'very difficult to trace'. The redistributive and informal economy described by Mrs Shaked supports a situation where 'people in learning are subsidised hugely by people who are earning'.

An authoritative and dedicated body in Jewish Manchester was instituted to support Haredi locals to navigate the British welfare system, similar to the case of Haredi constituencies in London (Gonen 2006). Some non-Haredi locals were quick to portray the Haredim as 'frummies' who fraudulently abuse welfare benefits,⁷⁸ but government support was conversely described as being an imperative medium through which Haredi women could fulfil the expectations of being a Haredi wife and mother and meeting the demands of the domestic domain. As *Rebbetzin* Yad claimed, welfare benefits were an essential 'need [for women] to be able to serve *Hashem* by running their homes'.⁷⁹

Indicators of poverty that are applied to the non-Jewish population do not fully reflect the Haredi Jewish context as economic circuits are redistributive. A ring of the Haredi elite subsidises the more deprived families, which ensures that nobody is left without food, shelter and economic resources. For these reasons, as Mrs Shaked told me, 'I think there is nowhere that you can find a true

indicator of the level of poverty or the level of need because so much is patched up’.

‘Hashkofic Contamination’

Protection from social contagions was not only pursued against the external world, but also within the settlement. When I joined Mrs Birenbaum (a Haredi Litvish mother) and her children for dinner one evening, she privately recounted to me an incident that occurred in the secondary school that her twelve-year old son attends, which serves many Haredi families. She expressed her horror that a pupil had defaced a classroom locker with ‘Rabbi Fleischman wanked here’, as onanism constitutes a grave *aveirah* (transgression) in the Judaic cosmology. Mrs Birenbaum viewed her son’s exposure to this language and illicit act as a consequence of the secondary school bringing together children from two very different Orthodox Jewish primary schools: one being viewed as more Haredi (where ‘that kind of thing would never happen’), but the other positioned as less religiously stringent, where it apparently would happen. When I asked why her son could not attend a local Haredi independent school, Mrs Birenbaum remarked that the family were not religiously stringent enough to meet its requirements, partly because, she felt, they owned a television in the family home and the children were allowed to watch DVDs.

The danger of mixing children from different religious families was a fear for Mrs Birenbaum and many other *frum* mothers whom I encountered. Jewish youth services that were marketed as being ‘cross-community’ but not Haredi-led were seen as deeply problematic – if not dangerous – because bringing different Jewish children together meant bringing their worldviews into contact, which could consequently threaten standards of religious observance (or interpretations of religious authenticity).

Mrs Birenbaum actually preferred her boys to engage in sport and exercise activities organised by non-Jewish clubs because then a clear contrast could be made between Jewish and non-Jewish children, whereas it was harder to make a moral distinction between ‘Jewish and Jewish’. The issue of ‘*hashkofic* contamination’ – as Adoniyahu put it – is much greater because modern Orthodox Jews still define themselves as observant of *halachah* yet conform to different stringencies than their *frum* or Haredi counterparts, so the boundaries effectively become more blurred. Thus the difference

was one of *hashkofos*: the nuanced worldviews of modern Orthodox or Haredi Jews and how each situates themselves within Jewish Manchester. In this instance, boundaries serve to protect particular groups from differences (or perceived threats) that are internal or inherent rather than external (cf. Esposito 2008).

Mr Dror was one participant who had transitioned his children from a 'black' Haredi private school to a state-aided Jewish school that was more modern Orthodox and Zionist in its outlook.⁸⁰ He remarked how intra-group differences can be demarcated by outlook and observance:

There are significant worries that if you speak to other children, the kid might hear things that are not quite appropriate for them – or ideas that are not [of the] 'correct' *hashkofoh* which might influence their children to take a non-Haredi lifestyle and they want to protect them against it.

The fear of '*hashfokic* contamination' ran across the continuum of *frum* families in Jewish Manchester, rather than being an issue at the 'extremities'. Describing herself as modern Orthodox (but with children attending schools that were widely regarded as being more Haredi), one mother elucidated her concerns about differences in outlooks or worldviews:

Mrs Harris: It's more to do with people coming from very different homes. It's hard to stop your kids being friends with people whose homes I'm not so keen on them going to. So either watching *stuff* that you don't want them to be watching, or wearing *stuff* that you don't want them to be wearing, or eating *stuff* that you don't want them to be eating. (Emphasis added)

When interviewing a *Satmar*⁸¹ mother, she commented that a defining principle of being Hassidish is what she described as a 'very insular outlook, and we do an awful lot of *protecting* ourselves from anything that might not be appropriate' (emphasis added). Protection extended to avoiding the use of a local organisation that claims to be 'cross-community', also serving the local non-Jewish population, and has an agenda to bridge sports and social activities with education about Israel. When I asked if her children would use the service for physical activity and recreation, she replied:

Mrs Burshtein: Our children definitely not, other [*Satmar*] children presumably also not. This is going to sound extremely snobbish and I don't mean it the way it sounds, we try to be careful about who they mix with, and if it's going to be children who might introduce them

to *stuff* that we're not very excited for them to know about, we'd like it to be with strict supervision and very carefully controlled. It sounds very snobbish and elitist, but we don't mean it like that, it's being exposed to the outside world. (Emphasis added)

In these instances the issue at play is less about physical space (such as 'different homes' or the physical 'outside world'), and more related to the worldviews that underpin different interpretations of the Judaic cosmology and the unwelcome, unanticipated, or disruptive exposure this could bring to what are viewed as less stringent modalities of Judaism. The 'stuff' that Mrs Harris and Mrs Burshtein refer to is non-descript and un-defined, but remains a threat to the moral order that they try to inculcate as Haredi mothers and 'God-fearing' women. Stuff, however intangible it is represented to be, is a medium and a marker in which purity can encounter *potential* danger – for 'where the lines of abominability are drawn heavy stakes are at issue' (Douglas 2002: 196). It is in these zones, that demarcate internal from external, where possible contamination or contagion can occur, warranting the deployment of 'immunitary reactions' in order to preserve collective life (cf. Esposito 2015).⁸²

Jewish and Non-Jewish Encounters

Historical and contemporary relations between Jews and non-Jews in Manchester illuminate the complex ways in which connections with the outside world are negotiated – but are also telling of the precariousness and internal anxieties surrounding self-protection. Whilst implicit and explicit prejudice was certainly mutual between Jews and non-Jews in the historical slum areas, I would argue that inter-group relations during the nineteenth and early twentieth centuries should not be reduced to a homogenous experience.⁸³ Louise Dawson lived around the former Jewish Quarter as a child and remembered how her mother would not welcome Jewish children in the house, so they would often instead play together in the street.⁸⁴ The same could be said in reverse, especially in cases of intermarriage, as Jewish neighbours would remark to Mrs Glantz, 'fancy letting a Christian into the house'.⁸⁵ Manchester Jews would look down upon their non-Jewish neighbours and vice-versa.⁸⁶ Despite the fact that Jewish and non-Jewish neighbours were apparently cordial to each other they actually 'mixed very little'.⁸⁷ The Jewish slums can be understood as sharing a frontier

area with non-Jews – rather than a complete separation or ‘ghetto’. The overlapping nature of the area meant that hostilities certainly did occur, and Raymond Levine recalled slurs of ‘you killed Christ’ being hurled by non-Jews, particularly around the landmark of Saint Chad’s Church, which still sits amidst the bygone Jewish Quarter to this day.⁸⁸

Many Jewish welfare organisations of the time had committed themselves to supporting non-Jewish neighbours, again demonstrating the potential for encounters in the shared area. In some instances, serving the local non-Jewish population was intended to elevate the status of the Jewish minority and aid its integration into society, as was the case for the Jewish hospital in Manchester (Chapter Two). Archival records also expose how the Jewish settlement supported non-Jews in broader areas of life, such as the aforementioned Jewish soup kitchen but also maternity and infant care provisions.⁸⁹ However, the inclination for mutual support on the part of the Jewish settlement now seems confined to the archives, as some Haredi-led support groups in present-day Manchester are explicit in not making their services available to non-Jews (Chapter Three).⁹⁰

The contemporary relations with, and regard for, the non-Jewish population is further indicative of the Haredi preference for self-insulation and protection, but also attests to how the settlement cannot be completely self-contained and cut-off from the external world. Haredi Jews in Israel have been described as living voluntarily in ‘ghettos’ (Aran, Stadler and Ben-Ari 2008: 32), which is a conceptual and topographic reference that should be viewed with caution if not avoided outright, in the case of Jewish Manchester at least. The term ‘ghetto’ is bound up with historically-situated tactics of isolation imposed *upon* Jews, yet conceals the porous, fluid and relational character of Jewish Manchester vis-à-vis non-Jews and non-Jewish cosmologies.⁹¹

The local non-Jewish population are typically regarded under the collective term ‘*goyim*’, which I often found was used pejoratively and itself glosses over immense social and ethnic diversity formed of ‘born and bred’ Mancunians, Eastern European émigrés, as well as religious minorities of South Asian and Middle Eastern origin. Mancunian and especially Eastern European women often service the needs of *balabotish* (middle class)⁹² *frum* families in the form of domestic work,⁹³ demonstrating how some regular Jewish and non-Jewish encounters do occur. Muslims, as I go on to discuss, are generally viewed with suspicion and avoided.⁹⁴ The preference for

frum Jews to be ‘self-contained’ (as Sara put it) amidst the area’s non-Jewish diversity reflects the Haredi lifeworld in ethnically diverse boroughs of London. The absence of encounters and lack of public participation on the part of Haredim in Hackney is perceived as ‘not *wanting* to mix’ by other locals, which can, in turn, give rise to limited understandings and subsequently ‘enhance prejudice’ (Wessendorf 2013: 410 [emphasis in original]).

Antisemitism is widely seen to be on the rise in the UK, and residents of Jewish Manchester had complained that ‘you do feel it is more acceptable to be antisemitic than it used to be’ (Mrs Gellner). Such concerns can be understood when cast against the backdrop of targeted and murderous attacks against Jews in Europe and the United States that occurred consistently during my time in Jewish Manchester and afterwards, as mentioned in the Introduction. The rise in antisemitism experienced over the summer of 2014 (following the Israel–Gaza conflict) and proceeding years was threatening for many *frum* Jews I met, not least because Haredim are visibly identifiable as a Jewish minority. Many anxieties related to Muslims due to a fear of being ‘outnumbered’. In the words of one *frum* woman, ‘the Muslims are everywhere. They’re very strong and I don’t think we’re immune at all’ (Mrs Dreer). What is striking is how she deploys the language and imagery of *immunity* when discussing protection of the social body against the perceived threats of neighbouring minority populations, assimilating contemporary media stirs of demographic anxiety. Jewish–Muslim relations at the local level should, however, be viewed in a deeper context of how minority groups are constructed and (re)presented as threats to the body of the nation in historical, social, and political debates in the UK (Egorova and Ahmed 2016).

On another occasion I met Mrs Glassberg, who described herself as an Orthodox Jewish woman, for coffee in an area that was once in the heart of the former Jewish Quarter, but is now largely populated by South Asian émigré and Muslim families. She walked towards me and announced, ‘it’s like Gaza City in here’, before sitting down to our interview. Mrs Glassberg made this reference to the Muslim (but not Middle Eastern) social body that surrounded us rather than the physical structure of the non-kosher café or the environment, and in relation to political tensions occurring in Israel and Gaza at the time. However, my interpretation is that the ethno-religious separation and disdain that is marked through her comment – as well as the spatial distance between Jewish Manchester and the predominantly Muslim neighbourhoods (in what was the former

Jewish Quarter) – evokes Mrs Glassberg’s comparison with Gaza. The prominent shopping area in question, with a large Tesco supermarket, sits a short walk away from Jewish neighbourhoods, but I was told by Mrs Gellner that a lot of *frum* and Haredi people ‘would not visit full stop, even to Tesco’ despite its array of competitively priced kosher produce.

Rather than an issue of cultural-distinctiveness between Jewish and non-Jewish groups in Manchester, ethnicity becomes a marker of difference when there is a point of contact between the two; ‘differences are made relevant through interaction’ (Eriksen 2010 [1993]: 263).⁹⁵ Mrs Glassberg likened the café as ‘Gaza City’ by pointing out the Muslim regulars and thus making the ethnic difference relevant. By doing this, her comment demonstrates how ‘the *context* of interaction is constituted prior to the interaction itself and must therefore form part of the explanation of interpersonal processes’ (Eriksen 1991: 129 [emphasis added]). Barth has argued that it is ‘the ethnic boundary that defines the group, not the cultural stuff it encloses’ (1969: 15). However, rather than being demarcated by a boundary, there has evidently been a *zona franca* in the Jewish Quarters of Manchester where encounters – and thus the possibility for either inter-group and also intra-group interactions (however dangerous they might be) – can take place.

Discussion

The development of organised services and a system of mutual support has been a historical feature of Jewish Manchester, which has enabled the former émigré and now Haredi Jewish settlements to establish varying degrees of self-sufficiency, dissimulation and, increasingly, protection. However, this does not mean that the Jews of Manchester constitute a homogenous ‘community’ – an *imagined* category that bears little relation to the lived realities of internal marginality experienced by some émigré and Haredi Jews.⁹⁶ Recurring constructions of internal fragmentation, social gradations, and relational positioning have historically been at play, demonstrating how protection is a graded strategy that is sought *within* the Jewish settlement – and also between it and the outside world.

The aspiration for self-sufficiency and self-protection from the external world illustrates how minority groups can negotiate citizenship or ‘subject status’⁹⁷ as well challenge the ways in which they are incorporated within the body of the nation. McCargo (2011)

has argued how gradations or ‘graduated’ positionalities in relation to the state occur where citizenship is conveyed by degrees of (in) formal belonging along a socio-politically constructed continuum, rather than as a given or equally-bestowed category. The Malay Muslim minority in Thailand are exemplary of this, as holding Thai nationality is only one grade, but subscribing to ideals of ‘Thai-ness’ (as expressed by loyalties to the social order) is another (McCargo 2011). A paradox of marginality then exists, especially for some minorities, who ‘can neither escape the nation-state nor be full-status participants in its programme’ (Tsing 1994: 289).

Viewing citizenship as a graded – but also relational status – reflects how the Jewish elite positioned themselves as ‘natives’ and their co-religionists as ‘foreign’ during the nineteenth and early twentieth centuries. However, attempts to narrow this gap and convert the ‘alien’ Jews into English Jews (and thus relationally closer to the body of the nation) provoked resistance to assimilation on the part of Haredim, indicating how graduated statuses were intentionally sought as a form of protection. The historical relation between anglicised and émigré Jews is recurrent with present day dynamics in Jewish Manchester, and reflects the anxieties felt by the broader and mainstream Jewish social body towards the Haredim and the extents to which they do or do not integrate into UK society (cf. Staetsky and Boyd 2015). Services that are instituted by the broader Jewish population in Manchester can bring exposure to ‘stuff’ that is viewed as dangerous and threatening to authoritative interpretations of the Judaic cosmology.

Haredi Judaism should be understood as sitting ‘relationally and positionally’⁹⁸ to the outside world, and continuously responding to political and socio-religious shifts in the state and national culture. Maintaining a graded relation to both the broader Jewish social body and the state enables Haredi Jews to maintain autonomy over their lifeworld. Exposure to external influences can then be avoided, or, at best negotiated, which demonstrates the complex ways in which social *immunity* is pursued against worldviews or pressures that are perceived as contaminating. The relationship between dissimulation, graded protection and *immunity* in the Haredi context serves as the point of departure for Chapter Two, where I critique the ‘hard to reach’ label that routinely appears in public health discourse when portraying the so-called ‘ultra-Orthodox Jewish community’.

The ‘hard to reach’ margins are not only about territories, but also ‘an analytic placement that makes evident both the constraining, oppressive quality of cultural exclusion and the creative potential of

rearticulating, enlivening, and rearranging the very social categories that peripheralize a group's existence' (Tsing 1994: 279). Health is subject to the 'constraint and creativity'⁹⁹ associated with the lived reality of marginality (and life at the margins), and I go on to argue how this is particularly acute in the Haredi context as it is one of the few points in which the state and minority encounter each other. Not only does this mean that healthcare and how it is used demonstrates that Haredi Jews evade a 'subject status' rather than the state (and its institutions) per se, but more specifically the way in which a relationship with the state is carefully mediated and managed. The next chapter addresses how responses to healthcare services can be most appropriately framed.

Notes

1. According to Dobkin (1994) the slum areas of Red Bank and Strangeways (parts of which are now known as Cheetham Hill) had been the 'centre of Jewish life' in Manchester before the periods of mass Jewish immigration.
2. Hebrew, meaning 'house and garden'.
3. Also *hashkafot*, pl. *Hashkofah* (also *hashkafah*), sing.
4. Term introduced by a local (who described herself as Orthodox) in reference to Jews who have become more *halachically* observant than they were raised (*Ba'al teshuvah*, literally master of repentance).
5. *Giyur* is taken from the root *l'ger*, meaning 'to sojourn' ('conversion' in English).
6. See MANJM J162. Mrs Levy was born in 1893 and interviewed in 1977 (making her eighty-four at the time of her oral history recording), which would indicate that internal divisions were already occurring by the later decades of the twentieth century.
7. A (relative) term that is used to describe and position Jews along a gradient of observance rather than fixed categories of 'Orthodox' or 'Haredi'. See also Valins (2000) who makes reference to the 'religious "right"' or 'the right of the religious spectrum'.
8. Staetsky and Boyd (2015: 2) describe 'denominational switching' as moving from one Jewish denomination to another, by way of moving to a more or less *halachically* observant form of Judaism.
9. Whilst the context of Scott's (2009) argument is the physical relation between a mountainous refuge and plains of economic activity, I apply it to the protective strategies taken by Haredi Jews (and also authoritative interpretations of the Judaic cosmology) vis-à-vis the encroachment of the external world.

10. Benjamin (2002) critiques the concept of community in relation to the immensely diverse but amalgamated 'Malay world'.
11. MANJM J144. Phina Emily (Sissie) Laski was the daughter of Rabbi Dr Moses Gaster (former *Haham* or Head of the Spanish and Portuguese Head of the Spanish and Portuguese Jews), and wife of Judge Neville Laski, who was among Jewish Manchester's social elite.
12. MANJM J273. Dr Rich was born in 1910 and interviewed in 1980 (making him seventy at the time of his oral history recording). I emphasise 'we' to signpost the broader prejudices held by some Jews towards Muslims in Manchester, an issue that I return to later in this chapter.
13. Reuter (2016) offers an excellent discussion of medical racialism and anti-'alien' politics in relation to Tay-Sachs disease, which was historically considered exclusive to Ashkenazi Jews despite the fact that it is not and never has been. Tay-Sachs Disease is an autosomal recessive disorder that is always fatal in affected infants. As Reuter (2016: 15) argues, Tay-Sachs is 'exemplary of a disease idea that has long served to delimit a notion of racial difference'.
14. William Moses Feldman was a leading Jewish physician of Russian Jewish origin (See Rubinstein, Jolles and Rubinstein 2011: 271).
15. Attempts to reduce maternal and infant mortality in England over the course of the twentieth century were accompanied by the less positive side-effect that women and their bodies have become intensely vulnerable to control and technological supervision and management. The early twentieth century brought a previously unseen focus on motherhood as a strategy to improve infant survival and child health, bound up in ideas of a healthy and numerous population being a 'national resource' (Davin 1978). The combination of high infant mortality rates and a falling birth rate was viewed as an issue of national security and was central to British imperial ambitions because 'population was power' (Davin 1978: 10). Infant mortality, for example, accounted for twenty-five per cent of all deaths recorded in 1901 (Griffiths and Brock 2003). Calls were made at this time to provide poor birthing women with skilled maternity care free-of-charge as a public health priority (Donnison 1988: 161), exemplifying how individual women and motherhood became entangled in the concerns of the nation's welfare. Maternal mortality rates in England began to rise by the First World War, inflaming national anxieties around population quality (Loudon 2001 [1992]). Maternal mortality rates remained elevated until 1935, with one in every two hundred women dying in childbirth (Drife 2002).
16. Midwifery in the UK was subject to increasing regulation from the turn of the twentieth century. The 1902 Midwives Act marked the beginning of a series of political interventions to regulate, professionalise and supervise midwifery practice in England, see Donnison (1988)

- and Loudon (2001) for an in depth discussion. Beier (2004: 379) notes how 'the management of birth shifted from informal, working-class, female, neighbourhood authorities to formally trained and licensed midwives, health visitors, nurses, and physicians'. See Oakley (1984) for an in depth historical discussion of the medicalisation of pregnancy, women's bodies and infant care.
17. GB127.M443: 1921. Reflecting on the early 1930s, Sidney Taylor (MANJM J294) regarded Saint Mary's as the 'best' local hospital and 'being under their care from the beginning to the birth' was highly desirable.
 18. GB127.M443: 1921.
 19. MANJM J273.
 20. GB127.M443. A *brit milah* (also *bris milah*) can only be delayed for medical reasons, such as neonatal jaundice.
 21. GB127.M443.
 22. A quorum of ten Jewish men, who perform the recitation of certain prayers required at a *brit milah*. It was explained to hospital authorities that it was not 'absolutely necessary' to have a celebration at a *brit milah*, if this was the primary concern of the hospital authorities (GB127.M443). This position presents historical discontinuities with the contemporary conducts of Haredi Jews that are presented as normative by rabbinical authorities. At the time of my research, information distributed by *rabbonim* to *frum* women in Manchester and London notes that if a *brit milah* occurs while a woman is still under hospital care, then 'arrangements should be made with the Hospital Administration to perform this short ceremony in a room away from the ward, in order not to disturb general routine, as this entails having a "minyan" present'. The agency in which Haredi religious authorities attempt to negotiate the performance of the *brit milah* on maternity wards (when relevant) is then discontinuous with the historical need of a minority to submit to the demands of the medical establishment.
 23. MANJM J273. Rich's oral history indicates that the conditions in which obstetric procedures were practiced, such as the reduced ability to deal with blood loss, may have been an important factor in making emergency obstetric care less safe.
 24. MANJM J294.
 25. Crumpsall Hospital (North Manchester) is approximately six miles in distance from Saint Mary's Hospital.
 26. MANJM J273.
 27. MANJM J273.
 28. MANJM J273.
 29. Articles had featured in prominent medical journals before political events in the 1930s, which, by contemporary standards, would be construed as circulating, manipulating, or perpetuating (or being written in response to) stereotypical and racialised representations of Jews

- (see, for example, *The Lancet* 1884; Pearson and Moul 1926; Feldman 1926; James 1928).
30. The Poor Law Amendment Act (1834) was introduced with the intention of making care for the poor more cost-effective, which was an expenditure that had, until then, been met by taxing the middle and upper classes, who claimed that the poor could afford to avoid work and 'be lazy'. Through the institution of the Poor Law, relief to the unemployed, sick and old was typically granted by entering the punitive environment of a 'workhouse', where basic accommodation was available in exchange for manual mundane labour (National Archives n.d.). Each parish was responsible for the poor in its bounds, and groups of parishes were managed by a 'Board of Guardians', each with a designated medical officer (Davey Smith, Dorling and Shaw 2001).
 31. Modelled on London's Jewish Board of Guardians (established 1859).
 32. This is not to say that the Jewish poor did not enter the workhouse at all. Cases considered by the Board to be 'underserving' after thorough investigations were referred to local workhouses. The Board also negotiated the terms through which Jews entered workhouses, such as not working on *Shabbat* and, in some instances, Jewish orphans and 'deserted children' could instead attend a Jewish residential school (Williams 1976: 288–289). Marks (1994) notes how London's Jewish Board of Guardians was among England's most progressive philanthropic bodies at the time, but also deployed disciplinary practices and went as far as repatriating émigré Jews to Eastern Europe who were unable to maintain themselves, and also used the workhouse system as a form of coercion (particularly in the case of 'deserted wives' to force husbands into acting on marital responsibilities).
 33. As was the case in London (see Reuter 2016: 74). Prior to the establishment of the Board and allied services, synagogues were responsible for the poor of their congregations (Dobkin 1994), as well as other Jewish social welfare organisations.
 34. The German philosopher Friedrich Engels reflected on his experience and observations of Victorian Manchester's insalubrious living and working conditions when writing 'The Condition of the Working Class in England in 1844'.
 35. See GB127.M182/3/1: 1873–1874, 1874–1875.
 36. GB127.M182/3/1:1869–1870.
 37. GB127.M182/3/3: 1890–1891.
 38. Small room used for prayer. These were usually comprised of ethnic sub-groups, such as Polish or Russian Jews.
 39. Society, *chevra* (sing.), *chevrot* (pl.).
 40. These émigré Jews preferred to avoid what they viewed as the 'English *shul*' (synagogue), which was primarily used by the anglicised and integrated Jewish classes. Resistance to the anglicised Jews did not only manifest because of religious oppositions but also gradations in

- socioeconomic status between the émigré (as well as upwardly mobile) with the elite Jews (see Heggie 2011).
41. GB127.M151/4/12: 1895.
 42. GB127.M182/3/1: 1871–1872.
 43. GB127.M294/2. See also Williams (1985: 156), who notes that the Society for the Relief of Really Deserving Distressed Foreigners was instituted by non-Jewish German merchants but had a considerable Jewish membership providing financial donations. Whereas the charitable body could select who was ‘deserving’ of financial and material help, synagogues would tend not to refuse ‘the kind of temporary financial assistance which the Society “avoided [giving] as much as possible”’ (Williams 1985: 157).
 44. See Lock and Farquhar (2007: 307) who note that colonised bodies were portrayed as the ‘symbolic inversions’ of Europeans, which needed saving through colonial endeavours that were often portrayed as ‘humanistic’.
 45. MANJM J143. Margaret Langdon was a prominent philanthropist in Jewish Manchester, born in 1891 and interviewed in 1978 (making her eighty-seven at the time of her oral history recording).
 46. MANJM J279. Dina McCormick (née Glantz) was born in 1907 and interviewed in 1980 (making her seventy-three at the time of her oral history recording).
 47. See, for example, GB127.M182/3/4: 1904–1905; GB127.M151/4/2.
 48. See GB127.M182/3/4: 1904–1905. In contrast, non-communicable diseases such as diabetes were noted, at the same time, to be more prevalent ‘among the better classes’ of Jews who lived in the more affluent districts (GB127.M182/3/4: 1905–1906).
 49. Burman’s (1982) notes that Jewish women in Manchester would tend to give up employment immediately before marriage, whereas non-Jewish women would continue working. Her fascinating study compares Jewish women’s increased working patterns in the *shtetls* of Eastern and Central Europe where men earned social status through religious study and knowledge, and in Manchester, where social status was earned through men’s employment to emulate as much as possible the Jewish and English middle classes. In both cases, Burman argues that Jewish women were typically excluded from the processes through which ‘social recognition was acquired’ (1982: 37).
 50. See MANJM J279.
 51. MANJM J279; GB127.G25/3/6/8: 1909.
 52. MANJM J279.
 53. GB127.M151/4/2: circa 1910.
 54. MANJM J279.
 55. MANJM J279. Similarly, some émigré and Manchester-raised Jewish women claimed how they would rather starve than be compelled to take employment against local norms (Burman 1982: 31–32).

56. See MANJM J162.
57. Emphasis in original. Ecks and Sax (2006: 208) argue that that marginality is a construction of society and social hierarchy, and a practice that 'people do to each other'.
58. MANJM J279.
59. See MANJM J279; MANJM J229; Golding 1932.
60. MANJM J279.
61. Whilst Valins (2003) notes that the imagination of a 'community' remains from an emic perspective, I argue in this chapter that the term 'community' obscures the internal divisions and fragmentations in Jewish Manchester.
62. Gifts of food that are given to friends and family on *Purim*, *mishloach manos* was the vernacular among Ashkenazi Haredim.
63. See Kahn-Harris and Gidley 2010: 7, who make a distinction between 'Anglo Jewry' (the collective population of Jews in the UK) and the 'Jewish community', 'in order to emphasise how not all British Jews are involved in institutional life or even see themselves as Jewish and as having anything in common with other Jews in the UK'.
64. Mr Emet's distinction between Haredi and Orthodox Jews reflects the historical process in which the term 'Haredi' initially began to circulate as a conceptual separation of Jews who held different standards of religious observance to mainstream Orthodoxy (also instituting separate lines of religious authority), see Introduction.
65. MANJM J279.
66. MANJM J273.
67. Central to Passover (*Pessah*) is the *Seder* meal, which recounts the journey of exodus taken by the ancient Hebrews out of Egypt, which concludes by reciting the phrase 'next year in Jerusalem'.
68. MANJM J144.
69. I borrow and adapt the concept of privileged marginality from Faubion (1993: 191), who describes 'distinguished women, distinguished "homosexuals", distinguished "provincials" who belong to the Greek intelligentsia' as 'privileged marginal'. I describe the Sephardim in the UK during this period as 'privileged marginals', as they formed their own Jewish minority yet had relatively more social capital and resources than émigré Ashkenazi Jews in Manchester.
70. MANJM J153. Rachel Black (pseudonym) was interviewed in 1977. No record of her date of birth available.
71. MANJM J144.
72. Inter-marriage between Ashkenazi and Sephardi Jews in Manchester did occur. It is customary for a woman to follow the *minhagim* of the man she marries, so a Sephardi woman marrying an Ashkenazi man would take on his *minhagim*. That being said, it was not uncommon for Haredi Sephardi men to instead attend Ashkenazi synagogues. One boy with mixed Ashkenazi and Sephardi parents told me how his

- (Ashkenazi) mother preferred him to attend an Ashkenazi synagogue so that he 'would have Ashkenazi friends'.
73. A stamp or certificate to reassure consumers that a product has been subjected to rabbinical supervision under the auspice of a particular *Bet Din* and can be consumed.
 74. *Kedassiah*, managed by the Union of Orthodox Hebrew Congregations (UOHC), was viewed as the most stringent *hechsher*.
 75. Although commonly translated into English as 'charity', the root meaning of *tzedakah* or *tzedokoh* is justice or righteousness. It is an aspect of *halachic* law that requires all Jews to donate a tenth of their earnings to charitable causes.
 76. Hebrew; an abbreviation of *gemilut chassadim*, acts of kindness.
 77. See also Chapter Three, where I discuss how a Haredi culture of maternity care attempts to meet the limitations of NHS maternity services rather than replace them altogether.
 78. 'Frummies' (also frummers) is a pejorative play on the word '*frum*' (pious), and was used by non-Haredi Jews to describe Haredim.
 79. Hebrew, the name. Used by pious Jews in place of 'God' or more formal references such as '*Adonai*'.
 80. 'Black' was commonly used in the field-site as being Haredi, religiously right-wing, or '*shtark*' (strict).
 81. According to some estimates, *Satmar* are one of the largest Hassidish groups. *Satmar* religious leaders are known to hold 'anti-Zionist' views, but generally not to the extent that *Neturei Karta* take a publically 'anti-Zionist' position.
 82. Hakak (2009) has described how, in the context of *yeshiva* students in Israel, the Haredi body is an artefact in which any slight change in appearance or conduct is scrutinised as being indicative of (or at risk of) religious transgressions. Institutional resistance to exercise, a 'gentile custom' (Hakak 2009), positions the body as a margin that must be fortified. It must be noted that Haredi men in Israel are cast against a large (non-Haredi) Jewish population and a social expectation to join the Israeli Defense Forces, an institution which cultivates a specific corporeal ideal of the 'chosen body' (Weiss 2002).
 83. One notable testimony to Jewish and non-Jewish relations during the early twentieth century is the literary masterpiece 'Magnolia Street', written by Louis Golding (1932) and inspired by his formative years in Jewish Manchester.
 84. MANJM J76. Louise was born in 1892. No available record of interview date.
 85. MANJM J279. Dina married Jack McCormick, a non-Jewish man who did not practice a religion yet and was positioned as a Christian by Jewish neighbours, probably by virtue of belonging to the dominant majority population.
 86. MANJM J279.

87. MANJM J74. Leslie Davies (Jewish) was born in 1912. No available record of interview date.
88. MANJM J160. Raymond was born in 1919 and interviewed in 1975 (making him 56 at the time of his oral history recording).
89. M151/4/2; M790/2/6(2): 6 January 1904; 1 February 1904; 31 October 1904; 22 November 1905. Annual report for the Jewish Soup Kitchen notes 'resolved that assistance be given to Christian parents, if considered deserving'. Coupons designated for 'Christian' neighbours (a broad category essentially meaning non-Jewish) were handed to the superintendent of police for distribution, and donations made to the Jewish Soup Kitchen often came with a prerequisite that a certain number of coupons be allocated for non-Jews.
90. The current preference to provide maternity care only to Jewish women, as I discuss in Chapter Three, is arguably part of a broader strategy of self-protection and dissimilation that breaks with the historical course of integration taken by the Jewish establishment in England, and is a point I return to in the discussion of this chapter.
91. The notion of a Jewish 'ghetto' draws upon a historical tactic of separation imposed upon Jews by the external Venetian social order as a 'spatial solution to deal with its impure but necessary Jewish bodies' (Sennett 1994: 227).
92. Yiddish: middle-class, respectable, good-standing.
93. Women domestic workers were referred to in the Yiddish-derivative of *goytah* amongst Hassidish circles.
94. It is important to note that there is a prominent group for Jewish and Muslim interreligious dialogue in Manchester formed mainly of non-Haredim, so the concerns of these locals may not reflect those of the broader Jewish population.
95. Eriksen's claim also underlies my argument (see introduction) against referring to Haredi Jews as 'ultra-Orthodox', a label that is only made relevant through interaction or discourse with non-Haredi Jewish modalities.
96. See Anderson (2006).
97. Scott (2009).
98. Cf. Scott (2009: 32) who, in the context of the Zomia region of Southeast Asia, has argued that 'hill peoples cannot be understood in isolation ... but only relationally and positionally vis-à-vis valley kingdoms'.
99. See Tsing 1993: 18, who describes marginality as both a 'source of both constraint and creativity'.

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Oral Histories, Manchester Jewish Museum (MANJM)

- J74: Leslie Davies. Date of interview not recorded, by B. Williams.
- J76: Louise Dawson. Date of interview not recorded, by B. Williams.
- J143: Margaret Langdon. Date of interview: 1978, by R. Livshin, R. Burman and P. Roberts.
- J144: Phina Emily (Sissie) Laski. Interview date not recorded, by B. Williams.
- J153: Rachel Black (pseudonym). Date of interview: 9 March 1977, by R. Livshin.
- J160: Raymond Levine. Date of interview: 6 February 1975, by P. Games.
- J162: Esther Levy. Interview date: 26 January 1977, by P. Games.
- J229: Marjorie Smith. Date of interview: 22 December 1976, by R. Livshin.
- J273: Louis Rich. Interview date: 7 November 1979 and 17 July 1980, by R. Burman and J. Emanuel.
- J279: Dina McCormick. Date of interview: 2 January 1980, by R. Burman.
- J294: Sidney Taylor. Date of interview: 14 July 1980 by J. Emanuel.

Archives & Local History, Manchester (GB127)

- M151/4/2: Manchester Jewish Soup Kitchen
- M790/2/6(2): Manchester Jewish Soup Kitchen
- M182/3/1–4: Manchester Jewish Board of Guardians for the Relief of the Jewish Poor
- M294/2: Society for the Relief of Really Deserving Distressed Foreigners
- M443: Manchester Hebrew Visitation Board for Religious Ministration in the Manchester Regional Hospital Area.
- G25/3/6/1–8: Manchester Medical Mission and Dispensary (Red Bank Working Men’s Christian Institute).

Chapter 2

CULTURE, FAITH AND HEALTH

Within weeks of having moved to Jewish Manchester in 2014, a driver had suddenly and dangerously pulled out of a side-street as I was cycling past, thrusting me into the middle of a busy road. A *frum* man passing by used his mobile telephone to summon *Hatzolah*, an emergency response brigade powered by Haredi male volunteers twenty-four hours and seven days a week including on *Shabbat*.¹ The service is mainly funded by one of Jewish Manchester's wealthiest patrons but also *tzedakah* donations from the settlement's redistributive economy, so call-outs are bestowed at no cost to locals in need of emergency assistance.²

Hatzolah do not intend (and are not able) to replace NHS ambulance services: their role is to manage emergency medical issues until NHS paramedics arrive, and to assist them with caring for *frum* and Haredi Jewish patients if required.³ The Haredi volunteers respond to emergencies within the same neighbourhoods that they live in, and thus have a rapid arrival time compared to NHS services. The *Hatzolah* brigade is formed of vehicles and ambulances equipped with emergency medical equipment such as basic life support and resuscitation kits, oxygen and defibrillators. All volunteers receive on-going life support training and provide rapid response care that is perceived to be 'culturally appropriate'.⁴ This is because *Hatzolah* is identifiable as an internal (Jewish) service and some of its volunteers may speak Yiddish, which is particularly useful for Hassidish call-outs, and to a lesser extent Modern Hebrew (Ivrit).⁵ The male volunteers are also identifiable as *frum* professionals because they

wear black velvet *capels* (male head covering),⁶ Hi-Vis jackets labelled with 'Hatzolah' (in English and Hebrew), and 'EMT' (emergency medical technician) as well as a six-pointed 'star of life'. For all these reasons *Hatzola's* Haredi manpower is viewed with an enormous sense of *naches* (Yiddish, pride) in Jewish Manchester, which gets materialised and celebrated through children's games and paraphernalia (Figure 2.1).

The *Hatzolah* model was brought from the United States to North London in 1979 after two *frum* Jewish residents died whilst waiting for NHS ambulance crews to arrive (Ryan 2003). *Hatzolah* units have since been instituted in the Haredi neighbourhoods of Golders Green, Hendon, Edgware, Gateshead and Jewish Manchester in order to mobilise rapid responses at the 'hard to reach' margins of the state. *Hatzolah* is highly valued by locals because of the instruction to preserve life (*pikuach nefesh*), which, I was told overrides any other commandment in Judaism and explains the heightened expectations of health services often held by Haredim. On the one hand *Hatzolah* indicates how the *halachic* imperative of *pikuach nefesh* is materialised in Haredi social organisation when the state is not perceived or trusted as being able to do so. On the other hand, *Hatzolah* introduces the ways in which medical care becomes the target of immunitary interventions by Haredi Jews when attempting to maintain degrees of autonomy in critical areas of interaction with the state.⁷

Opening this chapter with an account of Jewish Manchester's *Hatzolah* brigade serves as a vehicle to critique public health representations of Haredi Jews being a 'hard to reach' minority, which, as mentioned, implies a preference to evade formal healthcare services. Juxtaposing archival and ethnographic material throughout this chapter demonstrates how health and healthcare is a contested area of bodily governance between the minority and state because it has historically been, and remains, one of the few points at which Haredi and non-Jewish people engage with *each other*. An historical approach contextualises how concerns around healthcare have persisted over time, as Jewish medical cultures in Manchester developed within a broader struggle of insulation and integration for émigrés during the nineteenth and early twentieth centuries. Haredi cultures of health nowadays perform a critical role in negotiating how the social body is exposed to – and incorporated within – mainstream biomedical services. Culturally-specific care is explored as a primary strategy to reach the settlement's broader preference for self-protection and autonomy, enabling a level of protection and *immunity* over the social body to be maintained.



FIGURE 2.1 Hatzalah Go! board game, available in Jewish Manchester. Photograph by the author.

Health protection and surveillance is then explored as a particular and continuous technique of assimilating and saving émigrés,⁸ and now Haredim, in Manchester, but these attempts often fail to appreciate how health and bodily care is situated in the Judaic cosmology. Overall the chapter illustrates the complexities faced by minority groups when accessing healthcare services, and the implications for evaluating how health messages might be received and answered with selected conducts (that may include forms of resistance) amongst ethno-religious groups regarded as ‘hard to reach’ by Public Health England.

Framing the ‘Hard to Reach’ Margins of the State

The romanticised and idealised construction of ‘communities’ in public health and biomedical discourses is often synonymous with underserved or excluded minority populations who are the intended beneficiaries (read: targets) of interventions (cf. Holloway 2006). Some minority groups in England are amalgamated and portrayed as a ‘community’ at the ‘hard to reach’ margins of the state in public health discourse – as is the case for the Haredim, as well as ‘Gypsy’ and ‘Traveller’ groups.⁹ The latter population are similar to the Haredim in that they form a composite collective and have a historical preference for dissimulation in order to preserve their lifeworld, not least because of persecution from state authorities

and dominant-majority populations. Yet self-protection does not necessarily equate with wanting to be excluded from mainstream healthcare services (see Perez 1995: 116).

The 'Gypsy' minorities in England have experienced rampant marginalisation and explicit racialisation over time (see Buckler 2007; Okely 1983; Perez 1995), and current mistrust against the outside world and authorities (including public health) can only be understood against this backdrop.¹⁰ The 'hard to reach' label portrays minority groups such as the Haredim and gypsies as outcasts and as shelving the expectations that the state holds of citizens (see also Chapter Four), but overlooks the socio-historical context in which minority groups position themselves and how (or where) they are positioned by the state. In short, it ignores the conditions in which certain minorities are portrayed as withdrawing to the 'hard to reach' margins of the state.

Minority groups may therefore cast themselves at the margins of society as a protective response to historical and lived experiences of prejudice. In a similar way to how the majority can exclude difference, minority groups can consequently be exclusive in their attempt to 'create and to defend their own identities and "purified communities"' (Valins 2003: 160). Being within 'reach' of the biomedical authority then presents historical (and recurring) controversies for some ethnic and religious minority 'communities', which is a reality that should not be ignored when attempting to understand current relations with biomedical services.

The preference to evade what Scott (2009) terms a subject status more appropriately frames the representation (and accusation) of Haredi Jews being beyond the 'reach' of political and biomedical grasp in the UK, as well as the preference of pious émigré Jews to insulate themselves during the nineteenth and early twentieth centuries. Being hard to reach does not mean an outright evasion of the state but rather a negotiated relationship, in a similar way to how autonomy does not equal independence. Certain elements of the state are vital to meet the needs of the Haredi settlement, such as welfare benefits and healthcare, and thus necessitate a graduated relationship as citizens. Whereas locals told me how the Haredi settlement in Manchester is 'self-sufficient' and 'self-sustaining', I interpret this ideal as self-protection because dissimulation is vital for the *immunity* (and continuity) of the Haredi lifeworld.

The representation of being 'hard to reach' provoked conflicting responses from locals in Manchester. Whilst the status did

accurately reflect the self-protective nature of Jewish Manchester for one of my Haredi neighbours, for Mrs Birenbaum (a Haredi mother) she instead felt unease about being categorised as ‘hard to reach’ and exclaimed that ‘it makes us sound like hippies or something’. Her reaction was clearly one of surprise, and perhaps Mrs Birenbaum took exception to the Haredim being amalgamated with other historically marginalised or ‘counter-cultural groups – when each should be understood in their own historical, political, or cosmological context. Her reaction supports my argument that public health discourse constructs and boxes Haredi Jews into an imagined ‘ultra-Orthodox Jewish community’ that is ‘hard to reach’ without fully understanding the local perceptions or conducts pertaining to health and bodily care.

The Expectations of the ‘Other’

The degree to which public health ‘knowledge’ is constructed rather than discovered is often under-estimated (Fassin 2004), and this chapter explores how Haredi Jews can have complex and coexisting strategies of practicing health despite being positioned as ‘hard to reach’.¹¹ Whilst biomedicine is globally hegemonic it is also highly localised (Livingston 2012), and is acted upon at local levels. In the Haredi context it is made kosher to protect the life of the social body. Providing health information and services to (and within) the Jewish settlement emerges as a challenge that is persistent over time, the root of which is a mutual fault – on the part of both the Haredim and the state – to adequately understand the expectations of the other.

The mutual fault to grasp how health and bodily care is constructed in the biomedical and Judaic cosmologies brings into question how we should conceptualise responses to (or ‘non-compliance’ with) healthcare services. Rather than being interpreted as resistance per se, ‘refusal’, as a conceptual category, ‘marks the point of a limit having been reached’ (McGranahan 2016: 320).¹² In the Haredi context, I take refusal to mean a form of protective *reaction* that occurs at the margin where the threat of contagion is located (cf. Esposito 2015).

Culturally-specific care¹³ has emerged from a historical refusal of mainstream health services among émigré, and especially Haredi Jews (and their rabbinical authorities), particularly as an attempt to reach a graded level of *immunity* from what is associated as belonging to the outside or non-Haredi world. Studies of the Haredim of Gateshead in North East England have claimed that ‘one of the few

areas in which the community has contact with non-Jewish people is health care' (Purdy et al. 2000: 233). However, I would instead argue that health and medicine are one of the few remaining sites where Haredi and non-Jewish people have to confront *each other*. With this encounter brings a negotiation of both the Judaic cosmology and biomedical dominance, where each authority attempts to uphold its governance of the body (but not always the needs of an individual, as I go on to discuss). Culturally-appropriate care (also termed cultural competence) enjoys a prominent place in public health discourse. Tailoring areas of healthcare to meet the needs of minority groups has been viewed as a potential solution to improve access to biomedical services among ethnic and religious minority groups, particularly in the context of maternity and child health (World Health Organization 2015; Napier et al. 2014; Summerskill and Horton 2015). Culturally-specific care in the Haredi context has a nuanced meaning and purpose. Firstly it grasps how health conducts are not considered in isolation but rather as part of a cosmology or worldview, and secondly is an attempt to reinforce a preference for autonomy and self-protection through the management of healthcare services.

The entanglement of cosmology and health in the case of Jewish Manchester is illustrated by the historically contiguous demand for culturally-specific care among émigré Jews and now Haredim; demonstrating the ways in which biomedical hegemony can be negotiated at the conceptual margins of the state. The Haredi context shows that the preference to negotiate care has also evolved from ideals of health and the body that are based on interpretations of the Judaic cosmology. Culturally-specific care therefore serves as a strategy for Haredi Jews to maintain a distance from the authoritative knowledge of public health, which is viewed with caution, but also meets their heightened expectations of healthcare services and supplements the perceived limitations of the state. The development of the Jewish hospital at the turn of the twentieth century and the perceived need for Haredi rapid response services exemplify attempts at bridging the gap between expectations of health services and what the state falls short of providing, and such interventions also mediate the position of the Jewish minority vis-à-vis the state. This chapter illustrates the recurring strategies taken by Manchester's Jewish settlement to meet local medical needs, and indicates that there is a complex bond between health and faith in the Haredi worldview, which is not adequately summed up by the notion of a group being 'hard to reach' – or beyond the reach of state services.

Helping and Healing in Primary Care

Conflicts between the Judaic and biomedical cosmologies can occur because of opposing values of care, which, for Haredi Jews, involves attention to the body as a vessel for the soul – as they are viewed as being inextricable from each other. Biomedical conceptualisations of health and bodily care can also present implications for the *halachic* governance of Jewish bodies, which has been a recurring issue for Jews in Manchester when accessing healthcare services, and, in turn, for healthcare services to be delivered (both internally and externally to the social body). The ‘hard to reach’ designation is at risk of stigmatising and over-simplifying the ways in which socio-religious groups navigate healthcare and how health-related decisions may be grounded in specific contexts and worldviews.

Mapping out the therapeutic landscape in Jewish Manchester demonstrates how culturally-specific and organised services operate with the intention of mediating mainstream health provisions and to address their perceived shortfalls. When looking at how this plays out in practice, the direct intervention of rabbinical authorities in the design and delivery of healthcare services forms part of a broader strategy of *immunity*. Their aim is to protect the Haredi social body from external threats that are feared to present a contestation with the Judaic cosmology and its governance of Jewish bodies – such as birth spacing technologies. Exploring the intra-group services that are available to Jewish locals therefore challenges established conceptions of Orthodox and Haredi Jews as showing a lack of compliance with health care services, and indicates how this only offers an incomplete picture of health conducts and perceptions of health in this religious minority.

Rabbi Silberblatt is a respected authority within – and an activist on behalf of – the Haredi and Hassidish constituencies. He is, according to one resident, a ‘medical *askon*’, which translates as a lay ‘helper’ or ‘doer’, and I am told that medical *askonim* are ‘Jewish people who aren’t actually doctors but know quite a bit’.¹⁴ Rabbi Silberblatt is often a first port of call for Jewish constituents needing advice on affairs relating to healthcare or when lobbying for particular courses of treatment, but also in complicated cases where medical procedures encounter *halachic* governance of the body. By possessing a strong command of (lay) medical knowledge, Rabbi Silberblatt is in great demand and *frum* Jews are constantly ringing or visiting him for direction on decisions affecting their health. His role can

primarily be interpreted as mediating with healthcare services to secure the rights and needs of Haredi Jews, whilst also managing the degree to which their bodies are incorporated within the mainstream biomedical culture.

The projected growth of Jewish Manchester's population led Rabbi Silberblatt to foresee an already overstretched local health service struggling to meet their increasing needs. In his mind, this presented a 'danger' of having a 'growing population without an adequate GP surgery to treat them'. Aside from increasing the service-capacity to meet the needs of the Haredi population as it continues to grow, the task of primary care involves meeting the culturally-specific needs, standards and expectations of the Haredi clientele.

Silberblatt was inspired to wage a long-running campaign for the construction of the *Arukah* Centre, in order to avert the 'dangerous' implications for health that he anticipated the growing Haredi settlement would face. Although *Arukah* is used as a pseudonym here, it is the Hebrew word for 'healing' and reflects the aspiration of Silberblatt and his design for an engine of health in Jewish Manchester. *Arukah*, as a local Sephardi rabbi told me, epitomises how 'a person often doesn't just need a cure (*refuah*, *marpeh*), they also need "healing" in the broader sense of support that is more "holistic" than just physiological cure'.

Pioneering a health centre that is appropriate and conducive to the care of Haredi Jews, for this *askon*, means upholding the principle that healthcare involves more than seeing a patient and offering what is considered 'right' from a biomedical perspective. The concept of 'right' must also exist in relation to the dictates of the group's cosmology, with which Haredi Jews can expect primary care services to comply.

At the core of Silberblatt's aspiration for a centre of '*arukah*' or healing is an expectation for NHS services to be culturally appropriate (or culturally-specific), which constitutes a form of pluralism or syncretism of knowledge-systems concerning the governance of the body. Prominent authorities in the Haredi minority, such as this *askon*, are demonstrative of the struggle over 'authoritative knowledge' by demanding a standard of service from the national health provider in order to meet their heightened expectations of bodily care.

The *Arukah* Centre was initially envisaged to conveniently bring together services that were otherwise fragmented and which, in turn, place unnecessary 'barriers in the way when wanting to access services' (Rabbi Silberblatt). The demand to use and access health

services in the Haredi settlement can then be inferred to exist, but the current design and delivery of services was failing to meet the expectations of local Jewish residents. One of the initial aims of *Arukah* was to 'promote health' amongst Haredi Jews by housing together GP, diagnostic, laboratory and pharmacy services under one roof. The conception of *Arukah* then developed into an NHS centre commissioned by the local health authority to serve both the area's non-Jewish and Jewish population, whilst considering the particular needs of Haredim.

General practice can apparently be viewed as an 'inaccessible service' for some Haredi Jews, who, according to Silberblatt, find waiting rooms problematic by virtue of exposure to information through televisions, radio, magazines, as well as unwelcome areas of health promotion. The mixing of genders is a particularly pertinent issue, 'and even more so when the female population aren't dressed modestly. The same would apply to any female health professional who could be providing a service' (Rabbi Silberblatt). This reference to immodesty in dress probably refers to the comportment of women from the neighbourhood's overlapping non-Jewish population, who share the same primary care services but not the same interpretations around covering the body. It was not uncommon for these women to be referred to vernacularly as *shiksas* within Haredi and Hassidish circles, a highly derogatory Yiddish term. A *shiksa* not only denotes a non-Jewish woman, but is drawn from the Hebrew word *sheketz*, meaning abomination or impure. For these reasons, waiting rooms are a '*zona franca*' or 'borderland' at which socially constructed ideas of 'purity' and 'danger' potentially come into contact (cf. Douglas 2002).

Haredi expectations of health services are allegedly high because the body, in the Judaic cosmology, is viewed as a gift from *Hashem* and Jews are mandated 'to look after it, maintain it and do everything we can to live a healthy life for as long as possible' (Rabbi Silberblatt). This means that Haredi patients apparently seek out the best quality services in order 'to ensure they will meet the obligation of leading a healthy life, [but] it is often felt that the wider [non-Jewish] community do not share the same values' (Rabbi Silberblatt).¹⁵ The public health representation of Haredi Jews being 'hard to reach' is therefore at conflict with the view of this rabbinical authority that the Haredim actively pursue services to maintain their health – whereas the broader non-Jewish population apparently does not. Haredi Jews may then be unfairly stigmatised as 'hard to reach', when their health conducts may be similar to the

broader non-Jewish population (which is the case for childhood vaccinations, discussed in Chapter Four).

Constructing a health centre that would accommodate the needs of the local Jewish population had benefits in countering the discomfort that local Haredim otherwise experience when accessing services ‘outside the community’ (Rabbi Silberblatt). Apparently this discomfort was attributed to the fact that ‘it is very difficult for a patient to receive healthcare advice from a GP who does not have the same value of understanding’, especially regarding areas of public health, which can intervene with the *halachic* commands and conducts governing the body. Thus, for Silberblatt, the value of healthcare is inextricable from the socio-religious values governing Haredi bodies, which he tasks himself with negotiating.¹⁶

Rabbi Silberblatt told me that, although ‘Torah values dictate even medical decisions, this does not mean to say the Torah is going to override and dictate what a Doctor will prescribe’. He went on to say that this means that a medical practitioner serving Haredi patients must consider the religious implications of the medical decisions he may have to make, and, in these instances, consult rabbinical advice on his decisions. There is evidently some negotiation between these biomedical and Judaic cosmologies, although this may ultimately depend on the willingness or ability of physicians (whether *frum* or not) to make health decisions that are kosher and in accordance with rabbinical approval (when necessary).

Haredi patients can (perhaps wrongly) assume that *frum* physicians understand the complex ways in which biomedical conducts interfere with *halachah*, which was a challenge for one Orthodox GP: ‘often, at times, I’m expected to really know the *halachic* family purity laws [*niddah*]. So I think they expect me to know more than I actually do’ (Dr Seiff). But when operating in the NHS, a religiously observant physician can be tasked with crossing cosmologies and having to either maintain a separation between, or a compromise of, their dual biomedical and *halachic* responsibilities:

BK: Can there be a relationship between a Jewish practice and medical practice?

Dr Seiff: I always wanted there to be, but I think since working in the NHS it’s very hard to do that. The NHS doesn’t treat people based on Jewish principles and *halachah*. In general, the NHS treats people based on NHS and Western secular type of values. So it’s been hard, but I’ve had to kind of put my values aside, my own principles, and my own way of thinking medically and *halachically*.

Thus practicing medicine as a *frum* physician in the NHS, for Dr Seiff, does not always allow for the integration of biomedical and *halachic* knowledge (as well as value-) systems when caring – or perhaps healing (*arukah*) – Jewish bodies.

Culturally-Specific Care, Collective Autonomy and Individual Choices

Mr Dror is a formerly-Haredi research participant who had been going ‘off the *derech*’¹⁷ over the course of my time in Jewish Manchester. During one of our many discussions, Mr Dror recalled how his family’s health and wellbeing needs were circumscribed by *halachah* and also *hashkofos* (worldviews) when requesting access to several kinds of NHS services from his Haredi GP – a discussion that introduces the competing and conflicting agendas of culturally-specific care.

Concerned with his ailing mental health and wellbeing after ‘feeling suicidal’, he had apparently requested a referral to an NHS psychiatrist for consultation. However, he told me that his Haredi GP refused the request on two occasions, allegedly on the basis that local *rabbonim* did not endorse referrals to NHS psychiatrists. The reasons for withholding this request for referral, according to Mr Dror, were because such healthcare professionals would not be *frum* and would therefore hold opposing views to Haredi *hashkofos*, which could, in turn, ‘open you up to non-*frum* ways of thinking’. Whilst the GP instead proposed a referral to a local *frum* therapist, Mr Dror declined on the basis that (from his past experience) Haredi *hashkofos* and social codes of conduct ‘did not allow you to explore forbidden stuff’.¹⁸ There was also widespread concern in Jewish Manchester surrounding the training of *frum* therapists and the confidentiality of intra-group mental health services (see also Loewenthal and Rogers 2004; McEvoy et al. 2017). Mr Dror’s encounter unravels the complexities of culturally-specific care in the *frum* Jewish context, which is evidently not only about delivering healthcare services that comply with *halachah* but also withholding those that challenge the established norms and worldviews of the social body. Culturally-specific care can have the potential to lend autonomy to rabbinical authorities, who can gate-keep access to healthcare services, and which can impact on an individual’s wellbeing.

The field of family planning and birth spacing technologies (BST),¹⁹ discussed in more detail in Chapter Three, is introduced here as it forms a particularly sensitive and complicated area of primary care for Haredi Jews. The contention lies primarily in the fact that, as Rabbi Silberblatt put it, BST can ‘interfere[s] with Jewish

beliefs, values and *halachah*'. Male condoms are interpreted as being forbidden because of the *halachic* imperative to not destroy 'seed'²⁰ and to 'be fruitful and multiply', whereas some female forms of BST are permitted. The combined oral contraceptive pill ('the pill' or COCP) is one *halachically*-acceptable example, access to which, for Orthodox and Haredi Jewish couples, can depend on support and dispensation from their rabbinical authority.

Mr Dror described the birth of his second child as 'traumatic' for his wife, and they later visited the same local *frum* GP to request a course of BST, but were told to first seek rabbinical approval. A dispensation was apparently allowed for his wife to take BST during the period that she was breastfeeding, but their subsequent request to continue using BST was not granted by their rabbi.²¹ Mr Dror's experience illustrates the complexities that Haredi men and women can face when negotiating primary care services with rabbinical authorities or *frum* GPs, and how their personal care needs can be overruled.²² This is especially the case when requests to access biomedical services, specifically those that are perceived to be deleterious to the social body, are over-ruled.

It should be noted here that, by order of the General Medical Council (GMC), medical practitioners in the UK can 'conscientiously object' to performing a procedure or service if it conflicts with their personal standards of morality or ethics.²³ However, the patient 'must' be informed of their right to consult another practitioner and be provided with enough information 'to exercise that right', without any expression of 'disapproval of the patient's lifestyle, choices or beliefs' (General Medical Council 2013: 17). Must – in the context of the GMC guide of 'good medical practice' – means a duty or obligation. Mr Dror's account instead points out how this Haredi physician responded with resistance to authoritative and professional mandates as a form of cosmological intervention, as he interpreted established worldviews or *halachic* interpretations to be at risk of infringement.

Kosher-ing Healthcare

Haredi Jews are known to involve a religious authority or 'culture-broker' (*askon*) as part of their healthcare decision-making strategies, and these arbiters enable the social body to access and negotiate mainstream biomedical services whilst maintaining a level of autonomy and self-protection (cf. Coleman-Brueckheimer, Spitzer and Koffman 2009).²⁴ Whilst chaplains hold an established and increasingly diverse role in NHS hospitals because of broader

transformations in society and a 'multi-faith' body of patients (Collins et al. 2007), the interventionist roles of some *rabbonim* and *askonim* may differ to those of other faith leaders. Some clinicians may then, for instance, be unfamiliar with the extent to which culturally-specific care can involve mediating biomedical services with a rabbi in the Haredi context (Coleman-Brueckheimer and Dein 2011; see also Spitzer 2002). Although clinicians may be better placed to practice culturally-specific care if they share a cultural and religious background (and therefore worldview) with a patient (see, for instance, Kahn 2006: 472), this does not always mean that a patient's needs and autonomy are prioritised.

An *askon* (or culture-broker) might have undergone extensive study of *halachot* or may even be an ordained rabbi who cooperates with healthcare professionals (Greenberg and Witztum 2001).²⁵ *Askonim* tend to form part of the local elite by virtue of their status and religious knowledge, therefore earning more trust than mainstream healthcare professionals, however they do not consider themselves (or might not be held) accountable to state laws in the same way that healthcare workers are (Lightman and Shor 2002). When involving a religious authority in healthcare-making decision strategies, the weight of a ruling can differ between an *askon* (even if this is a rabbi or one who holds rabbinical ordination) and one's own rabbinical authority.

Whereas rabbinical rulings are considered binding and potentially hazardous if their decisions prohibit certain treatments,²⁶ patients are not *halachically* obliged to accept the opinions made by 'culture-brokers' (or *askonim*) and can instead pursue a 'second opinion' (Coleman-Brueckheimer, Spitzer and Koffman 2009). Involving religious authorities in healthcare decisions can therefore be precarious, because by ensuring that a patient's treatment plan complies with a *halachic* interpretation, the interests of the cosmology and social body to which they belong are upheld possibly at the expense of individual 'rights'.

The mediation of certain biomedical conducts in compliance with interpretations of rabbinical law has given rise to a syncretic modality of 'kosher medicine' and 'medicalised *halachah*', whereby religious authorities play a prominent role in determining permissible fertility treatment plans for observant Jews in Israel (Ivry 2010, 2013).²⁷ The incorporation of reproductive technologies within health systems reproduces as well as entangles biomedical, political, cultural, moral and economic interests as well as implications concerning the social body and that of the nation. However, the negotiations

between rabbinical and biomedical practitioners involved in kosher healthcare might also extend to what are otherwise *routine* areas of primary care, such as reproductive choices and ‘family planning’.

Culturally-sensitive care in the form of ‘kosher medicine’ therefore does not always acknowledge or allow for the needs of individual patients, and indeed it can, as Ivry argues, be ‘about doctors’ coming to terms with authority figures that claim to represent communities and not necessarily about their interaction with individual patients’ (2010: 675). Whilst Ivry (2010) discusses this in the context of religious authorities and clinicians in Israel, Mr Dror’s experience illustrates how there is evidently an added layer of complexity when a practitioner of *both* medicine and religion makes healthcare decisions for a patient within the same social body.

The intervention of Haredi religious authorities can instead be described as an act of cultural ‘refusal’ in order to (re)assert their interpretations of the cosmological order and established norms that govern the social body. Interactions between proponents of the biomedical and Judaic cosmologies give rise to a contestation of authority (and authoritative knowledge) in regards to health and the treatment of the body, the negotiated outcome of which I regard as ‘culturally-specific care’. When some *frum* Jewish medical practitioners re-formulate care decisions to be culturally-specific, biomedical practices then defer to the *halachic* custodianship of the body. Whilst this can be advantageous in terms of upholding the interests of the social body, it can consequently come as a compromise for the individual. The side-effects of culturally-specific care draw on a deeper discussion regarding how elements of Haredi health cultures can produce vulnerabilities that are created by the social body’s quest for autonomy and self-protection. In the case of Jewish Manchester, healthcare provisions and policies can be subject to negotiation and contravention in order to make bodies kosher according to the standpoints of rabbinical authorities and *frum* healthcare professionals.

Visible and Invisible Vulnerabilities

Rabbi Silberblatt perceived certain areas of NHS health information and posters in current GP surgeries as being irrelevant to the health and conduct of Haredi Jews, inappropriate to their *hashkofos* and not always culturally appropriate. This, apparently, ‘compromises on religious values’. For Rabbi Silberblatt, this meant that health information targeting the Jewish constituency should be more ‘relevant’ to *frum* worldviews. Certain areas of public health interest that were

viewed as specifically controversial or compromising consisted of health material that was not considered modest, perhaps by including images of women, reproductive health and family planning or drugs and alcohol abuse.²⁸

The frontier area at which Haredi Jews are exposed to 'general society' is seen as a channel through which certain conducts, which the settlement prefers to exclude or protect itself from, can be introduced. Conversations with mothers in Jewish Manchester highlighted the realities of 'risky' behaviours that local youths can engage in and are vulnerable to, such as smoking, alcohol and drug abuse and unsafe (and pre-marital) sex. More pertinent for some local women was the need to recognise education pertaining to forms of domestic abuse. Mrs Katan, who described herself as an Orthodox Jewish woman, deplored the lack of information available to young *frum* women concerning abuse; commenting on how young girls get married:

But they have actually no idea of what's considered okay, what's not considered okay. What they're experiencing is the first thing they experience so that's their standard. So they think whatever their husband does is the norm and it's like that for everybody else. So they're just not aware that what's happening at home is abusive and it's not okay.

The fact that Rabbi Silberblatt considered some health and wellbeing promotional material as irrelevant to Haredi Jews, was, for another *frum* mother, bound up with a larger 'inability to admit that whatever is going on in general society must be going on here'.²⁹ Mrs Shiloh, a Haredi mother of seven, described how *rabbonim* would be approached in instances of abuse yet were not necessarily trained to handle these sensitive situations:

The rabbis for the most part in all Haredi communities around the world are like the *Hatzolah* members, they are like the EMT, the port of call. The question is, are the rabbis doing the correct thing? They need to be so much more qualified than they actually are because they have that family's life in their hands.

When very relevant services and information are portrayed as *irrelevant* by rabbinical authorities, the Haredi preference for protection and the degree to which the outside world is avoided consequently presents a threat from within. There were adolescents in Manchester portrayed as going (or who had actually gone) 'off the *derech*', or what might instead be viewed as embarking upon

another (non-Haredi) 'path' in life. The lack of support available to these youths and the disenfranchisement they experienced from the Haredi social body certainly did lead individuals to alcohol and drug abuse, especially in a nearby park where groups of youths could be seen hanging out over *Shabbat* and religious festivals. As I was told by one *frum* mother, 'if it's forbidden, it just drives it underground, doesn't it?'

Intra-group youth services for drug, alcohol and sexual abuse (that are framed as being 'culturally-specific') have been initiated but are viewed as deeply problematic by some *frum* mothers because of the 'shame' they can bring and the consequent obstacles they can present for marital opportunities and the process of matchmaking (*shidduchim*).³⁰ The focus on securing a 'good match for your child' means that there is a heightened sensitivity around the use of these intra-group services, which some locals described as being incapable of upholding confidentiality. As Mr Green, a convert to Haredi Judaism, told me, the pressure surrounding *shidduchim* is so great that 'you can't send them [children] to anything that would actually help anybody out. Only when you're desperate would you do so'. The perceived lack of confidentiality around Haredi cultures of health and wellbeing, coupled with the inability to access information on youth issues that are positioned as being external to the group, suggests how *frum* youths may then be particularly underserved within their own minority.

Whilst Rabbi Silberblatt described Haredi Jews as forming a 'very insular and protected community with very little outside knowledge', a cycle of vulnerability is perpetuated by the strategies of self-protection that are sought. The process of filtering information in and out of the Haredi social body can prevent marginalised individuals *within* the group from accessing NHS information that can actually be very 'relevant'. It is here that we can clearly see the social manifestation of autoimmunity, as strategies to protect the Haredi social body become so severe that 'immunitary' responses to the preservation of collective life and the creation of protective barriers against the 'outside' come to present an internal and potentially grave danger to the persistence of the Haredi world from within (cf. Esposito 2008).

'The NHS Don't Understand Us'

Silberblatt implied that Haredi and Hassidish Jews were, in some cases, systematically excluded from being able to reach mainstream healthcare because of inequalities in access to certain areas of service

provision. His allegation centred on the absence of Yiddish and Ivrit in language and interpretation services at the nearby NHS Hospital, despite the presence of a prominent and composite Jewish minority population.

Jewish Manchester is home to a sizeable minority of Haredi residents who are not native speakers, or have a limited grasp, of English, which could partly be a result of growing inward migration from Europe and Israel but is more likely due to the fact that boys are taught Yiddish as a first, and sometimes the only, language in many Hassidish circles. The emphasis on speaking Yiddish as a first language amongst Hassidish groups means that, in some cases, girls converse more fluently in English whereas boys might only learn to speak English as a second language, arguably forming part of a broader strategy of self-insulation or 'dissimilation'.³¹ Haredi Jews who acted as mediators of healthcare services shared their frustration that Yiddish and Ivrit interpreters were not made easily available to Jewish patients, and Rabbi Silberblatt claimed that 'they're disadvantaged because of it'. However, it is important to note that a Yiddish interpreter is likely to be an 'insider' to Jewish Manchester (which could raise further concerns surrounding confidentiality for some patients) whereas an 'outsider' (or non-Haredi Jew) might be viewed with caution, with either scenario having the potential to present implications for care.

The selective-exclusion of Yiddish and Ivrit for Silberblatt, points to something more than a cause of inequality between Jewish and non-Jewish patients. Instead he saw this as entrenched with a deeper issue of how local healthcare services are designed for certain populations over others. Excluding languages that are spoken within the Jewish minority, for Silberblatt, is 'telling of a very strong message: when we're putting together services, we don't have you in mind'. Moreover, one Haredi healthcare mediator argued that this exclusion could be interpreted as an expression of antisemitism, therefore indicating how mainstream healthcare services are regarded as being oiled with prejudice towards groups at the margins of society.

A consequence of this selective-exclusion has been for Haredi mediators to organise interpreters within their already existing body of culturally-specific care, due to the importance of understanding how medical procedures will be carried out and any potential implications. The perceived role that language currently plays in excluding Hassidish Jews from NHS services, and the consequent preference it has created for the *Arukah* Centre, is deeply reminiscent of the driving forces behind the establishment of the Manchester Victoria

Memorial Jewish Hospital at the turn of the twentieth century: familiarity in language and culturally-specific care.

Historical Medical Cultures

Archival records from the nineteenth and early twentieth centuries illustrate how health and bodily care were cultivated as a strategy to assimilate difference by both the Jewish elites and the external world in a climate of anti-alien and anti-Jewish hostility. The Manchester Victoria Memorial Jewish Hospital (henceforth the MVMJH) exemplifies how the development of culturally-specific services were similarly entangled with the struggle for integration and the insulation of 'alien' and poor Jews, who were simultaneously the target of assimilation and conversion as an explicit Christian medical 'mission'.

Only a remnant of the MVMJH remains, since it was enveloped into the newly established NHS in 1948 and later disbanded in the 1980s as part of structural changes in the region's healthcare. Opened in 1904 on Elizabeth Street, the MVMJH was mandated to provide a degree of medical and surgical relief to those unable to pay. It was therefore looked upon as a treasured 'jewel' for the constituency, being the first Jewish hospital to be instituted in England and also for the strategic role it played in nurturing agreeable relations with non-Jewish neighbours (Dobkin 1986).

The laying of the hospital's foundation stone, however, followed dissent and staunch opposition between Jews from the émigré, anglicised elite and the aspiring middle classes (Heggie 2005). The examples of the MVMJH and Christian missionaries in Jewish Manchester exemplify how medicine and health at the historical margins mark a broader struggle of positionality, marginality, integration and attempts to assimilate – or immunise against – difference.

Conversion and Assimilation as a Christian Medical 'Mission'

Evangelical Christian groups regarded émigré Jews as 'the foreigner in our midst',³² and provided free medical services and pharmaceuticals as a strategic opportunity to convert and assimilate them into the dominant religion of the national culture. Previous studies have demonstrated how Christian medical missionaries in London's East End targeted Jews who needed health and welfare services throughout the nineteenth and twentieth centuries, spending vast amounts of money on procuring potential converts (Tananbaum

2015). It has also been suggested that the presence of Christian missionary medicine in London may have signalled an inadequacy in the quality or coverage of Jewish institutional services (Tananbaum 2015). In the case of Manchester, the presence of Christian medical missions during the nineteenth and early twentieth centuries was apparently further justification for the subsequent development of a Jewish hospital (Heggie 2015).

The *zona franca* that has historically characterised the area shared between Jews and non-Jews in Manchester (Chapter One) meant that the chronically poor Jewish slums were within direct reach of Christian medical missionaries, who took great pride in the fact that ‘not a week goes without some conversions’.³³ The annual reports remark that the methods for procuring potential converts needed ‘no special description’, except for the ‘double healing [...] of body and soul, to the poor and needy’.³⁴ Whilst missionary medicine was typically described as being a feature of the colonial world in which the saving of souls and the curing of bodies was inextricably linked (Lock and Nguyen 2010: 162), missions evidently also formed part of a broader strategy of ‘internal colonialism’³⁵ to assimilate difference in England. Christian missionary medicine in Manchester can therefore be viewed as an attempt to overcome the bodies (and souls) that constituted the margins of the state.

The methods employed by evangelical Christians in Manchester were certainly craftier than the annual reports indicate. One ‘mission’ was to coerce Jewish patients into performing prayer rituals when attending free clinics and dispensaries as well as providing medicine bottles wrapped in Christian tracts (Heggie 2015). It is likely that these tracts were printed in Yiddish, the vernacular language of many émigrés and ‘foreign Jewish poor’, as the mission had a large pool of Yiddish literature at their disposal for the attempted conversion of local Jews.³⁶

By 1909 the Christian medical missionary in Manchester had boasted an almost record number of 12,000 attendances, approximately four thousand of whom were Jews, therefore demonstrating how a sizeable portion of the Jewish settlement (then estimated to number some 28,000) had been ‘reached’ through their mission.³⁷ Many of these émigré Jews probably sought care from the Christian medical mission due to the insalubrious realities of poverty in the slums, illustrating how decision-making around healthcare can be made in contexts of severe constraint. What matters most is that health ‘borderlands’ played host to encounters between émigré Jews and a range of actors from the dominant majority culture,

involving a continuum of methods to 'de-marginalise' Jews through medicine.

The Manchester Victoria Memorial Jewish Hospital

Local health and medical facilities were not always accessible or appropriate for 'foreign' Jews, with 'religious scruples' and language barriers occurring as far back as 1868.³⁸ In the eyes of the anglicised Jews, however, a dedicated hospital would appear as an act of Jewish exclusivity that ran in contrast to their strategy of pressuring 'foreign' Jews to assimilate into the social body and integrate into the body of the nation, particularly during a period of profound anti-alien and specifically anti-Jewish sentiments. The Jewish Board of Guardians had instead led attempts to push for the establishment of a kosher kitchen or Jewish ward at the Manchester Royal Infirmary as a counter-proposal to a 'Jewish hospital ghetto' (Heggie 2005; Williams 1989).³⁹ Local hospitals were no doubt irked by these requests for a Jewish ward, and one institution claimed it would be 'likely to interfere with the effective management of the hospital' (Dobkin 2004: 50). Hospital compromises around culturally-specific care mark a major difference between the social histories of Jewish Manchester and London; the London Hospital made these special facilities available to Jewish patients (in exchange for generous financial support), and had the Manchester Royal Infirmary taken a similar approach to patient care by agreeing to a Jewish ward the MVMJH may never have opened (Black 1990). Thus the historical health encounters of Jews in East London were not a norm that can be projected in the 'provinces'.

Marjorie Smith remarked how the anglicised classes feared that a hospital specifically serving the needs of the Jewish minority would provoke antisemitism, whereas her father 'of course, being one of the foreign religious ones, thought it would be a good thing'.⁴⁰ Hostility to the Jewish hospital on the part of the anglicised elites has led to suggestions that 'they were too worried about being seen to encourage integration and appeasing antisemitic politicians to properly care for their own people' (Heggie 2015). Despite the initial reluctance of the anglicised Jews to support the establishment of the Jewish hospital, they later formed its hierarchy. The conception of the MVMJH was then one of the most acute markers of intra-group differences in Jewish Manchester, exposing the internal dissent within, and between, the different 'classes' of Jews but also the Jewish settlement's relational and positional reach to the state.

Regarded as the '*Yiddisher* Hospital'⁴¹ in the émigré vernacular (Golding 1932), the MVMJH was situated in the (then) Jewish Quarter and funded by significant grants and a subscription system of one penny per week (paid for by Jewish custodians). The need for medical care among the non-Jewish poor in the shared frontier area arguably presented an opportunity for the Jewish minority to establish itself as a fundamental part of society. The hospital, a year after its inception, then began to treat 'all humanity irrespective of denomination on an equality when applying for assistance in their time of sickness and suffering'.⁴²

Initially the MVMJH was instituted, like many hospitals of its kind in the nineteenth and early twentieth centuries, to provide 'not necessarily expert medical treatment, but some treatment to the sick-poor'.⁴³ Beginning with just ten beds (six for men and the remainder for women), the hospital soon prided itself on 'quickly gaining the confidence of the medical profession and the public', with admissions continuing to rise significantly year on year (Figure 2.2).⁴⁴ Importantly the Jewish hospital was born out of the demand for an institution that catered to the specific needs of Jewish patients, all within an environment that would 'hasten the patients' convalescence in more homely [or perhaps familiar] surroundings'.⁴⁵ Familiar or culturally-specific care in this sense involved a space



FIGURE 2.2 Women's Ward, Manchester Victoria Memorial Jewish Hospital. © Manchester Jewish Museum 1984-679. Published with permission.

where religious dictates could be observed, with kosher food served during periods of hospital admission as well as ‘the consolation of [patients] seeing Jewish faces around them’.⁴⁶

Patients expected to receive medical and surgical provisions (at no cost) that were immersed in an environment of care conducive to the dictates of *halachah* and social codes, or delivered by practitioners who were identifiable as internal to the group. Despite culturally-specific care being one of the catalysts behind the Jewish hospital, certain medical procedures were quickly found to present insurmountable challenges for the Jewish hospital when attending to the needs of its pious émigré patients. This was especially the case when the body became entangled in a conflict between biomedical aspirations and interpretations of *halachic* imperatives. The 1908 Medical Report remarked how:

It is to be regretted that such a strong prejudice exists against “post-mortem” examinations, and we wish that this could be overcome; for it is frequently in cases of complicated and obscure disease a source of satisfaction to the bereaved relative to have any doubts they may have had completely settled, whilst there is undoubtful gain to science and thereto to future patients.⁴⁷

This ‘prejudice’, or what might instead be interpreted as ‘non-compliance’ with autopsy, is attributed to the fact that the body, in Judaism, belongs to the Creator and must ‘return’ to the ground, as inscribed in the Torah, ‘for dust you are, and dust you shall return’ ([*Tanakh*] Genesis 3. 19). The émigré Jews evidently upheld *halachic* governance of the body, causing frustration to the hospital’s authorities, as post-mortem examinations were regarded as an opportunity for the nascent Jewish hospital to develop biomedical protocols for future patients, contribute to emerging scientific debates, and perhaps raise its institutional profile during the early twentieth century. Rather than solving the issue of culturally-specific care, the ‘*Yiddisher* Hospital’ can be interpreted as a contested margin between the biomedical and Judaic cosmologies, provoking conflicts and negotiations between the two over the bodies of émigré Jews.

The ‘non-sectarian’ nature of the hospital became a source of contention for its predominantly Jewish funders, who provided ninety per cent of the institution’s funds when, by the 1930s, around two thirds of the 24,000 patients treated annually were not Jewish.⁴⁸ Having a sharp imbalance between Jewish and non-Jewish patients and staff resulted in public criticism being aired due to the claim

that Jewish patients could no longer benefit from the purpose of a culturally-specific institution, such as conversing with staff in Yiddish when English was not understood or not being able to gather ten Jewish men for a *minyan*.⁴⁹ The mandate of the MVMJH to serve non-Jewish patients was challenged by a Jewish subscriber, which, in turn, prompted Nathan Laski (the hospital's Chairman at the time) to publically announce that:⁵⁰

The hospital was built for a Jewish atmosphere. It is managed by Jews, and the food is in accordance with Jewish law. But the law – of which, I believe, this gentleman is an ardent student – tells us that we must treat our neighbours as ourselves, and if he does not follow the law as laid down in the Bible, then neither I nor any of the ministers in Manchester can help him.⁵¹

Opposition to the non-sectarian nature of the MVMJH indicates how the identity of the hospital continued to be a cause of contention between Jewish subscribers and the anglicised classes long after its establishment. Whereas the former sought an institution that could offer culturally-specific care around markers of ethno-cultural difference, such as the Yiddish language, the anglicised Jews arguably saw the hospital as a tactic to safeguard their position within society by caring for their non-Jewish 'neighbours'. Treating a substantial number of non-Jewish patients can therefore be interpreted as an opportunity for the Jewish constituency to be established, integrated and become a fundamental part of the 'host' society – therefore realising the aspirations of the anglicised Jews.⁵²

The '*Yiddisher Hospital*' closed in the 1980s. What Leah Martin described as having once been 'the jewel in the crown of the Jewish community' had become 'nothing but a sad memory' (Figure 2.3).⁵³ Positioned as a margin between integration (for anglicised Jews) and insulation (for émigré Jews), the MVMJH is contiguous with the opposing conceptualisations of healthcare in the Manchester settlement today. Attempts made by non-Haredi Jews to 'save' their Haredi co-religionists by distributing NHS information and bringing them within reach of the state can, for instance, have the result of pushing them further away (as I will go on to discuss). In contrast, services that are instituted by the Haredim are now intended specifically for Jews as a strategy of 'dissimilation' and *immunity* from perceived threats to the Judaic cosmology and its governance over bodily care, which points to a historical departure from the enabling role of the MVMJH in fostering inter-group relations.



FIGURE 2.3 Princess Elizabeth ward for children, Manchester Victoria Memorial Jewish Hospital. © Manchester Jewish Museum 1984-679. Published with permission.

Gehah: Bridging Distances in Health

Greater Manchester is a region characterised by varying levels of deprivation and deficits in health, and one of the local authorities is raising awareness about non-communicable diseases within the area – including Jewish Manchester.⁵⁴ The burden of premature mortality outcomes in the area has led to the development of local health promotion programmes, one of which targets *frum* and Haredi Jews in Manchester. This can, however, ‘culturalise’ the intended targets of intervention.⁵⁵ The local health authority in present-day Manchester views non-Haredi Jews as a passport to reaching the Haredi settlement, which is continuous with the historical role of public health surveillance in the former Jewish Quarter.

Since 2013, one of the councils responsible for the area in which Jewish Manchester sits, has sought to improve health by piloting a ‘community led’ project which empowers activists to deliver preventive health information and increase uptake of the NHS Health Check programme among men and women aged forty and above.⁵⁶ The peer-led programme focused on promoting health information

for cardiovascular disease, diabetes and a range of cancers, which remain the leading causes of morbidity and premature mortality in the Greater Manchester region.

The programme can be viewed within a broader context of health economics as part of a drive to 'cut costs' by prevention rather than treatments, and I term the Jewish wing of this region-wide project *Gehah*.⁵⁷ Over the course of my time in Manchester I accompanied the Jewish activists of *Gehah* as they staged various health forums and attempted to distribute health material within local *shuls*, homes, educational institutions and also a council-managed library.

The health authority saw *Gehah* as strategic for itself as well as for the interests of the Jewish 'community'. By using Jewish volunteers the local health authority saw itself, in their words, as having a 'significant resource and passport' in order to access 'community networks' – especially one that is viewed as being hard to reach. In turn local people are, in theory, given control over the process of gathering solutions to significant health challenges. However, the vast majority of *Gehah* volunteers were typically anglicised, middle class and non-*frum* Jews, with very few exceptions. It increasingly became clear that the majority of volunteers did not always fully understand the complexities and sensitivities of the context in which they had sought to work. The construction of 'communities' in health promotional work can then have the repercussion of *misrepresenting* the very people to whom it seeks to reach out.

Championing the cause of *Gehah* was Shimon, who was keen to take me under his wing and perform his trusted tactics for selling health – an expertise developed over his life's work in trade and commerce. I accompanied Shimon one afternoon in June 2014 to a library and multipurpose centre that is well frequented by local Haredim, mostly for its Internet services but also the good range of fiction and Jewish interest books available to families. Shimon arrived at the centre dressed in a dark beige suit and wearing a black velvet *capel*, he looked dapper but in stark contrast to the *frum* and Haredi men he was attempting to approach.

I was curious to know from the *Gehah* volunteers what challenges and barriers existed to optimising health in Jewish Manchester. Shimon picked out certain aspects of *frum* Jewish life in the UK as not being conducive to good health, ranging from the lack of avenues for NHS information to reach the home, low levels of physical activity, the unprecedented growth of the kosher junk food market, as well as certain Ashkenazi culinary traditions such as eating *cholent* (a heavy meaty meal) and *schmaltz*.⁵⁸ He went on to tell a joke of a

man who was caught on the roof of his house in a great flood: the doomed man is insistent in his faith that God will save him and declines help from a helicopter that attempts to rescue him three times. But when he drowned and rose to heaven, he was refused entry because he didn't act to save himself and instead remained in a position of danger. Preventive health, in Shimon's view, followed the same logic of acting against foreseen risks.

Leaflets informing *frum* locals of health events organised by *Gehah* were often accompanied by Biblical Hebrew or Yiddish references, perhaps to emphasise a shared sense of culture and kinship between the peer-led programme and its intended audience – but also to reinforce the legitimacy of *Gehah* as a Jewish organisation. One example was the Yiddish expression '*sei gesund-bleib gesund*' (be well, stay well). Shimon would often mobilise Jewish teachings during conversations with passers-by, such as 'we want you to live to 120'⁵⁹ or 'it is written "to guard yourself"'.⁶⁰ These examples can be interpreted as asserting a religious rationale for the prevention of non-communicable disease, or, more likely, a commonality through which *Gehah* activists could engage *frum* locals.

Such tailored health messages were read by Haredi locals as being superficial and appearing out of context. When I attended one of the monthly meetings between *Gehah* volunteers and officials from local health authorities in 2014–2015, the team were discussing a prototype for a health promotion campaign targeting the Jewish population. The Jewish volunteers contributed to the design of the draft, and suggested to include the message 'be a "*ner tamid*"⁶¹ to your family', which can, in this instance, be interpreted as a constant model and example of health to younger generations. When discussing the flyer, one *frum* local told me how 'it's obvious that it has not been done by an Orthodox person. No one has ever used that [expression] before. It sounds very nice but it's just been plucked off the computer'.

Contesting Gehah Volunteers

What Shimon saw as a steady foot-flow of potential male targets were, in reality, men hastily making use of their free time in between busy schedules of religious study, work, *davening* (Yiddish, prayers) and family life. Observing encounters between the *Gehah* volunteers and local Jewish constituents illuminated how knowledge praxis were mobilised to contest the health promotion material on offer. One Haredi passer-by was Rabbi Kaplan, who disputed the health promotional material displayed on the table and claimed that the

NHS 'is at least fifty years behind' with regards to nutrition and nutrition-related disorders. He went on to argue that there was a more extensive cultural issue of promoting nutrition within the NHS primary care system:

The nutritional knowledge of the average GP or professional is one or two hours out of the seven-year training. All they know is one thing: Eat a healthy balanced diet. And what does that mean? They have no idea ... There is no proof that cholesterol is actually a major issue at all. If you research it, you'll see. We need cholesterol, there are different types and they [GPs] just say lower your cholesterol: 'High cholesterol? Lower it down'. Saturated fat has also come about but people have been eating egg and meat for thousands of years, they all didn't have these diseases. Ask anyone over fifty or sixty, they will tell you when they were young they all cooked with *schmaltz* and they all didn't have these diseases. The whole thing is baloney ... The NHS is way out of touch in what is going on. Statins are a twenty billion dollar industry: They are all based on pharmaceutical companies wanting us ill and taking medications for [the rest of] your life.

His rebuke demonstrates an intense distrust and lack of confidence in the national healthcare provider, which is informed by his claim that pharmaceutical moguls profit from human morbidity and mortality. Rabbi Kaplan then dismissed the 'authoritative knowledge' that is produced and circulated by the NHS, arguing that saturated fat (which *schmaltz* contains) is not a causal risk factor for coronary heart disease.⁶²

On another occasion I accompanied Mrs Goldsmith, a (non-Haredi) Jewish healthcare professional, as she targeted a Haredi and Hassidish neighbourhood with promotional material for an upcoming *Gehah* ladies health event. Whilst stopping Mrs Lisky, a Hassidish local, the two fell into awkward dissent over the alleged consequences of preventive health services – especially relating to mammography and vaccinations (Chapter Four). Like Rabbi Kaplan, Mrs Lisky voiced her criticism and intense distrust of the biomedical authority, and claimed that 'the medical establishment also works for money and therefore you can't rely on what they say about health either'. Following this encounter with the *Gehah* volunteer, Mrs Lisky told me 'you can't discuss things with people [healthcare professionals] because they say, "we are science and you are anecdotal."' The perceived feeling of biomedical or scientific dominance as an incontestable power suggests how her reluctance to engage with NHS services can be attributed to irreconcilable ideas of 'authoritative knowledge'.

One *Gehah* volunteer told me that the low numbers of Haredi women attending the health events indicates a deficit in the service, and perhaps a poor relation with the Haredi settlement. When I enquired how effective the peer-led health promotional team were, a local (Litvish) Haredi mother told me that *Gehah* and its volunteers were not taken seriously because they did not understand the *frum* 'community'. The schism between the Jewish volunteers and the Haredi constituents resulted in acts that might best be described as resistance to the agenda and approach of *Gehah*. Mrs Goldsmith recalled how she was met with unexpected opposition at a nearby synagogue one afternoon when distributing promotional material for a women's health event:

One young man took a leaflet from me into the synagogue, saying he would see if it could be put on the women's notice board. Then a few minutes later he returned with it crushed up and torn in half and said I could have it back because they couldn't use it. There was nothing that could be considered controversial or inappropriate about our leaflet, which was only asking for women to come to a health information meeting.

Public health delivery strategies in Jewish Manchester are therefore entrenched with complex social relations between the state (or external world) and the Jewish minority of Manchester, but also internally, with the broader Jewish population attempting to assimilate (or 'save')⁶³ émigré and Haredi Jews in ways that are historically contiguous.

Public Health Surveillance as an 'Art of Government'

The culturalisation and racialisation of émigré Jews in England and the interventions levied upon their 'alien' bodies during the nineteenth and early twentieth centuries can be situated within a broader discourse of assimilating difference. To borrow Esposito's analogy, 'the body defeats a poison not by expelling it outside the organism, but by making it somehow part of the body' (2015: 8). State attempts to assimilate difference follow a similar rubric, and immunitary or assimilatory responses are provoked because foreign bodies challenge or threaten the body of the nation and its sense of collective identity. When immigration is portrayed as a malignant danger to the body of the nation and appears to threaten collective identity, prevention and containment of difference therefore become

a vital immunitary response to control contagion (cf. Esposito 2015). Strategies to immunise, and thus protect, the body of the nation from difference are therefore marked by an intersection of socio-political and biological interventions.⁶⁴

Émigré Jews in Manchester were subject to a regime of public health surveillance as a means to assimilate them into the Jewish social body, but also the body of the nation. The slum areas of Strangeways and Red Bank were generally regarded as filthy and insalubrious, reflecting the poverty and neglected sanitary conditions of the time. Poverty in the area was apparently graded during the 1870s, with a 'very unfavourable comparison' between the 'poor' of Jewish and 'other denominations', meaning, most likely, the neighbouring Christian populations.⁶⁵ The tail end of the nineteenth century consequently saw the deployment of Jewish Health Visitors to inspect and survey the living conditions in the slums that were typically home to the 'foreign' poor. Whilst this local and public health intervention may have performed a role in improving infant health and mortality rates in the area (Heggie 2011), it also further exemplifies the level of surveillance experienced by the Jewish poor from their settled co-religionists and the mainstream authorities.

Infant morbidity and mortality was a feature of life in the Jewish slums, with fourteen incidences occurring between 1871–1872,⁶⁶ The Board's Medical Officer had, at the time, described his 'regret that the dwellings of the poor are not more wholesome, and that the habits of the inmates are not subjected to more supervision and control'.⁶⁷ In a classic example of attributing blame to the poor rather than counteracting the trappings of poverty, it was the 'habits' of the parents that were considered to require intervention rather than the salutogenic and structural reconstruction of the slums, which had inflicted a virulent and attritional assault on child health during the nineteenth century. Recurring incidences of infant morbidity and mortality were caused by malnutrition and exposure to infections – and certainly the mutual reinforcement of the two – with rickets, diarrhoea, marasmus (acute malnutrition) and measles being commonly reported causes of concern at the time.⁶⁸ Despite the adversity of life in the slums, the Board did praise the efforts of Jewish mothers to respond to infant health crises and cited the attentiveness and 'affectionate solicitude' of mothers as contributing to the avoidance of a higher infant mortality rate.⁶⁹

The reality of the slums meant that daily life was not without risk or exposure to disease, with the streets (which children would

be playing in) characterised by filth and stenches caused partly by refuse and fouling from heavy horse traffic.⁷⁰ The confluence of poor sanitary conditions, street pollution and poor nutrition was exacerbated by climatic extremes, making conditions like ‘English cholera’ (also called ‘summer diarrhoea’) endemic (see also Kidd and Wyke 2005). One example was the case of 1880, when the area experienced a ‘great heat’ that caused ‘Summer or Autumnal Diarrhoea’ and enteric fever, as well as the severe winter which provoked ‘chest affections’, causing particular morbidity and mortality for children.⁷¹

Strict vaccination policies were enforced to prevent outbreaks of smallpox (Chapter Four), yet the same measures could not be deployed against frequently occurring and overlapping epidemics of measles, scarlet fever, chickenpox or whooping cough during the nineteenth century. Such outbreaks could be prolific in the slums by virtue of their cramped and overcrowded living conditions. Whilst disinfecting and deodorising ‘infected habitations’ was a typical resolve to prevent infectious outbreaks in the early 1900s, the Board admitted that ‘much is yet required in this direction as a means of prevention’.⁷²

Despite the Manchester slums trapping both Jewish and non-Jewish residents in their bounds, it was the Jewish poor that were overwhelmingly constructed as vectors of disease risk. Prevailing judgements at the turn of the twentieth century were of ‘the uncleanness of the “Jewish poor” and of the overcrowding and supposed insanitary conditions of their houses’.⁷³ However, these portrayals were contradicted by the morbidity and mortality reports submitted by the Board’s Medical Officer, prompting him to argue that ‘the popular notion is *now* very much exaggerated’ (emphasis added).⁷⁴ The Medical Officer’s statement, evidenced by the use of ‘now’, implies that these ‘popular notions’ were embedded in a lived reality of antisemitism during the formative years of Jewish immigration. Not specific to Manchester or England, there is a historical rhetoric of émigré Jews experiencing institutionalised prejudice over the course of the nineteenth century owing to fears about their ability to assimilate – particularly in the context of immigration to the United States (Markel 1997; Reuter 2016). Jews and émigré groups more broadly were socially ‘reviled’ to the extent that they were placed in quarantine under the guise of public health (Markel 1997), indicating how the broader relations between government and public health led to protocols that were laced with antisemitism.

Manchester Jewish Ladies Visiting Association

One response from the Jewish constituency in 1884 was to institute and coordinate a team of health and wellbeing inspectors in the slums, known as the Manchester Jewish Ladies Visiting Association (MJLVA). It largely mirrored the Manchester and Salford Ladies' Public Health Society, which was 'unsectarian' in nature and had been mandated to 'spread hygienic knowledge among the poor' from as early as the 1860s.⁷⁵ At this time a general public health strategy was to recruit women as local health visitors, who would survey the homes of those from a similar class and background (Manderson 1998: 38). Compliance with mainstream public health dictates was apparently improved through the work of Jewish health visitors, as 'it is well known that these people are more easily influenced by those of their own race and faith, than by a strange inspector'.⁷⁶

Jewish health visitors were initially 'leisured people' from the anglicised or aspiring middle classes that came to act as mediators between the mainstream health authority and the social body. These leisured women were also usually married or related to the male elites who led the Board, often making the work of these two organisations complementary and mutually-reinforcing (Heggie 2005). However, the Jewish poor quickly responded with resistance which prompted the MJLVA to employ women who were 'closer in class' to conduct house visits (Heggie 2011: 407). Resistance among the 'foreign' and Jewish poor to public health interventions delivered by their assimilated and privileged co-religionists forms a historical parallel with the present, as will be discussed later in this chapter.

In colluding with the Board to advance its aims, the MJLVA sought to implement 'a high standard of hygiene among the poor'. Lists of residences that required surveillance were received directly from the Medical Officer of Health for Manchester,⁷⁷ and two active health visitors were divided between the Red Bank and Strangeways areas. It has also been claimed that the MJLVA were more zealous in referring cases requiring the intervention of the public health authority than their non-Jewish counterparts responsible for surveying the non-Jewish neighbourhoods (Liedtke 1998: 178). The work of Jewish health visitors was considered so successful by the turn of the twentieth century that the Jewish Board of Guardians in London had apparently been 'begging for particulars' regarding the strategic inspections of the Jewish poor as well as protocols for disinfecting the homes of people suffering from 'consumption' (tuberculosis).⁷⁸

The MJLVA's primary focus was surveying houses to monitor compliance with public health strategies relating to containment and contagion, often distributing whitewash brushes and sanitary limewash (usually following infectious outbreaks) 'to satisfy the requirements of the Health Department of the Corporation of Manchester'.⁷⁹ The duties of the health visitors later included supporting mothers with infants less than one year old on issues relating to nutrition and clothing, at a time when maternity care and infant health were becoming an area of increasing political attention (Introduction, Chapter One). They also distributed health instructions in both English and Yiddish on behalf of Manchester's Sanitary Department, ranging from such concerns as 'Suggestions to Householders', 'the Prevention of Diarrhoea', Whooping Cough', 'Measles' and 'Precautions against Consumption'.⁸⁰

Virulent epidemics such as typhoid, which spread through the city of Manchester in 1901, allegedly did not afflict the Jewish slums, therefore indicating that 'in spite of the squalor and misery found in many of the houses we visit, they are more sanitary than they *appear*' (emphasis added).⁸¹ Whilst the slum areas did have deficits in health (as the archival records make clear), it is likely that the *appearance* of the slums (densely populated by an identifiable minority) also warranted intervention and surveillance from the Jewish elites and public health authority – even if this did not always manifest in a more pronounced mortality or morbidity rate.

The relatively better health profiles among the Jewish poor was seen partly as a result of pious émigrés maintaining an Ashkenazi diet and keeping high standards of *kashrut* – such as eating plenty of fish and abstaining from 'old or diseased meat', as well as alcohol.⁸² Margaret Langdon, who came from the 'Jewish "leisured classes,"'⁸³ was a health visitor in 1910 and described how colleagues would express their revulsion towards the chaotic mess of the émigré slum-neighbourhoods they encountered. Margaret claimed that, despite the mess, the Jewish Quarter actually experienced much less infant diarrhoea than the neighbouring non-Jewish districts, which she also attributed to the stringently observed and apparently protective laws of *kashrut* upheld by the pious foreign poor.⁸⁴

By the 1930s, the MJLVA was visiting some 8,000 to 9,000 homes each year as well as hundreds of meetings with Public Health Offices to report on 'infectious diseases and verminous people'.⁸⁵ The imperative of surveying the Jewish poor began to ease by the mid twentieth century with steady improvements in the structural conditions surrounding the slums, such as demolishing the

characteristic back-to-back slum houses as well as re-draining and re-building neighbourhoods to combat overcrowding (National Archives n.d.). Home visits became less of a priority for the MJLVA by the middle of the 1950s as ‘the refugees from the turn of the century had long since died and their children had *assimilated* into local Jewish communities’.⁸⁶

Deploying anglicised Jewish health visitors to coerce their poorer and ‘foreign’ co-religionists into accepting public health interventions is a classic example of ‘the art of government’ and its stealth use of multiform tactics to lead a population into a state of assimilation (cf. Foucault 2006).⁸⁷ Except assimilating the émigré Jewish population was not only the local authority’s strategy of contagion control at the time, but was also an aim of the settled or ‘native’ Jewish elites due to their anxieties around representation given their own process of integration vis-à-vis the mainstream.

The case of the MJLVA and *Gehah* illustrates how health ‘borderlands’ involve recurring strategies to integrate previously ‘foreign’, and now Haredi Jews who are positioned as being beyond the ‘reach’ of the state (as well as a threat to established representations of Jews in the UK, see Introduction). Care should be taken, however, not to conflate the context-specific and historically-situated public health realities within which the MJLVA and *Gehah* are embedded, respectively. Whereas the former is a response to the insanitary living conditions that made exposure to infectious disease part and parcel of everyday life in the slums in a pre-welfare state era, *Gehah*, by contrast, exemplifies how public health authorities project an image of responsible and compliant citizenship by avoiding undue cost to the welfare state. What matters is the recurring and contiguous tendency to ‘culturalise’⁸⁸ émigré and now Haredi Jews, and how attempts to ‘reach’ out to the margins can have a recoiling effect – especially when the intended ‘targets’ of intervention feel misunderstood or misrepresented.

Discussion

Public health operates on the ‘moral assumption that response to the perceived suffering of others is a worthy action’ (Hahn and Inhorn 2009: 4), but this has historically resulted in ‘interventions’ that target the conduct of ethnic or religious minority groups. Public health has performed a historically persistent role in attempting not only to survey but also to assimilate (and immunise against) ethnic

and religious difference within the body of the nation. The example of Jewish Manchester demonstrates how ‘foreign’ Jews and the ‘ultra-Orthodox community’ have been targeted for their conducts which are not always ‘compliant’ with the aims and objectives of the biomedical authority, but also those of the broader and anglicised Jewish population.

Being ‘hard to reach’ is often framed implicitly or explicitly as showing an issue of ‘low uptake’ or (non-)compliance in response to health and treatment services. Yet the term ‘hard to reach’ is not without criticism and previous studies have instead claimed that ‘service restrictions and limitations may mean that it is the services themselves that are “hard to reach”’ (Flanagan and Hancock 2010: 4). Compliance or ‘adherence’ with health services and protocols is highly valued by biomedical authorities, as non-compliance with prescription medicines or clinical regimens presents a serious economic burden to a publically funded health system such as the NHS. However, as has been argued in this chapter, the Haredim also interpret (bodily) compliance as being a demand of the Judaic cosmology via rabbinic interpretations.

Conceptualising groups as ‘hard to reach’ is intimately tied up with issues of marginality as a perceived relational position to biomedicine as the ‘centre’, and this conceptualisation involves the subsequent attempts to penetrate what is considered to lie beyond the limits of biomedical influence and authority. In being constructed as occupying a ‘marginal’ position in relation to biomedicine as the self-proclaimed ‘centre’, minority groups are seen ‘to be cut off from the circulation of biomedical substances’ (Ecks 2005: 240) and are then viewed as warranting intervention. Extending biomedical services to the margins brings with it the intention of incorporating what exists beyond the ‘reach’ of the state into the body of the nation (Pandya 2005; Merli 2008).

The ‘hard to reach’ label that features in public health discourse is a convoluted representation of the Haredi minority. The protection and fortification of the Haredi lifeworld resembles a ‘zone of cultural refusal’ (cf. Scott 2009: 20), but it would be wrong to portray Haredi Jews as avoiding the state altogether – especially with regards to healthcare. Haredi Jews are mandated to guard their health and body, and maintaining a negotiated relation with the state is fundamental to meeting this Divine obligation. Culturally-specific care constitutes a compromise of bodily governance between competing cosmologies, and demands mainstream healthcare services to be accessible for Haredi Jews. However, culturally-specific care can also

mean that rabbinical authorities maintain a sense of ‘social *immunity*’ over the social body within one of the few remaining areas where Haredi and non-Haredi cosmologies intersect. The examples of *Hatzolah* and *askonim* demonstrate how Haredi authorities and institutions are stationed on the pulse of the social body, and affirm how ‘the equilibrium of the immune system is not the rest of defensive mobilization against something other than self, but the joining line, or the point of convergence, between two divergent series’ (Esposito 2015: 174).

Biomedical techniques and technologies, such as ‘contraception’, expose the Haredi body to contested guardianships as well as the exposure to the outside that comes with potentially dangerous implications for individual and collective life. The Haredi preference to mediate healthcare services through religious authorities or institutional and paramedic bodies (such as the MVMJH or *Hatzolah*) can then be understood as an ‘immunitary reaction’ stationed at the threshold between what is internal and external to the group. These authorities and institutions are tasked with making biomedicine ‘kosher’ for Haredi Jews, and prevent intrusions into the social body, protecting it from the potential virulence of the outside world, an over-reaction to which can present its own deleterious implications (cf. Esposito 2015). Chapter Three advances the notion of ‘immunitary interventions’ in the specific context of maternity and maternity and infant care, as these areas of biomedicine are feared to disrupt the cultural and biological perpetuation of the Haredi minority.

Notes

1. *Hatzolah* (vernacular), also *Hatzalah* (especially in Israel). *Halachah* prohibits working on *Shabbat* and *Yamim Tovim* (particular days within the calendar of religious festivals). Rabbinical exemption is granted to those working in medical services (including *Hatzolah* personnel) as the imperative of saving a human life (*pikuach nefesh*) takes precedence.
2. See Chapter One for explanation of *tzedokoh* (vernacular). Some Jewish individuals and families would elect to fund *Hatzolah* through their *tzedokoh* contributions.
3. Services that provide emergency care in private ambulances are not unusual in the UK, especially if we consider that the British Red Cross and the Saint John’s Ambulance Service (n.d.) have a historical presence as a paramedic body predating the rise of the welfare state in 1948.

4. *Hatzolah* divisions in Australia have been instituted out of the concern that *Shoah* survivors were 'reluctant to make contact with a "uniformed" external agency' (Chan et al. 2007: 639), and subsequently display their 'internal' status by maintaining their own culturally-specific 'uniformed' services.
5. Promotional and fundraising videos of a London *Hatzolah* branch feature Haredi locals calling the emergency line and speaking in Yiddish to the operator.
6. *Capel* (vernacular). Also termed *kippah* (Hebrew) or *yarmulke* (Yiddish).
7. *Hatzolah* attend to non-Jews in the area when called upon, though in most cases non-Jews would contact national emergency services. *Hatzolah* exemplifies how the Haredi social body have fashioned specific services which sit at the intersection of religion and health, and illustrate the nuanced ways in which socio-religious groups generate their own culturally-specific services in response to perceived failings and shortfalls by the state.
8. Cf. Abu-Lughod (2002).
9. See as examples Public Health England (2013a, 2013b).
10. Some Travellers report experiencing discrimination and disrespectful care in healthcare services, which damages trustful relationships between Traveller families and healthcare professionals (Jackson et al. 2017: 14).
11. Public health, Fassin argues, '*culturalizes* its subjects. In other words, it produces statements and acts on the culture of those for whom it is intended and whose representations and practices it is designed to change so that they may have a better or longer life' (2004: 173 [emphasis in original]).
12. Refusal can have the result of being 'generative and strategic, a deliberative move toward one thing, belief, practice, or community and away from another' (McGranahan 2016: 319).
13. I describe 'culturally-specific care' as a strategy of Haredi Jews to organise health-related services in order to meet the heightened expectations of health and bodily care, as dictated by the Judaic cosmology (or authoritative interpretations of *halachah*), but also to enhance group autonomy.
14. *Askon* (*sing.*), *askonim* (*pl.*). vernacular Ashkenazi pronunciation, also *Askan(im)*. From the root word '*Asuk*', meaning 'busy' or 'involved with' (see Lightman and Shor 2002).
15. See Kasstan (2017: 99).
16. cf. Lynch and Cohn (2017: 370) for discussion on values in healthcare.
17. 'Off the *derech*' literally translates as to go off the path or stray from the path of being *frum*. It is a common, relational and pejorative saying among Haredim to describe somebody who is viewed as becoming less practicing or non-Haredi, which I take to mean those exploring another path in life.

18. Described by Mr Dror as an unqualified therapist, which is probably viewed in relation to mental health professionals in the UK whose practice is approved and legitimised by formal qualifications, which 'unqualified *frum* therapists' might not have.
19. Taking inspiration from Birenbaum-Carmeli (2008), I prefer to use the term 'birth spacing technologies', rather than 'contraception' as it was more common for Haredi women in Manchester to use these interventions in order to delay pregnancy rather than prevent conception indefinitely.
20. *Hashchatat zera*: onanism.
21. Certain female BST are interpreted as being *halachically* permissible during breastfeeding as a subsequent pregnancy could cause harm to the mother. The likelihood of conception during intensive breastfeeding is reduced by way of lactational amenorrhoea. The 'progesterone-only pill' (POP) can be taken on the twenty-first day postpartum whilst breastfeeding. The 'combined-oral contraceptive pill' can reduce the milk flow of mothers who are breastfeeding babies under the age six months old, and the NHS recommend alternative methods of BST until breastfeeding has ceased (NHS 2014a). Similar incidences of rabbinical authorities refusing to allow uptake of BST has also been reported in the mainstream press (see Howard 2015).
22. Recent UK media reports relay how some Haredi women do access BST without consulting their rabbis, thus subverting authority (Ruz and Pritchard 2016).
23. The primary role of the GMC is to protect patients by regulating standards for doctors and medical students in the UK.
24. However, not all healthcare professionals may be willing to work with (or accept intervention from) an *askonim* because of their 'non-professional status' (Lightman and Shor 2002). Healthcare professionals might also be unsure of how to engage in clinical encounters that are led by a rabbi, rather than the woman concerned, as has been discussed in the context of antenatal services (see Teman, Ivry and Bernhardt 2011). The incorporation of what are termed culture-brokers within the NHS remains relatively under-researched (see Dein et al. 2010), with there being little understanding of the positive and negative implications of their role as mediators.
25. Here I refer to a rabbi who holds *smichah* (rabbinical ordination) but may not necessarily be practicing in a congregational capacity.
26. It is important to note that *halachic* rulings (*psak halachah*) are not black and white decisions, but can be formulated in relation to an individual's circumstances.
27. Reproductive technologies and (in)fertility treatments are a well-discussed point of contact as well as conflict between religious and biomedical authorities in both Judaism and Islam, holding severe implications for how the social body is reproduced (see Clark 2009;

- Hampshire and Simpson 2015; Inhorn 2015; Inhorn and Tremayne 2012; Kahn 2000, 2006).
28. Also *tziniut*.
 29. Several high profile cases of sexual and domestic abuse in Jewish Manchester were investigated during the period of research, demonstrating just how relevant this health and wellbeing information is.
 30. Hebrew, *shidduch* (sing.) *shidduchim* (pl.) refer to the practice of 'introducing' Jewish singles with the intention of marriage. *Shidduch* meetings are usually arranged by a *shadchan* (matchmaker) and entail thorough research into the backgrounds of both individuals and their families. The process varies across sub-groups, and is known to put great pressure on singles to get the 'right' match.
 31. In my experience, Hassidish girls have a stronger command of English, as they will be expected to navigate elements of the external world whilst their husbands are immersed in full time religious study. See also Fader (2009: 119), who notes that Hassidish girls in New York are, today, more versed in Yiddish than their mothers or grandmothers. Fader (2009: 199) notes that girls will learn Yiddish from an early age, but English is replaced as their main language, whereas Hassidish boys 'often have limited competence in English'.
 32. GB127.G25/3/6/6: 1906, 'the foreigner in our midst may be a Russian, German, or even Turkish Jew'.
 33. GB127.G25/3/6/2: 1902. Formally known as the Manchester Medical Mission and Dispensary (Red Bank Working Men's Christian Institute). See also Golding (1932), whose novel remarks on the attempts of evangelical Christians to procure potential converts to Christianity.
 34. See GB127.G25/3/6/2: 1902
 35. Cf. Scott (2009: 12–13), who describes the absorption of previous inhabitants as one of the strategies of internal colonialism, which has the effect of causing a 'massive reduction of vernaculars'. In the context of émigré Jews in Manchester, I adapt the concept of 'internal colonialism' to include the broader attempts of assimilating difference by way of asserting the dominant religion of the national culture.
 36. GB127.G25/3/6/2: 1902, tracts in Yiddish were provided (possibly gratuitously) by 'The Religious Tract Society'.
 37. See GB127.G25/3/6/8: 1909.
 38. GB127.M182/3/1: 1868–1869.
 39. See Jewish Chronicle (1900); also Jewish Chronicle, 28 September 1900 in Williams (1989: 101). The issue of providing kosher food in (non-Jewish) institutions seems to occur repeatedly in the early twentieth century, with notes from the minute book of the 'Manchester Hebrew Visitation Board' (GB127.M443) on 10 May 1921 noting that objections were raised to the provision of kosher food to 'mentally defected Jews'. Attempts at this time were made to meet with Sir Harcourt Clare, who held the position of County Clerk

- at Lancashire County Council as well as clerk to the Asylum Board, to address this.
40. MANJM J229. Marjorie Smith.
 41. Yiddish, Jewish.
 42. GB127.362.1 M64: 1905.
 43. GB127.362.1 M64: 1926–1927. The Jewish hospital went on to pioneer ‘innovations’ that were considered modern for the era. These included the employment of a female resident medical officer in 1908, which was apparently ‘no reason to regret’ (GB127.362.1 M64: 1907–1908]), though one could speculate that there might have been an economic incentive for having a female medical officer considering gender inequalities at the time. The hospital was also the first to implement time-allocated appointments for outpatient appointments, whereas before it was customary in all hospitals for people to be seen on a first-come first-serve basis (MANJM J192). By 1926 the purpose of the hospital had, like biomedical care more broadly, also changed, being ‘not merely dispensers of charitable relief, but centres assisting to foster progress of medical science’ (GB127.362.1 M64: 1926–1927).
 44. GB127.362.1 M64: 1908–1909.
 45. MANJM 1984.684: Jewish Gazette, 2 July 1931.
 46. GB127.362.1 M64: 1904.
 47. GB127.362.1 M64: 1907–1908.
 48. MANJM 1984.684: Manchester Guardian, 1 February 1932.
 49. A quorum of ten Jewish men needed for specific prayer rituals. See MANJM 1984.684 (Jewish Gazette, 2 July 1931).
 50. Nathan Laski was among the anglicised Jews who initially opposed the proposal for a Jewish hospital, as he was concerned it would prevent émigré Jews from integrating into mainstream society (see Manchester Jewish Studies n.d.).
 51. MANJM 1984.684: 2 July.
 52. The hospital’s role as a tool of integration can also be inferred from the dedication of its name to the memory of Queen Victoria, as well as the permission sought, and granted, to name wards after King Edward VII, and the Princess Elizabeth ward for children, which opened in 1932 (Figure 2.3.). See MANJM 1984.684 (Jewish Free Gazette, 13 November 1931).
 53. MANJM J192. Leah began working as a nurse at the MVMJH in 1930.
 54. Jewish Manchester, as mentioned, stretches across two regions that are administered by separate local authorities. One of the local authorities in question is consistently ranked as being one of England’s worst in terms of premature mortality caused by cancer, lung cancer (at all ages), lung disease, heart disease and strokes and liver disease. Here, the average life expectancy was last recorded as being 76.7 for men and 80.7 for women during the 2012–2014 period (Public Health

- England n.d. c.), falling short of the national average of 79.5 and 83.2 respectively (over the same period).
55. See Fassin (2004) for discussion on how public health can ‘culturalise’ minority groups.
 56. An NHS programme designed to prevent heart disease, stroke, diabetes and other age-related diseases. Anyone aged between forty and seventy-four who has not previously been diagnosed with these conditions, or is at risk of developing them, will be invited for a health assessment.
 57. One local described ‘*gehah*’ as being synonymous with ‘health’ (*briut*), with the root of the term meaning ‘to get rid of’ or ‘distance.’ In relation to this context, ‘*gehah*’ would then mean ‘to distance illness’.
 58. Rendered chicken fat, common in Ashkenazi cooking.
 59. A reference to Moses (Moshe), who is said to have died at the age of 120. A common saying to *frum* Jews on birthdays is ‘may you live until 120’, which also indicates how life is numbered.
 60. A reference to the Judaic teaching that the body is a gift from God and must be cared for.
 61. Hebrew, eternal light or flame. A *ner tamid* is placed near the Torah Ark in synagogues.
 62. Recent studies have challenged the view that saturated fat intake is a definitive risk for cardiovascular disease, but the NHS recommends that people continue to follow the current UK guidelines on fat consumption and particularly a reduced intake of saturated fats (see NHS 2014b).
 63. See Abu-Lughod (2002), also discussed in Introduction.
 64. Endowing the biomedical establishment with the power and authority to determine the bounds of exclusivity is something of a historical legacy. As Comaroff and Comaroff contend, this can be traced to the colonial period where ‘the frontiers of “civilization” were the margins of a European sense of health as social and bodily order’ (1992: 216).
 65. GB127.M182/3/1: 1872–1873. This surmise appears to be based on analysis of statistics from the Poor Law relief, which might not be considered an entirely accurate indicator of poverty in the wider population given the deliberately harsh conditions of the ‘workhouses’.
 66. GB127.M182/3/1: 1871–1872.
 67. GB127.M182/3/1: 1871–1872.
 68. See GB127.M182/ 3/1: 1869–1870; M182/3/2:1877–1878; M182/3/4: 1905–1906; M182/3/5: 1908–1909.
 69. GB127.M182/3/1: 1874–1875; M182/3/3: 1905–1906. See also Lara Marks (1994).
 70. MANJM J273.
 71. See GB127.M182/2/: 1877–1878; M182/3/: 1881–1882; M182/3/4: 1902–1903).
 72. GB127.M182/3/1: 1872–1873.

73. GB127.M182/3/4: 1902–1903.
74. GB127.M182/3/4: 1902–1903.
75. GB127.M182/5/2: 1903; see also Davin 1978.
76. GB127.M182/5/2: 1903.
77. James Niven was the Medical Officer for Health over the period 1894–1922. The relation between the MJLVA and the Medical Officer of Health indicates the degrees of collusion between the anglicised Jews and state authorities at the time.
78. GB127.M182/5/2: 1897; also GB127.M182/5/2: 1903.
79. Carbolic powder [disinfectant] and lime were given freely by the Sanitary Authorities of both Manchester and Salford, but redistributed in the Jewish areas by the health visitors.
80. GB127.M182/5/2: 1903.
81. GB127.M182/5/2: 1901.
82. GB127.M182/3/4: 1907–1908.
83. Langdon later established some pioneering services of infant and child health, such as provision of milk and meals in Jewish schools as well as the Cheetham Child Welfare Centre, and also initiated a Fresh Air School and respite home for new mothers and infants. See (MANJM) J143; Williams (2011).
84. MANJM J143.
85. GB127.M790/2/6: 1984.
86. GB127.M790/2/6: 1984 (emphasis added). I italicise ‘assimilated’ here to emphasise how the strategy undertaken by the Jewish elites and their allied organisations had apparently achieved the end goal of incorporating the ‘foreign’ or ‘alien’ Jews into Manchester’s anglicised Jewish social body.
87. Deploying Jewish health visitors to survey and ‘inculcate a high standard of hygiene’ amongst slum Jews can be contextualised in a body of historical anthropological work that explores attempts to exact empowered subjects as a means of increasing ‘compliance’ with public health interventions in the wider social body (such as Stein 2009).
88. Cf. Fassin (2004).

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Part II

MATERNITY AND INFANT
BODY POLITICS

Chapter 3

MATERNITY MATTERS

Mrs Bloom has served Jewish Manchester as a doula for decades,¹ but she told me the act of supporting women through childbirth is part of a much deeper legacy in Judaism that goes ‘back to the time in Egypt’. Like many of the doulas and midwives I met in Manchester, Mrs Bloom framed her role in relation to Shifrah and Puah, the legendary Hebrew midwives (*Hameyaldot Ha’ivriot*),² who hold a revered place in the Torah for making a vow to birth the enslaved social body at great risk to their own lives:

The king of Egypt spoke to the Hebrew midwives, one of whom was named Shifrah and the other Puah, saying, “when you deliver the Hebrew women, look at the birthstool: if it is a boy, kill him; if it is a girl, let her live.”

The midwives, fearing God, did not do as the king of Egypt had told them; they let the boys live.

So the king of Egypt summoned the midwives and said to them, “why have you done this thing, letting the boys live?” The midwives said to Pharaoh, “Because the Hebrew women are not like the Egyptian women: they are vigorous. Before the midwife can come to them, they have given birth”.

And God dealt well with the midwives; and the people multiplied and increased greatly. ([*Tanakh*] *Shemot*/Exodus 1:15–20)

Mrs Bloom elaborated on this excerpt by saying that the Pharaoh King of Egypt had ordered the ancient Hebrew midwives to practice male infanticide because of a prophecy that ‘there would be a

leader rise up in the Jewish nation', who, as the narrative goes, was Moses. She traced how the culture of supporting Jewish women through childbirth 'goes back as far as then', and is an ancient custom that has perhaps found renewed purpose when reproducing the social body within the mainstream biomedical framework. More specifically, in comparing her role as a doula with that of the ancient Hebrew midwives, Mrs Bloom alluded to an enduring need to challenge and subvert regimes that are seen to dominate Jewish births, or worse, limit them altogether.

Mrs Cohen, a Manchester-born midwife and *frum* Jew, described how Shifrah and Puah 'were known to be God fearing women, and that's something I try to aspire to'. Training in maternity care, she said, is vital because of its need in a constituency that is 'forever expanding', but also the awaited oracle of redemption. A fundamental tenet of the Judaic cosmology is the coming of the Messiah (*Moshiach*) and the ushering in of the Messianic era,³ which will, in short, gather and repatriate the Jewish exiles to *Eretz Yisrael* and bring the eventual resurrection of all the Jewish dead.⁴ I was told, 'when *Moshiach* comes, all other [healthcare] professions will cease to exist, because there wouldn't be any pain, so no dentists, no physios [physiotherapists], no doctors. Everyone will be healthy, whereas there will always be a need for midwives' (Mrs Cohen). Midwifery, she went on to tell me, made her a 'messenger for God's holy work', which constructs maternity care in Jewish Manchester as having both medical and spiritual attributes. One of the reasons that make these doulas and midwives popular and favoured in the settlement is because 'from a spiritual point of view, it's so nice to know that this baby is born with only Jews around it' (Mrs Susman, doula).

A network of qualified Haredi doulas and registered NHS midwives (who I refer to from hereon collectively as 'maternity carers') form the heart of Manchester's contemporary culture of care around childbirth,⁵ and they attempt to meet the diverse antenatal, labour, and postnatal needs of local Jewish women. These *frum* doulas and midwives see themselves as being useful (for the Jewish settlement and also healthcare professionals) because NHS maternity services are apparently one of the initial times when some Haredi – and especially Hassidish – men and women 'touch the outside world' (Mrs Yosef, doula). The *frum* doulas claim to be advantageous for the local NHS authority because they can contribute to making mainstream maternity services more accessible for Haredi Jews. Their maternity work, as will be made clear, is also intended to offset the perceived

shortfalls and limits of state-provided services – which do not always meet the heightened expectations that Haredi Jews hold when it comes to health and bodily care.

Whilst these doulas certainly do embody the rich cultures of maternity care that have developed in Jewish Manchester, I also consider them players in the highly political and politicised domain of reproduction because they attempt to negotiate the delivery of NHS care around childbirth in order to make bodies kosher. This chapter examines how NHS maternity services form a ‘borderland’ where Haredi parents are tasked with navigating and negotiating areas of health and bodily care that are seen to be at odds with the *halachic* governance of Jewish bodies – which can warrant the intervention of these doulas. Dedicated maternity carers can then be understood as affording a degree of protection to the social body and the continuity of social reproduction. Obstetric care emerges as a point of concern for some doulas in Manchester, and a focus on maternity politics positions birthing Haredi bodies under the gaze of both the biomedical and Judaic cosmologies and more specifically as a contested area of intervention.

I approach maternity matters in Jewish Manchester in three main ways: Firstly by outlining the nuanced roles of *frum* doulas and midwives when supporting childbearing women. The politics of parturition in Jewish Manchester are then illustrated in the specific context of opposition to caesarean sections as well as antenatal screening. The final section explores the broader culture of maternity and postnatal care that doulas help Haredi Jewish women to navigate, including birth spacing technologies and infant feeding practices.

Doulas and Midwives

There are differences between *frum* midwives and doulas, despite their being brought together under the collective term of ‘maternity carers’ in this book. Midwives in the UK must complete a three-year university degree at an accredited institution (leading to registration with the Nursing and Midwifery Council) in order to practice.⁶ Midwives in the UK are also trained to conduct clinical examinations, oversee the labour process and identify complications, provide health information to parents so that they can make informed choices throughout the antenatal, labour, and postnatal stages, as well as work alongside allied state welfare and social services (Royal

College of Midwives n.d.). Pursuing entry into formal midwifery training presents particular challenges for *frum* women in Jewish Manchester. Primarily, attending university can present an issue of contravening established gender norms. Keturah was an unmarried aspiring midwife at the time I met her, and said that it was ‘not the done thing’ for *frum* women in Jewish Manchester to study midwifery and nursing at local universities, though she said it is ‘becoming more acceptable’.⁷

Haredi women who do pursue midwifery or nursing training at university straight after their preparatory stage at sem (seminary) and *before* marriage are very much in the minority in Jewish Manchester (Keturah).⁸ However, Mrs Cohen described how choosing to undergo midwifery training as a married woman presents entirely different ‘moral questions and dilemmas’ of how Jewish women will meet their educational commitments alongside conjugal expectations:

What happens during those three or four years [of training]? Are they going to have kids in between? Are they going to abstain [from sexual relations]?⁹ It’s a massive thing for [married] Jewish women to go in [to university and pursue midwifery training], whereas if you do it whilst you’re single you don’t have those moral questions or dilemmas.

Reproduction in (Haredi) Judaism is a major conjugal responsibility; the imperative for men to ‘multiply’ the Jewish social body, and the pressure for women to be its bearer, is imparted through a range of scriptures and legal codes.¹⁰ Professional training before or after marriage can then be a decision fraught with implications that *frum* Jewish women have to consider, and illustrates the challenge in negotiating the external world alongside *halachah* and family-making decisions. Doulas (including postnatal supporters) are able to undergo shorter periods of training in order to be peer-supporters through mainstream organisations such as the National Childbirth Trust (NCT), La Leche League, and The Breastfeeding Network. It is for these reasons that there are more (married) women serving Jewish Manchester as doulas rather than registered midwives and nurses.

The role of a doula, in theory, is to support women (and their partners) through the process of childbirth *vis-à-vis* biomedical maternity models, advocating for their needs and requests, and offering are that is personal, emotional and woman-centred.¹¹ The senior doula (and also postnatal supporters) in Jewish Manchester

have been practicing in their roles for over twenty years; some of them have committed to further training and developed areas of specialism in complementary methods, such as aromatherapy, homeopathy, hypnotherapy and massage. These Jewish birth supporters do not exist in isolation, and were modelled on a pre-existing Haredi-led maternity care provision in London. Moreover, the doulas are invited to a specific conference for Jewish birth supporters, held in the UK once every two years, which enables an exchange of information for continued best practice between the main Haredi settlements of North London, North Manchester and Gateshead. For these reasons, Mrs Herskovitz (doula) informed me that ‘we’ve trained, and we’ve trained, and we’ve trained’, perhaps asserting the professionalism and legitimacy of their roles. In providing their services voluntarily,¹² the *frum* doulas hold a significant amount of status, not only within Jewish Manchester, but also the NHS hospitals they work in. Many doulas described how, in the eyes of some NHS professionals, they are viewed more favourably than private midwives who are remunerated for their services by clients.

That being said, the doulas do not form one integrated maternity service. There are nuanced strands of care available in Jewish Manchester – a situation that occurred after some of the doulas held diverging views as to how to most appropriately offer maternity and infant support. I was told that just one of these groups supports, on average, three hundred Jewish births every year (Mrs Herskovitz), indicating the prominent place of *frum* doulas in the settlement. The intra-group cultures of maternity care are made available to all local Jewish women regardless of their level of observance or background, but not to non-Jewish women, who apparently ‘need to work within their own ethnic community’ (Mrs Herskovitz). Having Jewish maternity carers available to support birthing women in Manchester is historically continuous, and reflects the push to establish a Jewish hospital during the formative years of the twentieth century and the perceived need for culturally-specific care among émigré Jews and Haredim. Yet a discontinuity can also be seen in the provision of culturally-specific care services in Jewish Manchester over time. Whereas the Manchester Victoria Memorial Jewish Hospital helped to enable the Jewish settlement’s integration and positioning by admitting non-Jewish patients for treatment, Haredi maternity services can now be understood as a means of ‘dissimilation’ by providing services that are intended specifically for Jewish women and which also afford a degree of control over the reproduction of the social body.

During the course of their pregnancy, women in the Jewish settlement are invited to contact a co-ordinator who then arranges for the most appropriate doula depending on the pregnant woman's needs (or personal request). Once a pregnant woman 'books in', the doula becomes available to them twenty-four hours a day and will go through a 'birth plan' consisting of patient choices regarding biomedical 'interventions'. These can include requests for pain relief (such as epidurals or 'alternative therapies'), an injection of syntocinon (or syntometrine) to stimulate uterine contractions and a prompt birth of the placenta, or administering a vitamin K injection to the newborn baby. As Mrs Herskovitz told me, 'we're only there to support the hospitals [be]cause it can be quite frightening for a young couple to go through the system alone'.

The choice to take on the services of a doula usually rests with the pregnant woman. In some cases the request can come from the husband, who is, in theory, prevented by *halachah* from being physically supportive during childbirth and can therefore feel they are caring for their wife by soliciting woman-woman birth support. The laws of *niddah* (separation) are the main example of this. Being *niddah* renders a Jewish woman *tameh* (impure) during periods of uterine bleeding, such as menstruation or labour, and a wife and her husband are thereby forbidden to physically touch or engage in sexual contact.¹³ Male practices around *niddah* and childbirth reflect nuanced stringencies: some men will attend the birth and others will remain in the hospital but not attend the birth, although it is usually the case that Haredi and Hassidish women leave their husbands at home.¹⁴ Thus, I was told that 'the main reason I think why the Jewish Orthodox community need the doula [is] for the touch' (Mrs Gross). Doulas are then called upon to perform tasks which husbands would otherwise not be permitted to do, such as massaging and physically comforting the labouring woman.¹⁵

The laws of *niddah* also mean that doulas have to mediate the socio-religious construction of 'support' and 'care' during a Jewish birth for hospital staff. Mrs Yosef relayed a situation where NHS health professionals were apparently confused as to why a Haredi husband was standing with his back turned to his wife reciting *tehillim* (Psalms):

In my job as a doula, it would be to smooth that out and explain what's happening and why that man is doing that. No, he is very much supporting his wife. He can't touch her, so for him, for their relationship, it's better for him to do that. It's not that he is *not*

engaging with her. He is very much engaging with her, but on a different level. (Emphasis added)

Doulas presented their work as an important source of support for *frum* men, who apparently feel reassured when their labouring wife is being attended to physically, whilst they perform the task of contributing to their spiritual protection by reciting *tehillim* and soliciting Divine guardianship.¹⁶ The role of a doula in Jewish Manchester therefore extends beyond labour support: they mediate relations between healthcare providers and Haredi Jews, and, as I go on to argue in this chapter, uphold the *immunity* of the Haredi social body from potentially dangerous biomedical interventions:

The more insular they are, the less they will make contact with the outside community. Therefore you need somebody to form bridges between the outside community and the Jewish community, the Jewish community and the outside community. (Mrs Yosef)

Mrs Yosef re-presents the settlement as both geographically and socially separate from the mainstream, where inroads need to be carefully built with the health authority in order to uphold the self-protective stance of the Haredi settlement whilst also ensuring access to essential maternity services. The Haredi maternity carers can then be understood as positioning themselves as an immunitary strategy at the threshold between what is considered to be within and outside of the group (cf. Esposito 2015).

Sketching the specific care needs of *frum* women and the issues they are tasked with navigating in NHS maternity services frames the struggles that pregnant émigré women would have faced in Manchester's historical therapeutic landscape. The Jewish hospital did not offer maternity services, and birthing in local hospitals would likely have been a deeply unsettling experience for émigré Jews arriving at the end of the nineteenth century and early twentieth century.¹⁷ These often pious Yiddish-speaking women would have encountered a care environment that was not conducive to religious observance, and communicating with their carers and physicians would have been a genuine struggle (Chapter One, also Marks 1994). Some émigré women in Manchester viewed local hospitals with mistrust when it came to childbirth and feared, for example, that their babies might be swapped.¹⁸ It is not surprising, then, that émigré women in the former Jewish Quarter typically preferred to birth at home with the support of local and valued maternity carers, such as Dora Black.¹⁹

Dora began supporting mainly émigré women through childbirth and postnatal care just before the First World War broke out, and was trained by an elder midwife who Dora knew from Roumania.²⁰ Whilst Dora practiced as an ‘unregistered midwife’, Lou Black described how his mother was regarded locally by the affectionate status of ‘Bobby Black’ – the Yiddish term for grandmother as well as midwife (also *heyvn*).²¹ Tucked away at the Manchester Jewish Museum is Dora’s ‘baby book’, etched with the records of 890 births that she attended between the years 1913 to 1934 (Figure 3.1).²² Dora’s maternity book maps out the considerable distances she travelled on foot or by tram when attending births, from the slums and predominantly émigré areas around Derby Street, right through to the Northwardly and more affluent neighbourhoods. Her book is a repository of a bygone maternity culture, holding scores of names, addresses, labour dates, attending Jewish physicians, sex of newborns and occasionally a tender annotation of ‘stillborn’ (Figure 3.2). Stillbirths were not officially recorded in England and Wales until the year 1927, signalling how meticulous Dora’s records were.

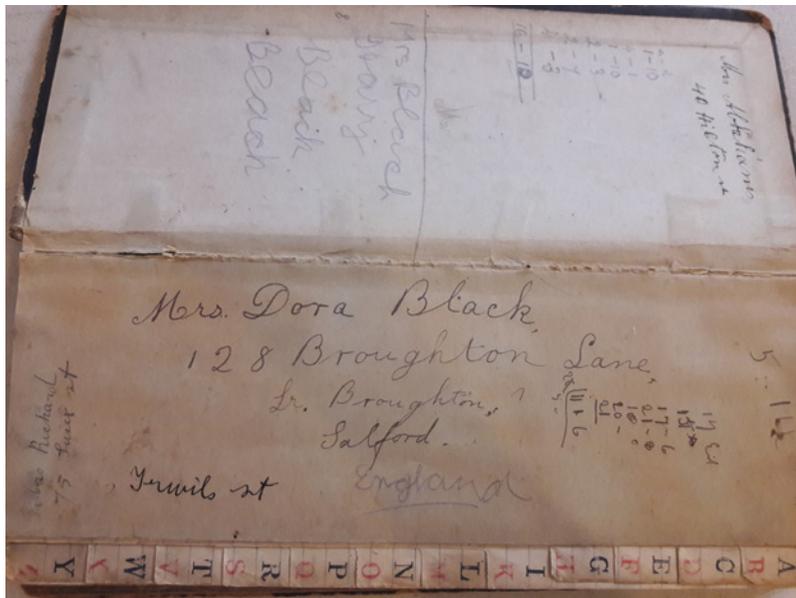


FIGURE 3.1 Dora Black’s maternity book. Photograph by the author.
© Manchester Jewish Museum, MANJM 1990-51. Published with permission.

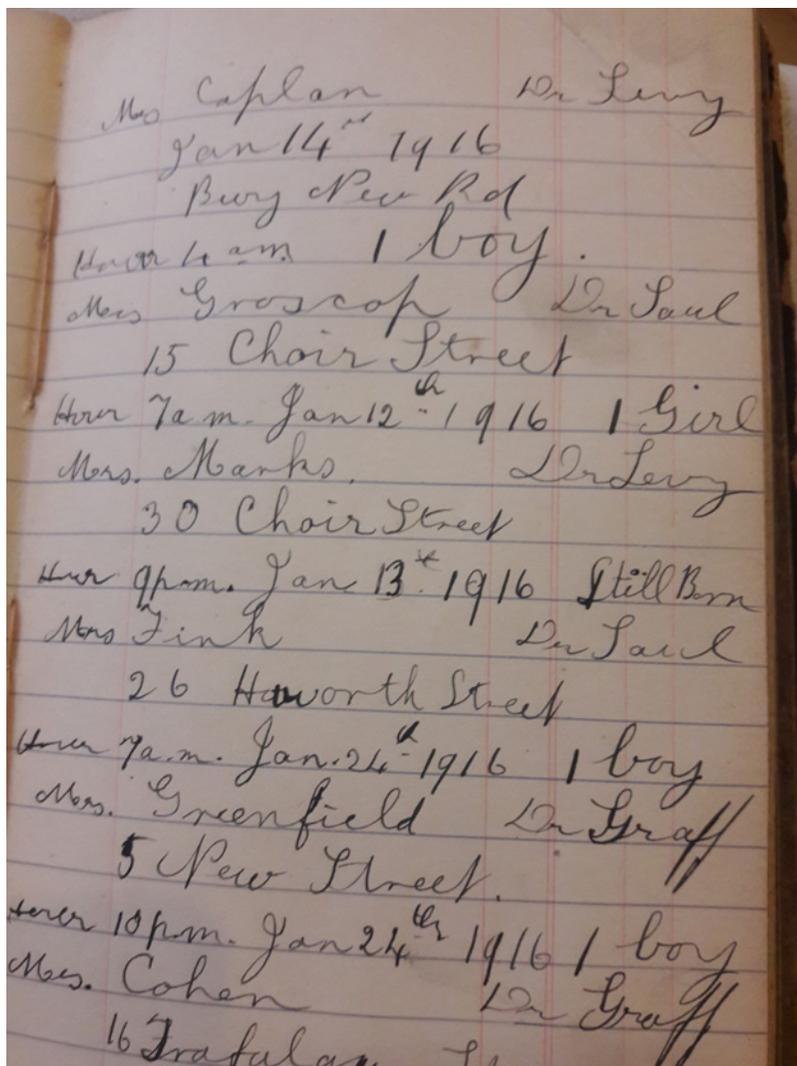


FIGURE 3.2 Dora Black's maternity book. Photograph by the author.
 © Manchester Jewish Museum, MANJM 1990-51. Published with permission.

Caring for women during childbirth was the main source of Dora's family income, though she also gained extra money by providing postnatal guidance around infant bathing:

She'd showed the first time, the newly wedded, mother ... how to bath the baby, put it in the water and hold its head up and sometimes

she would show two or three how to bath a baby. Then when the bath was empty ... they'd throw coppers in the bath. That was her perks, *butt geld* [sic], bath money.²³

Sidney Taylor recalled how the former Jewish Quarter 'depended' on its popular midwife, in his words, 'you know the "*heimeshe*" people, they always have somebody that they know from the "*heim*" that is always at [their] beck and call'.²⁴ Émigré Jewish women in Manchester continued this tradition of birthing with '*heimishe*' midwives, though Sidney described his (anglicised) generation as having 'newer ideas' by instead electing to labour in local hospitals.²⁵ He said, 'you progress here',²⁶ which captures how the emerging generation of English-born Jews were assimilating to the ideal that hospital care was the 'modern' way to birth in the early decades of the twentieth century.²⁷

There are striking historical continuities and discontinuities around the perceived need for maternity roles among émigré Jewish and Haredim, despite the fact that the setting and context of childbirth has changed considerably (also Chapter One). It goes without saying that émigré women in the former Jewish Quarter would not have had the option of birthing in hospitals with the same rigorous and regulated standards of care and accountability that Haredi women can now expect in NHS maternity services. What is also apparent across these historically-situated points in time, however, is the heightened value placed on a maternity care that is trusted and culturally-specific, and which enables biological and social reproduction to remain conjoined.

Pregnancy

Pregnancy and childbirth present pious Jewish women with the challenge of navigating complex *halachot* and social expectations that govern their body, and, by virtue of this, the reproduction of the social body. Local maternity carers are then entrusted with the responsibility of guiding Jewish women through the biomedical but also the *halachic* construction of pregnancy and labour. A full discussion on the relation between pregnancy and *halachah* (as well as social codes) is beyond the scope of this chapter, though certain examples illustrate how this can yield important implications for NHS services, such as antenatal screening. Maternity carers circulate information from both the biomedical and Judaic cosmologies when preparing women

for pregnancy and labour. Doulas can integrate the two systems of knowledge that govern childbirth by providing informative material that ranges from ‘advice for optimal foetal positioning’ as well as labour positions, to written guidelines that focus on the implications of pregnancy and reproduction for *halachic* observance.²⁸

Broader forms of guidance available to women cover the codes of conduct and types of comportment they are expected to fulfil. Reciting *tefillot*²⁹ and *davening*³⁰ for the wellbeing of the foetus and a ‘smooth’ birth is viewed as an essential act of pregnancy and labour for both *frum* men and women. The guidelines also mobilise the teachings of revered historical religious authorities when encouraging parents to *daven* that their child is specifically ‘successful in Torah and *mitzvot*’. The governance of pregnancy and reproduction in the Judaic cosmology is therefore intended to protect both biological and spiritual lives of the mother and foetus. Further instructions include observing *halachot* and associated stringencies, especially *kashrut*, or not being exposed to ‘undesirable places or images’ and instead only the teachings of the Torah that will ‘influence the *קדושה* [*kedushah*, holiness] of the foetus’.³¹ Thus the guidance circulated within the cultures of maternity care can reinforce the codes of conduct associated with being ‘God fearing’ or that reproduce the bounds of the Haredi social body.³²

Particular attention is given to preparing pregnant women for labour by explaining the laws governing the Sabbath, and when these can or cannot be transgressed (*chilul Shabbat*) during admission to hospital. Although the guidelines clearly and primarily state that ‘whenever there is any danger to life it is permitted, indeed essential to do anything on *Shabbos* which is necessary to preserve life’, the information ranges from imperative (dos and don’ts) to facultative (what is preferable) instructions. The differences in imperative and facultative instructions probably depend on the relation to *pikuach nefesh* – the commandment to ‘preserve life’ – and the birthing woman’s health. Women, for instance, are permitted to sign a document of informed consent on *Shabbat* for a procedure (such as a caesarean section), even if it is preferable not to.³³ A birthing woman cannot, according to these guidelines, sign documents over *Shabbat* that do not have a direct relation to her health, such as ‘property responsibility’ or the baby’s feed-intake chart.

Pregnancy and reproduction are discussed with heightened sensitivity within the Haredi bounds, and are avoided topics in public when children, unmarried youths and males are present. One maternity carer told me that pregnancy is a ‘very hush, quiet thing’,

and such discussions are consigned exclusively to the domain of married women. It is considered culturally inappropriate for unmarried women to learn about reproductive choices and conducts.

Some doulas and rabbinical authorities hold opposing interpretations of what 'modesty' actually constitutes in the context of discussing pregnancy and birth, which bore implications for the potential of having these discussions in Jewish Manchester. Making birth a 'normal everyday conversation' was a challenge but also an aspiration for Mrs Gross, who told me, 'I don't know where the line would be between the modesty and the Orthodox Jewish woman, and the openness about this beautiful topic'. The stringencies that demarcate Haredi Judaism can then be understood as precluding important and open conversations about areas of women's reproductive health, choices and rights. There was broader discomfort amongst some maternity carers as to when education about women's bodily and reproductive health should begin, as Mrs Susman (a doula) explained, 'it's scary, they [Haredi women] have to learn sometimes just by default and that's why women's education is very important. And I don't think it starts when you get married. I think it starts now, at a very, very, young age'.

The discretion surrounding reproduction extends beyond public discussions, and can affect the uptake of NHS maternity services during the formative stages of pregnancy. It is not uncommon for a Haredi woman to delay announcing to friends and locals that she is pregnant until either she is 'showing' (which can be a much more advanced stage of pregnancy), or around the twenty-week milestone (Mrs Susman). Haredi women, however, are far from unique in concealing news of a pregnancy during the first trimester. It is common for women in the UK to delay the announcement of a pregnancy until antenatal scans have been performed, particularly the twelve-week scan.³⁴ The difference for Haredi and especially Hassidish women, as I go on to explain, is that these antenatal screening services are often avoided.

The view of pregnancy as a time of uncertainty and precariousness requiring intervention is common to both biomedical and the Judaic cosmologies. Mrs Susman told me that the announcement of a pregnancy is delayed because 'there is nothing to be happy about yet, because this is only one part of the process'. Being pregnant does not qualify for a *mazel tov* when you are a God fearing Jew,³⁵ as Mrs Susman asked, 'congratulations on what? Conceiving?' For this important reason, the Hebrew expression *Bsha'ah Tovah* is instead offered to an expectant mother, translating as 'may the child be born

at an auspicious hour or time'. Wishing for a birth to occur at a favourable time is a reminder of how precarious pregnancy and childbirth is, for which Divine support is imperative (Sered 1992: 24–26).

Antenatal Screening

Concealing pregnancy until a woman is 'showing' also means that some Haredi women avoid going to the hospital for initial antenatal appointments and ultrasound scans,³⁶ which Mrs Salamon (a local childcare worker),³⁷ described as a naivety towards the risk and uncertainty that pregnancy can present. The active avoidance of antenatal screening services was, according to Mrs Salamon, attributed to the view held by some Haredim that the Judaic cosmology (or, more specifically, the interpretations made by religious authorities) would prevent them from making reproductive choices and decisions. Mrs Salamon claimed that Haredi women, 'have it in their heads: "if the child is ill, I can't do abortions. I can't do anything along those lines, so what the heck anyway? If I have a three-month scan and discover there is an issue with the baby, well I can't do anything about it anyway"'.

Active avoidance of antenatal screening services is not simply a manifestation of religious fatalism on the part of pregnant Haredi women, as Mrs Salamon claims, but also a result of guidelines that are circulated in order to promote Haredi interpretations of the *halachic* governance of pregnancy. Chapter Two illustrated how certain areas of healthcare or health delivery strategies are viewed as culturally inappropriate among rabbis because they have the potential to lead Haredi Jews to compromise on their religious values, and it is arguably the case that this has repercussions for the uptake of maternity services. One of the doulas presents pregnant women with a handbook entitled 'maternity issues and *halachah*' (endorsed by a rabbinical authority), which explains that parents must consider:

Carefully how they may react to a test result, which may *chas vesholom* [God forbid], detect a defect or disability in a baby for which there may be no therapeutic remedy ... Termination of pregnancy may be offered at such a time [by healthcare professionals], and this is generally not an option for an Orthodox Jewish family.

It is important to consider the *consequences* of ante-natal screening before embarking on such tests, and a mother may wish to discuss these issues with her husband, Rabbi, or GP, before reaching a decision. *It should be noted that parents have the right to refuse antenatal screening tests, if they so wish.* (Emphasis added)

Thus, whilst antenatal screening services do not contravene *hal-achah* or social codes per se, the results that these technologies produce might lead parents to make decisions – or be presented with options – that could result in such a contravention. Antenatal screening technologies can therefore present ‘consequences’ and threaten the Judaic cosmology and authoritative interpretations of religious law that preside over reproduction, and, by virtue of this, the protection and endurance of the social body as a whole. The advice circulated by rabbinical authorities therefore informs expectant parents that they have the right to decline an invitation for antenatal screening tests because of the consequences that these technologies can pose – or rather what they have the potential to *reveal*.³⁸ Yet the technologies that enable reproductive decision-making do not bring about social transformation or disruption by themselves, but rather ‘it is in how they are made socially meaningful that their power lies’ (Unnithan-Kumar 2010: 163).

Rather than holding a fatalistic attitude towards pregnancy and the potential for antenatal services to reveal a disability, there are instead opposing constructions of protection at play when reproducing the social body and that of the nation. The purpose of performing what the NHS term an ‘anomaly scan’ is to determine any ‘major physical abnormalities’ in a foetus which deviate from an established or socially-constructed norm (from the perspective of population and its control). Antenatal screening and genetic diagnosis technologies have been described as forming part of a ‘contemporary eugenic control program’, as they help to identify an anomalous life and present termination or abortion of a ‘defective’ pregnancy as legitimate and preferred solutions compared with the state having to ‘underwrite a lifetime of social services’ (Browner and Press 1995: 308). Acceptance of these reproductive interventions, as has been discussed in the context of amniocentesis in the United States, is not uniform and they are instead carefully selected or navigated, with opposition arising for complex and diverse reasons (Rapp 1999).

Antenatal technologies have been described as a ‘spiritual ordeal’ for Haredi women in Israel and are selectively-accepted, rather than rejected outright, because of the ramifications they can present for both the lives of religious women and the social body as a whole (Ivry, Teman and Frumkin 2011). Antenatal screening – like other biomedical interventions – is then an area of health and bodily care that must be negotiated carefully, which can ‘trap’ women’s bodies between the governance of competing cosmologies: through these

interventions women are tested both by the biomedical authority and by God (Ivry, Teman and Frumkin 2011; see also Ivry 2010). Reproductive interventions entail a dispute on 'birth control' in which the pregnant body and maternal subjectivity takes centre stage.

Reproductive interventions more broadly, as I go on to discuss in the context of caesarean sections (also birth spacing technologies), have the potential to contravene the *halachic* governance of Jewish bodies and become a cause for intervention by some doulas. Biomedical technologies such as antenatal screening services are negotiated in the form of 'selective-acceptance' – and are thus simultaneously incorporated into but also resisted by the Haredi social body – as they can have the potential both to protect and destabilise the Haredi lifeworld.³⁹

Maternal responsibility has, in the case of Israel, been articulated as a mother's willingness to submit to antenatal testing (such as obstetric ultrasound) in order to avoid an anomalous birth and abort what Ivry has conceptualised as a 'reproductive catastrophe' (2009: 201). Responsibility is presented as the safeguarding of a woman's healthy pregnancy but also the concern for how the social body (or that of the nation) is reproduced – all of which can become threatened by a 'reproductive catastrophe'. The preponderance of antenatal screening technologies, as has been discussed in the context of Israel, illustrates the potential for all women to carry a 'fetal catastrophe', which become implicated in a 'politics of threatened life' (Ivry 2009). The historical and political narrative of Jewish and Israeli collective life as under threat is reflected in women's bodies as constituting a terrain in which life (the pregnant woman) encounters a possible threat (the foetus), thus causing a pregnant woman to 'distance oneself from what is understood as embodying the threat and defend oneself against it (i.e., to undergo invasive testing, and to abort fetuses with minor anomalies)', (Ivry 2009: 207). Pregnant women take on the role of 'moral pioneers' or 'moral philosophers' when navigating prenatal screening and diagnostic technologies, and are tasked with policing the (socially-constructed) 'standards for entry into the human community' (Rapp 1998: 46). Antenatal screening technologies can then be situated as part of a broader immunitary apparatus upon which the preservation of both the individual and the collective depends, as the potential threat of a 'reproductive catastrophe' for the body of the nation warrants a protective – and destructive – response (cf. Esposito 2015).

The Politics of Parturition

Whereas obstetric interventions have become a routine practice of biomedical maternity care to safely birth the body of the nation, the *frum* doulas also serve as an ‘intervention’ to negotiate the delivery of biomedical obstetric care in compliance with the Judaic cosmology and its governance of Jewish bodies. Opposition to certain obstetric interventions such as caesarean sections is entangled in a politics of parturition for *frum* doulas, some of whom task themselves with managing biological and social reproduction in Jewish Manchester.

The aforementioned sensitivity that surrounds the education of bodily, and especially reproductive, conducts in the Haredi lifeworld can mean that doulas see themselves as being particularly supportive for *primigravida* women when helping them to understand the culture of NHS maternity services. The doulas also reported helping Jewish mothers to be more assertive in their care requests or needs – which they considered to be necessary when encountering the NHS.

The demand for Jewish doulas can be attributed to the standard of NHS maternity provisions, which fall short of local expectations. Mrs Cavod, a local Haredi Sephardi mother, described midwives in the NHS system as being more for ‘safeguarding’ than ‘supporting’ – with the latter role being that which the doulas have assumed over the past twenty years. She went on to say that NHS midwives and student midwives are, generally, viewed as being young and inexperienced, demonstrating an ability to ‘tell you what they’ve learned’ in university, whereas the doulas are seen to be ‘more experienced and more helpful’ – which illustrates the encounter between different constructions of ‘authoritative knowledge’ or ‘authoritative touch’ in maternity care (cf. Jordan 1997; Kitzinger 1997).

Mrs Herskovitz compared the role of a doula to the continuity model of midwifery care that supports women throughout pregnancy, birth and the postnatal period, which she perceived as being no longer available as part of local NHS maternity services.⁴⁰ Whilst organisational changes in local midwifery care have provoked different conceptualisations of maternity roles between NHS midwives and *frum* doulas (as Mrs Cavod implied above), the *frum* doulas themselves do not intend to be seen as a replacement maternity service. Instead, they described themselves as complementary and supplementary in meeting the perceived care limitations of what the state is able to provide. As I was told by Mrs Herskovitz, ‘we’re not

taking places of anybody, we're working together'. Midwifery, the doula told me, 'is not what it used to be' (Mrs Herskovitz). Midwives who are employed by the NHS spend, she said, 'a lot of their time on computers, writing up notes, rather than doing the hands on work that they actually committed themselves to training for'. It is important to note that administrative commitments reflect a broader culture of bureaucracy in the NHS which midwives are expected to manage, rather than being an issue of how midwives conceptualise their own roles.⁴¹ The changes observed by the doulas underlie their fear that negligence and malpractice could occur, as midwives are 'so busy note taking, something could be going on the monitor, something could be going wrong, and it's not noticed. Here [with a doula] you've got somebody who is with you and there all the time' (Mrs Herskovitz). Thus *frum* doulas not only task themselves with overseeing birthing bodies, but also the technologies of biomedical obstetric care to ensure that women are labouring safely.

Structural changes to NHS midwifery services and the perceived risk of subsequent malpractice have prompted local *rabbonim* to say to birthing women, "'take somebody with you," because they [the *rabbonim*] see what goes on' (Mrs Susman). Yet the concern of rabbinical authorities does reflect the realities of shortfalls in current NHS maternity provisions caused by systemic underfunding and nationwide shortages of midwives and healthcare professionals.⁴² Despite the reservations of rabbinical authorities and this senior doula towards state maternity services and the limits of its care ('they throw you out after six hours'), hospitals are viewed as a safer and a 'better place to be' in case the course of a homebirth that 'could go wrong' (Mrs Herskovitz).⁴³ The local *rabbonim* – whose support is vital to institute and maintain any service within the Haredi settlement – agree with the preference for hospital births and therefore the need for *frum* maternity carers. As it is apparently 'cultural' for *frum* Jewish women not to have a home birth (Mrs Cohen),⁴⁴ the doulas can then be positioned as an 'intervention' when reproducing the social body within a mainstream biomedical culture that is viewed with varying degrees of mistrust.

Issues of mistrust are not confined to rabbinical authorities, and the extent to which labouring Jewish women have confidence in NHS midwives (as being external to the Haredi settlement) can be dependent on the maternity carers:

I think because I am confident, they're confident. So I have a really important role. That's why the [non-Jewish] midwives have a sigh of

relief when I walk through the door, because up until that moment, that [Jewish] couple might not be believing her. When I walk in and say [to the midwife], ‘oh I know Mary, oh hi Mary, how are you doing?’ The couple immediately, it switches on something inside their head and they’ll listen to what that midwife is saying. (Mrs Yosef)

The quality of the doulas and of the NHS healthcare professionals has had an impact on the relationships between the two, and I was told that some ‘love doulas and some hate doulas’. Many doulas felt that health professionals generally appreciated their roles, probably as they understand their value in encouraging *frum* women to use NHS maternity services. The doulas told me that a key part of their role is mediating encounters and relations between NHS midwives and birthing Jewish mothers. There is, however, an undefined line between realising the mother’s needs and asserting their own perceptions on what might be in the best interests of the individual or even the social body – which might otherwise be read as a coercive practice.

The standard conduct for birth supporters is to present women with the relevant information to make an informed decision, such as the choices of hospital to labour in, and Mrs Herskovitz was explicit in saying, ‘but I will never tell them [what to do]’. Although doulas do not, in theory, instruct pregnant Jewish women, the actions of some doulas can take them beyond their primarily supportive role into a terrain of contest with medical professionals – best described as an opposing conceptualisation of the term ‘intervention’.⁴⁵ Healthcare professionals, in some instances, apparently included the doulas, or they intervened, in clinical decisions surrounding labouring Jewish women. Mrs Bloom told me, for instance, ‘I’ve had a doctor make a decision and I sort of twinge and they’ll say, “go on, what were you thinking?” and I’ll tell him what I thought and he said “well, go with Mrs Bloom, she’s a wise woman”. So the doctors are very respectful’. What matters in this reflection is how *frum* doulas position themselves at the centre of the spectacle in which constructions of ‘authoritative knowledge’ concerning women’s bodies (as conceived in both the biomedical and the Judaic cosmologies) are enacted, contested and negotiated. The approach that some doulas take when intervening in medical encounters is viewed with caution by some of the Jewish midwives, perhaps due to the ambiguity in the former’s role of providing support during medicalised births. Mrs Abrams (a maternity carer) told me, ‘the problem is that they [doulas] are not supposed to be medically

trained, their role is just to support', which is a role she perceived some doulas to occasionally overstep.⁴⁶

Alleviating Pain and Fear

Some maternity carers offer private birth preparation classes to expectant parents with a complete antenatal and postnatal preparation, not as an opportunity to educate, but to give confidence in *frum* people and their bodies. I was told that the crux of fear stems from the belief that birth is painful – but also the lack of exposure to birth that arises from the perceived need to protect unmarried young people from being exposed to reproduction and the process of birthing. Childbirth as a process can remain secretive because of the discretion surrounding discussions on and of the body. Doulas who were in favour of promoting homebirths also claimed that the complete removal of labour from the domestic realm can provoke a fear of pregnancy and childbirth among children because, 'mummy disappears and does something mysterious and then comes back with a baby. It's very scary, [whereas with a homebirth] mummy is at home, she has a baby, and life carries on' (Mrs Gross, doula). Mrs Gross instead holds the view that women have a smoother birthing experience when they are more comfortable and safe. For this reason she encouraged pregnant women to birth at home rather than in the unfamiliar environment of a maternity ward.

Mrs Bloom explained how she tries to lessen a woman's fear of childbirth by framing reproduction as a religious domain, because, she says, God chose to maintain jurisdiction over birth rather than delegate it to his angelic messengers. Childbirth – along with rain and the Biblical splitting of the Red Sea (*Yam Suf*)⁴⁷ – are the 'three jobs that *HaShem* never gave to any messengers'. The presence of God during childbirth is a point that Mrs Bloom would reassert when supporting labouring women, 'so I always remind the women, "it's God who is here with you, nobody else. There's no messenger, there are no angels, it's God alone here with you. You can do this, He's here to help you"'. Maternity carers hand women in childbirth a card inscribed with a specific Psalm (*Shir Lama'alot* [A Song of Ascents]), the verses of which are seen to carry Divine will to safeguard the birthing women and her baby during a vulnerable time (Figure 3.3).

Similar to the way in which information is circulated through 'the power of the mouth' in Jewish Manchester, the lack of access to information about childbirth (or perhaps the relatively later exposure to information surrounding it) can give rise to the circulation

of birth-related traumas by hearsay. In a social body where ‘everybody knows everybody else’s business and you’re carrying everyone else’s horror stories with you’ (Mrs Bloom), the doulas task themselves with empowering and supporting women to gain the self-confidence to believe they can go into labour, sometimes with a restrained use of biomedical interventions. In cases where pregnant women request or indicate an inclination towards a caesarean section, one midwife told me that ‘it usually boils down to fear, and fear equals a lack of education’. More broadly studies have demonstrated that caesareans can be preferred by some women during pregnancy and when contemplating pregnancy due to fears that vaginal birth can bring uncontrollable labour pains as well as physical bodily damage (Størksen et al. 2015:5; Stoll et al. 2017). What is different in the Haredi context, according to one midwife, is that a *primigravida* woman’s confidence in her capacity to labour vaginally is shaped by the limited flows of non-Haredi knowledge and information pertaining to the process of childbirth and bodily care.⁴⁸ For these reasons the maternity carers place an emphasis on antenatal classes, whether provided by local public services, or privately held by Jewish midwives.

Interventions on the part of maternity carers manifested over conflicting views on the provision of epidurals for pain relief. One maternity carer would attempt to reassure women by explaining that pain could be offset considerably because ‘we’re in a country that – thank God – provides epidurals’, thus presenting the option of accepting interventions for pain relief and acknowledging that it is a personal choice for birthing women. In contrast, Mrs Bloom encouraged birthing women *not* to take pain relief out of concern for the possible impact on the foetus. Rather than explicitly saying “don’t take pain relief,” she would explain the potential risks to women during pregnancy – detailing how paracetamol can come with a list of “could-be side effects” and ‘the more pain relief one takes, the more could-be side effects, and you can be affecting an unborn baby’. Paracetamol is an over-the-counter pharmaceutical in the UK, but Mrs Bloom also advocated against institutionalised pain relief, including epidurals, which are made routinely available to birthing women by maternity staff:

I had a mother come to me and say, ‘oh my darling [daughter], she can’t take pain. She’s going to need an epidural’. So I said ‘I hear you, but there’s a study being done in Israel at the moment to link learning difficulties with epidurals. There’s so many women there taking epidurals, so many children needing extra help’. And she said to me,

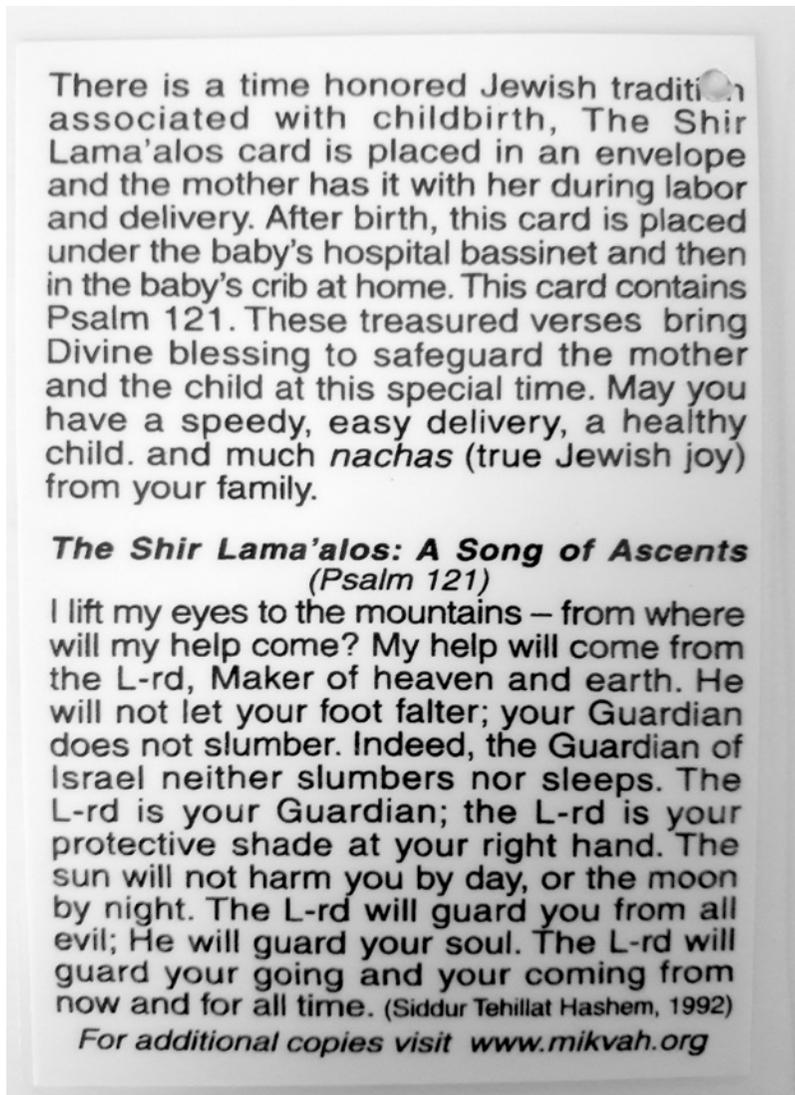


FIGURE 3.3 Card containing the verses of *Shir Lama'alot* (Song of Ascents) that are given to birthing women. Card collected by the author during fieldwork. © The Taharas Hamishpacha Organization/Mikvah.org. Reprinted with permission.

'I had one epidural and that's my child who has extra tuition'. I said, I can't prove it, but I know what I'm hearing. I'm not saying there is never a need, but there are so many more problems with epidurals that you're better off [without].

The concern for epidurals was not limited to one doula, but was shared amongst some of the network of maternity carers that she worked within. Another doula told me that the epidural procedure is bound up in a larger medicalised culture of childbirth where 'there are some hospitals that will meet you with a needle'. Thus some doulas circulate their own authoritative rulings on birth care and appropriate conducts, which might conflict with biomedical standards of practice and consent, and might not reflect the individual choices of *frum* birthing women.

Caesarean Section

In a cosmology that upholds the view that women have 'been given organs [by God] to give birth naturally' (Mrs Susman), caesarean sections can be a paramount area of advocacy and 'intervention' for the doulas. More specifically, this operative procedure is viewed as contentious because it can have serious ramifications for the bodily rites bestowed on (male) infants as well as a woman's future reproductive potential, and by virtue of this, the endurance of the Haredi social body.

Mrs Bloom was concerned that if a caesarean is performed on a woman's first labour, then the risk of an operative birth being performed in subsequent pregnancies can be increased. The potential for a Jewish woman's reproductive potential to be limited was a major issue for Mrs Bloom, because, she said, 'you can only have so many caesareans'.⁴⁹ When rising rates of primary caesarean section are coupled with a decrease in the numbers of VBAC (vaginal birth after caesarean) being performed, it is likely that the number of women having to undergo subsequent and multiple repeat caesareans will consequently rise (Nisenblat et al. 2006).⁵⁰ This outcome can present a challenge for women who expect to have large family sizes as there is evidence to suggest that multiple repeat caesarean sections (five or more) are associated with significantly increased risk of serious maternal complications, including a higher incidence of uterine rupture, blood loss, haemorrhage and admission to critical care units (Cook et al. 2012; also Kaplanoglu et al. 2015). The risk presented to a woman's life after multiple repeat caesareans could have the potential to impose a limit on a woman's reproductive potential.⁵¹ Considering the mandate placed on Jewish men to reproduce and 'multiply' the social body and the importance of childbearing in Haredi women's lives, Mrs Bloom argued that 'in the *frum* world, people would rather not have caesareans'.

Whereas vaginal birth can cause intense but 'relatively brief' intra-partum pain, maternal responses to caesareans (as a major operative procedure) have described the 'hard bit' as being the recovery due to 'horrendous' and enduring post-partum pain (Tully and Ball 2013: 106; and also Sargent and Stark 1987). The extended recovery time associated with caesarean intervention presents an additional challenge for *frum* women if they have a large family to care for at home, which is a point that Mrs Bloom would reassert when called upon for maternity advice.

Mrs Bloom described her proclivity to challenge the judgement of medical professionals recommending birth by caesarean section in instances she viewed as being medically unnecessary and avoidable. In particular she reflected on a clinical encounter that involved a *primigravida* woman with an undiagnosed breech:

The doctor said, 'right, this has got to be a caesarean' and I told the [pregnant] lady 'leave the talking to me, please'. I said to the doctor, 'she doesn't want a caesarean. She's labouring nicely and she's happy to try for a natural [vaginal]'. So the doctor said, 'I've never delivered a natural breech'. I said, 'I hear you, but this is her request'. A bit later she came in to say, 'Miss so-and-so who is the top consultant on the unit is coming out'. This was four in the morning, and the staff whispered to me, 'we have never seen this before' [laughs]. I said, 'Well, she's entitled to her *choice*'. She [the consultant] turned up and she delivered this baby naturally. (Emphasis added)

What is important is how Mrs Bloom portrayed herself as having the authority to assert her knowledge of birth over the healthcare professional, and how she challenged the clinician's recommendation to perform a caesarean by formulating and asserting the birthing woman's 'choice'.⁵² Thus Mrs Bloom's encounter demonstrates how contestations of 'authoritative knowledge', as upheld by proponents of either the biomedical or Judaic cosmologies, can be enacted on the bodies of Haredi Jewish women. Moreover, it can be inferred how individual women might experience pressures around the mode of labour when particular doulas task themselves with birthing the social body, which may appear as being coercive against hospital policies that attempt to respect individual patient autonomy.

Mrs Bloom's narrative (and her intervention) indicates the possibly avoidable contexts in which caesarean sections can arise from a 'misrecognition of need' when childbirth could otherwise proceed differently (cf. Tully and Ball 2013: 109). It is also worth noting that higher caesarean rates can form a routine part of a biomedical

culture when obstetricians fear allegations of medical malpractice (see Béhague 2002: 485). Mrs Bloom went on to acknowledge that operative births can be life-saving in some instances, but she explained there 'are few reasons that I would say *need* to have caesarean' (emphasis added). Rather than being an issue of medical necessity, Mrs Bloom claimed that in most cases it was 'easier' for obstetricians to 'perform the evil' than oversee a vaginal birth – which is constructed as risky, unpredictable and litigious in the biomedical worldview.⁵³

Mrs Herskovitz claimed that the local approach to doula care, including its model of continual care and advocacy, has caused the rate of caesarean births in Jewish Manchester to plunge to just three per cent compared with the 2013–2014 average of roughly twenty-six per cent in England and Wales.⁵⁴ She went on to assert how their work could:

Prove to you that working with women in the way that we're doing, it makes a massive difference. It's the kind of work that we're doing; it's the sitting with the women, it's the one-to-one, it's the being there. It's the relaxation that she has because she knows she's got somebody there for her. All those things are contributing and *not*, not, epidurals, right? All those things are contributing to the low caesarean rate. Obviously there are people with conditions [who] need caesareans, so you can't eliminate caesareans. (Original emphasis)

Common to both Mrs Bloom and Mrs Herskovitz is the concern that women in Jewish Manchester could be at risk of unnecessary medical interventions. The potential to 'cut' local caesarean rates by having a doula present is then mobilised to underscore the value of their work as well as the need for specific cultures of maternity care when working within NHS wards. Mrs Herskovitz' claim can, however, be critiqued by drawing on broader understandings of doula care in the UK.⁵⁵ Doulas in the UK have reported more optimal birth and postnatal outcomes in the women they support, including lower rates of caesarean sections as well as higher rates of successful homebirths and prolonged breastfeeding (Brigstocke 2008). This does not necessarily mean that the presence of a doula alone leads to better maternal and infant health outcomes, as women who commission doulas are more likely to be after a particular birth experience which might extend beyond NHS maternity provisions (Brigstocke 2008). Whilst doulas in Jewish Manchester share a model of continuous care with birth supporters in the broader UK context, the former can be set apart by their nuanced role in

supporting *frum* women to birth according to religious imperatives, and, in the case of Mrs Bloom, averting risks to social reproduction posed by elements of biomedical obstetric care.

Doulas are not expected to be ‘medically-trained’, but they are nonetheless trained to have ‘non-medical skills’ and are entrusted to help labouring women have a ‘safe and satisfying childbirth’ (Hunter 2012). However, some Haredi doulas would frame their supportive work in way that could be interpreted as para-medical or as if they were practicing midwives: ‘You’re definitely much higher risk; once you’ve had one caesarean, even though I do *do* VBAC, which means natural after caesarean. *I do encourage it*, and I will be there for the ladies but you do worry about it. It is a higher risk’ (Mrs Bloom [emphasis added]). Mrs Bloom presents herself as having responsibility for managing the course (and choice) of a woman’s labour, which would otherwise be considered the prerogative of a midwife in NHS maternity care. The supportive and advocacy roles which Haredi doulas craft for themselves can therefore be viewed as ambivalent, and were described as a cause for concern for other maternity carers, who told me, ‘they’re [doulas] not midwives but a lot of people get advice from doulas, and that’s not necessarily always the best advice’.

Part of Mrs Bloom’s aversion to caesarean sections lies in the fact that the surgical intervention can adversely ‘intervene’ in the birth rite that is bestowed on a male first-born (*bechor*).⁵⁶ Whereas the *brit milah* (circumcision) is a widely known male bodily and birth conduct in Judaism, the ‘*Pidyon HaBen*’ ceremony (redemption of the first born son) is held when a *bechor* is thirty days old. However, this rite of birth is only held under certain conditions. The ritual entails the *bechor* being ‘redeemed’ by his parents from a priestly descendant, such as a Kohen, which exempts the first born from the Divine and ancient obligation to serve in the Holy Temple.⁵⁷ The ceremony is held when a *bechor* ‘opens up the womb’ of the mother, but this ‘opening’ is interpreted as being strictly by way of vaginal birth – whereas ‘if you’ve had a caesarean, the baby has not come through the womb and opened up the womb’ (Mrs Bloom). Even if a *bechor* were born by caesarean, a *Pidyon HaBen* would not be conferred upon a subsequent male to ‘open up the womb’ if born vaginally.⁵⁸

As a caesarean birth does not ‘open’ the womb of a mother, the obstetric intervention can be understood to ‘cut’ off the infant from being bestowed this Jewish reproductive rite. The strict relation of the *Pidyon HaBen* as ‘opening the womb’, and the implications posed

by a caesarean, therefore offers a classic example of how reproduction is a contested field of ‘intervention’ – as individual parturition is so intimately tied to birthing the social body as well as its identity and cultural perpetuation. Jews in Manchester have been faced with a historically continuous negotiation when choosing hospital births (Chapter One), which are viewed as a safer option, yet can present a challenge to social reproduction and bodily conducts that define and perpetuate identity.

Overstepping the Mark

Interfering with the work of healthcare professionals or providing ‘a dissenting opinion’ to clinical recommendations is beyond the role of a doula (Hunter and Hurst 2016: 2). However, in reality the overstepping of professional boundaries and roles does occur through the negotiation of power dynamics and ‘authoritative knowledges’ on maternity wards, and over the maternal and birthing body. Healthcare professionals in the US can perceive doulas as attempting to influence clinical-decision making by asserting confrontational positions over caesarean sections and pain relief, and attempting to take charge of a birthing woman’s care (Morton et al. 2015). Yet doulas might resist biomedical obstetric cultures that condition the maternal birthing body as requiring a homogenous form of care and intervention if it deviates from a clinical ‘norm’ (cf. Castañeda and Searcy 2015: 136).

The perceived need for intervention during childbirth on the part of these *frum* doulas reflects the cardinal place of reproduction in Judaism, as well as the social politics of birth and maternity care for Haredi Jews. As has been argued in the broader context of responses to hyper-medicalised cultures of birth, ‘the ways in which a society defines women and values their reproductive capability are reflected and displayed in the cultural treatment of birth’ (Szurek 1997: 287). For some *frum* birthing women, medicalised childbirths have been left devoid of care and continuous support and instead overshadowed by the ‘safeguarding’ ethos of biomedical maternity care. However, Haredi cultures of maternity care are also not resistant to medicalisation and are not de-medicalised, a point that Ivry and colleagues (2011) also discuss in the context of Israel. On the contrary, I was told that local rabbinical authorities view hospitals as a safer option for *frum* women to birth in. The difference is that biomedical maternity care falls short of local expectations and also requires negotiation – in both cases to comply with the Judaic cosmology. Attention to the politics of parturition in Jewish

Manchester exposes how maternity care can bring to the fore the diverging conceptualisations between the biomedical and Haredi cosmologies, thus reflecting the broader anthropological discourse of birth which illustrates how ‘the maternal body is a much more complex entity in the social world than it is in the medical imaginary’ (cf. Stanford-ISERDD Study Collective 2016: 64).

Mothers in Jewish Manchester such as Mrs Cavod described how the *frum* doulas perform a formidable role in supporting labouring women. Yet some go beyond the supportive role of a doula by intervening in clinical encounters and influencing the care that birthing women receive.⁵⁹ The doulas of Jewish Manchester advance past conceptualisations of doula care, given their specific intentions to oversee the birth of the Jewish social body within the biomedical order, and especially as they form part of a larger immunitary strategy (cf. Espsito 2015) of self-protection from the outside world. Haredi doulas position themselves on state maternity wards because it is the threshold where a body becomes a margin between two competing cultures of bodily governance and knowledge. The maternity care provided by the *frum* doulas in Jewish Manchester illustrates how biomedical knowledge is appropriated and exercised to protect the social body and to counter threats to social reproduction.

Postnatal and Infant Care

The work of doulas generally finishes after childbirth, with a few providing the majority of postnatal care in Jewish Manchester. These carers were also in a strategic position to identify postpartum concerns such as the need for birth spacing technologies to promote maternal wellbeing. It is in such contexts that these carers act as points of referral by directing women to rabbinical authorities, who often form primary gate-keepers for access to birth spacing technologies (Chapter Two). I was told that maternity carers take on postnatal and infant care work because of the limitations of NHS health visitors, who, when attending to families in Jewish Manchester, apparently struggle to understand the cultural context in which they work.

NHS health visitors ordinarily form the frontline of public health surveillance in the UK, especially for monitoring the health and wellbeing of children less than five years of age and also assessing ‘parenting skills’ and ‘the family and home situation’ (NHS Careers

n.d.). These professionally qualified midwives and nurses therefore constitute a crucial element of the health authority's strategy of surveillance, and arguably supervise whether parents meet the state's expectations of 'good' parenting and childhood development, which has implications for how the body of the nation is reproduced.

Mrs Yosef told me that NHS health visitors apparently receive cultural awareness training only 'if they are lucky'. With the extremely composite nature of Jewish Manchester concealed in public health representations of one homogenous 'ultra-Orthodox Jewish community', health visitors are apparently unprepared and untrained for the reality that awaits them:

If they haven't had that [cultural-awareness training], the health visitor is thrown into this community that she doesn't really understand what's going on. There's so many subtleties, so many layers, so many different sorts of people. If she comes over as not understanding the community, they will put barriers up straightaway. If the health visitor comes in and they [Haredi mothers] can see that she's kind, she's gentle, she's listening to them and not pushing, then they'll work with her. As soon as they feel that there's antagonism, then the barriers come down and you've lost it. (Mrs Yosef)

Conflict between NHS health visitors and Haredi Jews is not specific to the case of Manchester, and has been observed in previous studies conducted elsewhere in the UK. Some Haredi mothers in Manchester have described a 'fear' that health visitors 'look around your house and judge you' (Wineberg and Mann 2016: 28), which suggests that NHS health visitors may be viewed by locals as a technique of covert surveillance. Relations between health visitors and Haredi families in London also articulate how 'each side feels misunderstood by the other', and healthcare professionals were viewed as being ignorant of the context in which they work and *frum* Jewish women were considered unaware or uninterested in the role of health visitors (Abbott 2004: 82). Moreover, recommendations that health visitors pushed on behalf of the public health authority had the potential to be viewed as 'counter-cultural' in the eyes of *frum* women, having the effect of alienating and undermining the way in which Jewish women view their maternal role (Abbott 2004). Opposing conceptualisations of what constitutes appropriate or 'good' parenting, infant care and bodily governance arguably underlie the conflicts observed between Haredi Jews and NHS health visitors.

By being internal to the Haredi settlement, the *frum* maternity carers describe themselves as being able to navigate the

socio-religious diversity and fulfil a postnatal role that NHS health visitors have apparently so far failed to grasp. What is acceptable for one Haredi mother might not be acceptable for another, and that 'is very hard for the non-Jewish health visitor to negotiate' (Mrs Susman).

The act of assessing the postnatal care provided by Jewish mothers harks back to the formative years of Jewish Manchester, and illustrates the continuity between the historical Jewish Ladies Visiting Association (Chapter Two) and the contemporary role of *frum* maternity carers in meeting the needs of the settlement over time. More specifically, postnatal care has been a historically continuous area of intervention in Manchester, with sophisticated and novel services having been developed for émigré and now Haredi Jewish mothers and infants. These services, running within Jewish Manchester, are seen to meet the limitations of the standard of care that has been provided by the state and now afford a degree of protection against a biomedically-oriented postnatal care that can be potentially disruptive to the Haredi cosmology, such as 'contraception', but they also buffer the added pressures that come with motherhood for *frum* women.⁶⁰

Maternal Convalescence

A distance away from Jewish Manchester sits a postnatal rest home called *Shalom Bayit*⁶¹ (peace of the home), which is designed specifically to offset the pressure of motherhood for Haredi women and the care of their infants aged up to five weeks. Funded solely by one of the settlement's wealthiest benefactors, the postnatal service is bestowed at no cost to the mother and is conceptualised as a 'specifically targeted method of *chesed* (kindness) that is to make the beginning of a new mother's life as easy as possible because it's so susceptible to things like postnatal depression' (Mr Attias). The provision of maternal psychosocial services is then framed as a mandate of the Judaic cosmology, as acts of 'kindness' form the core of Orthodox and Haredi lifeworlds.

Mothers from across the Jewish continuum in the UK are eligible to apply,⁶² but the majority of the women who visit *Shalom Bayit* are *frum* because 'if you're not in a community, you probably won't know about it' (Mr Attias). *Shalom Bayit* is only open to Jewish women because of the expense of running such a 'luxury' (as one mother described the postnatal service), which can be understood as a historical departure from the maternity care home instituted in 1920 (introduced below). As Mr Attias informed me, a line has to be

drawn between who is eligible to apply and who is not, as ‘you have to look after your community, so it’s limited to the members of the wider Jewish community’.

The postnatal care home was compared to a ‘five star hotel’ by Mrs Cavod, being fully catered and set besides the sea with tended gardens – making *Shalom Bayit* ‘just a dream’ for mothers. All eligible women are allowed to stay for a period of two weeks (but returning home over *Shabbat*) and husbands are generally not encouraged to visit, as the focus of the home is maternal convalescence. The physical seclusion of *Shalom Bayit* apparently forms part of the ethos of care. It enables Jewish mothers to ‘rest, relax and recover’ (Mrs Gross), and the home was described as being positioned far away enough from Jewish Manchester to ‘make it completely disconnected from the community’ (Mr Attias).

One doula told me that ‘there’s nowhere in the world where anyone can go and get that facility for free’, as the home is professionally run and serviced by registered midwives and healthcare support workers who attend to mothers on (approximately) a one-to-three basis. *Shalom Bayit* is not designed to replace NHS postnatal or high-dependency care, but instead operates to meet the shortfalls of state-provided postnatal wellbeing services. Mr Attias (a father of a growing family) went on to claim that the ‘traumatic experience’ of birth is not sufficiently alleviated by current standards of NHS maternity care in what he described as an absence of post-birth support for women, or what can instead be read as opposing constructions of what constitutes care:

The first night after giving birth in a hospital, I can’t imagine how difficult that is. It must be so difficult. That first night in the hospital, because the nurses don’t care for the baby: you have to care for the baby but you’ve just given birth. They’ve [the women] just gone through one of the most traumatic experiences of their lives. When you go in the morning to see the mother they’re like “thank God”.⁶³

Perceptions of deficiencies in NHS maternal health and wellbeing were also shared by a Hassidish *rebbetzin*, who claimed that the mainstream provider of health ‘has really not come up to the needs of the mothers post-birth’. For the more stringent or Hassidish groups in Jewish Manchester, *Shalom Bayit* then enables women to be ‘given a chance to get healthy and strong again’ (*Rebbetzin Yad*). The home is also viewed as an imperative counter-balance to the childbearing and familial pressures that women face when particularly Hassidish men and women oppose the use of birth spacing

technologies, or when Haredi families are perhaps denied access by rabbinical authorities (Chapter Two). Thus an incomplete image of the Haredi lifeworld is presented in constructions of Haredi Jews as being 'hard to reach', a term that implies a distance from the biomedical authority and thus a deficit of health when instead there is a sophisticated level of health and bodily care that – from an emic perspective – meets the limitations of state care.

Van Esterik (2015) describes the 'social womb' as the first six months of breastfeeding and 'person making' (the nurturing and moulding of an infant into a social and cultural being), which stimulates maternal–infant co-dependence and intensifies the process of 'personing'. Postnatal care in Jewish Manchester can be read as a culturally-specific strategy to nurture maternal–infant bonds and processes of personing in the womb of the Haredi social body. Institutions such as *Shalom Bayit* form part of a broader strategy to create a protective womb and control a margin of autonomy for Haredi Jews, preventing the need to seek external services, and also ensuring that cosmological requirements to preserve health and care for the body are met. Immediately from the time of their birth, Haredi Jews are channelled from one protective and culturally-specific zone to another, which serve as 'immunitary barriers' in order to protect and reduce 'the porosity of external borders to contaminating toxic germs' (cf. Esposito 2015: 123).

Offering a historical parallel with *Shalom Bayit* are the maternity and postnatal provisions developed for the 'foreign' and working poor of the former Jewish Quarter, which illustrates the continuous attempts of the social body to manage its reproduction as well as the re-presentation of its image. Maternal wellbeing and infant health would have been a historical struggle for the Jews living in the slums, and the Board's Medical Officer noted in his 1872–1873 report that 'extreme poverty, with a corresponding lowness of the mother's diet, tend essentially to sap infant life'.⁶⁴ By the turn of the twentieth century, however, it was a point of pride for the Manchester Jewish Ladies Visiting Association (Chapter Two) that public health authorities viewed Jewish mothers as capable 'with the feeding and management generally of their infants', and also that they were compliant with 'the advice they are given'.⁶⁵

With local hospitals only admitting mothers and babies in cases of illness, Manchester's anglicised Jewish women recognised that poorer childbearing women with young families needed respite and preventative care 'if their health is not to be permanently impaired'.⁶⁶ In 1920 Margaret Langdon led attempts to gather funds

to equip a rest home for (married) Jewish mothers, also admitting non-Jews depending on capacity, as part of the United Sisters' Maternity Society.⁶⁷ Jewish mothers would be expected to make a small contribution to the cost of their care, which was subsidised by subscriptions made by the broader Jewish population in Manchester (in ways that are continuous with the funding of Haredi services, see Chapters One and Three).⁶⁸

The home was initially instituted as a summer retreat in Derbyshire, a short distance from Manchester, with the intention of 'restoring to health the most precious members of the community, the mothers of a future generation'.⁶⁹ Unique for the era in admitting women together with their babies, the home was a pioneering enabler of maternal wellbeing and infant health and was apparently unparalleled by locally-provided mainstream care.⁷⁰ The maternal rest home can be conceived as a culturally-appropriate (or culturally-specific) service offering both preventive as well as restorative care,⁷¹ running along 'orthodox Jewish lines' and perceived as being the only suitable service for Jewish mothers and babies.

Convalescent care in the context of Jewish Manchester clearly had a visceral concern with what Davis-Floyd and Sargent have described as the 'cultural control of human perpetuation' (1997: 6). The culture of postnatal care exemplifies how mothers were focused on as the propagator of a 'future generation' – or more specifically, a future *Jewish* generation. The analysis of archival material relating to child health and wellbeing services presented here demonstrates how Jewish Manchester sought to reproduce and maintain the social body by managing maternity cultures.

Maternity and postnatal care in Manchester's former Jewish Quarter was less extensive than in London's Jewish East End, signalling the nuanced experiences of émigrés who settled in the North West of England.⁷² Specific to Jewish London was the development of The Sick Room Helps Society (SRHS) in 1895, which provided midwifery visits to 'sick poor' women during their confinement as well as postnatal 'home helps' to take over household chores, cooking and childcare. These home helps were vital in the context of London's poor and insalubrious East End because they enabled Jewish women to recuperate, and also prevented husbands from foregoing much-needed earnings if they had to provide familial care (Marks 1990). Moreover, the Jewish Maternity Home (affectionately termed Mother Levy's) was built in Whitechapel in 1911, around the time when hospital-based births had been increasing. Old Mother Levy's provided a base for the SRHS and was fully

equipped with maternity wards, an operating theatre, midwifery training and later developed an Infant Welfare Centre which provided free milk supplements and vitamins if mothers struggled to breastfeed (Marks 1990). Not only were these culturally-specific maternity and postnatal care provisions highly prized by émigré and poor Jewish women, but the care itself was an important buffer and advantage that would not have been available to non-Jewish families in the area (Marks 1990).

Immigration to London's East End, like Manchester, brought a growing presence of émigré and poor families who became a concern for the social body. Tananbaum (1994) has explored the distinction and, in some instances, discordance, between 'biological' and 'communal' mothers during the period of Jewish immigration to London. Whereas the former were biological mothers, 'communal' mothers were regarded as an attempt by the largely middle-class and rooted Jewish 'community' to develop maternal and infant social care services, primarily as a strategy of anglicisation to uphold the standards of morality and 'good' motherhood amongst their 'foreign' co-religionists. The family-making dynamics of émigré Jews were, at the time, a point of scrutiny and pejorative discourse during the formative decades of the twentieth century, with the 'contention' made that 'Jews are a prolific race' – a claim that was subsequently refuted by a prominent Jewish physician (Sourasky 1928: 469). Racialised representations of Jews such as this offer historical continuities with England's growing Haredi minority, which is portrayed as having among the highest fertility rates in the country and as presenting a challenge to the dominance of the broader non-Haredi Jewish population (discussed later in this chapter).

Through revisiting past maternity cultures in Jewish Manchester, it becomes clear that birth, as Van Hollen has discussed in its broader socio-political context, can be analysed 'as an arena within which culture is produced, reproduced and resisted' (1994: 501). Jewish Manchester developed culturally-specific maternity care provisions to buffer mothers against the city's insalubrious, urban and industrial conditions in an era that predated the NHS and welfare state, when standards of maternal and infant care services were formative but subject to increasing political attention. The surveillance and assimilatory mandates of particular organisations aside, maternity cultures in the former Jewish Quarter (especially around breastfeeding) were thought to influence the lower rates of infant mortality observed in the area⁷³ – reflecting the experience of émigré Jews in the East End of London.⁷⁴

Breastfeeding and Modesty

Breastfeeding is a physiological process that is significantly shaped and defined by cultural norms, and is also sensitive to the social, political and economic situations in which a woman is positioned (Van Esterik and O'Connor 2017). The rules and social codes surrounding reproduction and breastfeeding are generally patriarchal and involve the reinforcing of male-dominated institutions in many societies (Kitzinger 1995; Maher 1995). Haredi Judaism is no exception, as rabbinical law (or its current interpretations) and social codes of conduct determine the practice of breastfeeding. Just as in broader UK society, the role of breasts in infant feeding is overshadowed by their being viewed as a hyper-sexualised organ in the 'West', where breasts – and their exposure – are seen primarily in a context of eroticism (Dettwyler 1995). Aversions to public breastfeeding among Haredi Jews can reflect this taboo status that characterises broader society, and nursing is an area of motherhood that requires *frum* women to negotiate competing expectations of bodily knowledge, modesty and physiology. The social and biological issues that can affect nursing (and also maternal wellbeing) have consequently become a significant aspect of the postnatal support provided by maternity carers in Manchester.

Part of the need for breastfeeding or infant feeding supporters is that mothers are confronted by what is described as an intense expectation in Jewish Manchester to nurse, which is regarded as optimum for infant health. As one doula told me, 'peer-pressure in the community to feed is very high, why is peer-pressure very high? Because, as you understand, everything is about the health of the children' (Mrs Susman). The challenge for postnatal supporters such as Mrs Wiener (a local maternity carer) is that she is called upon only at the point when a mother is struggling to nurse and is 'just about to give it up' – rather than forming part of an antenatal or postpartum preparation programme. Mrs Wiener described how often the problems associated with feeding are practical issues, such as how the baby latches on to the breast, the position in which the mother holds the baby during feeding, issues relating to soreness, infection or blocked ducts, or the 'misconception' that mothers should cease nursing when an infant reaches six months of age.⁷⁵

Mrs Yosef patiently told me, the young and unmarried male researcher, that there is 'an art to breastfeeding. It's not natural, well, it is natural. You have to be shown'. Continued cuts to the NHS welfare budget over recent years has seen the number of

post-birth visits by midwives in England continuously decrease, with little understanding of how reduced services affect mothers (Royal College of Midwives 2014). Whereas Mrs Yosef recalled how midwives would previously make daily and routine visits to young mothers, she now described the state-provided postnatal service as ‘patchy’ – which she claimed increased her own workload to supplement what is no longer offered by midwifery services. Considering that many of the postnatal anxieties held by mothers are to do with infant feeding, Mrs Yosef expends a considerable amount of time making house visits.

The issue of reduced midwifery attendance and the implications for maintaining breastfeeding are probably not specific to the Haredi context, but they are compounded by the broader issue of circulating health information within the *frum* minority and how its authorities define the stages in life when accessing reproductive health information is acceptable. The struggle against ‘secular’ education in the Orthodox and Haredi educational system leads to a lack of awareness about the ‘ins-and-outs’ of human biology, which is maintained when young girls attend seminary. Despite seminaries being a preparatory stage for marriage and running the home (some also offering vocational skills and qualifications for employment to sustain husbands in full time religious learning), I was told that reproductive and sexual health is not routinely included in the curriculum.

Mrs Susman made clear that ‘at sem, they don’t learn about breastfeeding or things like that. So where are they meant to learn it from? I don’t think biology is one of the most important subjects in Haredi schools [laughs]’. The avoidance of biology in schools is, I was later told by a *frum* maternity carer, because it is considered culturally unacceptable for *frum* girls to learn about pregnancy and related issues before they are married, which I interpret as presenting a threat to the moral order. In theory, it is not until young Haredi men and women are engaged that they learn about their marital responsibilities – including those of a sexual and intimate nature. Preparation for marriage will see young men and women meet with a rabbi (*rov*)⁷⁶ or *rebbetzin* respectively for a series of around ten (often quite pricey) groom and bridal (*chosson*⁷⁷ and *callah*) lessons.

Preparatory marriage lessons do not typically teach about sexual and reproductive health, thus delaying the stage at which Haredi men and women encounter this information. What some research participants described as a ‘naivety’ and ‘ignorance’ among the Haredim when it comes to reproductive processes and health,

is, I argue, better interpreted as a strategy to protect unmarried Haredi Jews from learning about areas of life that are constructed as being inseparable from marriage. Despite being offset by the work of Jewish maternity carers, male and female reproductive health may therefore be an acute vulnerability caused by strategies of self-protection that are perpetuated by religious authorities. As I discussed in Chapter Two, it is also apparent in the context of primary care, where religious authorities have attempted to filter and restrict important public health messages directly related to reproductive and sexual health.

Issues with infant feeding could also be tied up with what Mrs Wiener described as ‘misconceptions’ concerning modesty (*tzniut*) and comportment, which may be complicated by the fact that *hal-achot* are practiced with stringencies rather than as a standard. Mrs Wiener claimed how one issue of the Haredi educational system is that ‘a lot of these girls, they grow up but they don’t actually know about the *halachos*’. She went on to argue that:

It’s not [considered] *tznius* to breastfeed in front of men, because you should not make a man think about your breast. It’s a completely sexualised image of the breast and that’s not what it’s meant for. It’s meant to nurture your baby – and in that context of nurturing your baby – it doesn’t have the sexual connotations. And it’s not [sexual]! Even the Rambam [Rabbi Moshe ben Maimon] says you should feed at least for two years. You can even feed with the *aron kodesh* [Torah ark] open in *shul* if you wanted to. Not that somebody would feel comfortable doing that in *shul*, but you could potentially do it and it’s not an issue of *tznius*. (Mrs Wiener)

The social constructions of modesty can present competing conceptualisations of the breast – as having sexualised and nurturing roles – which Mrs Wiener attempts to decouple for Haredi women by referring to Rabbi Moshe ben Maimon (Moses Maimonides), the revered Jewish medieval scholar and physician. Moreover, the prevailing social codes that circumscribe breastfeeding and *tzniut* are arguably at odds with its recognised role, as women can feed even when the Holy Torah ark (*Aron HaKodesh*) is open during prayer services in synagogue – without presenting a threat to constructions of what is modest or not. Consistent with broader Talmudic interpretations, the breast ‘was not conceptualised as having a sexual purpose. Thus, the exposure of the breast was not considered to be either a sin or a lewd act’ (Eidelman 2006: 38). Contemporary taboos surrounding exposure of the breast for infant feeding in

the Haredi cosmology appear to be discontinuous with historical positions encoded in the Talmud.

Not only a physiological process, breastfeeding is governed by socio-cultural laws and customs (defined by male religious authorities), which cannot always be upheld by women – primarily because of what is viewed as practical or impractical in daily life. After touching an area of the body that is usually covered, the *halachah* is to wash hands with water poured from a vessel (*netilat yadayim*), as one would in the morning.⁷⁸ The same conduct applies to women when touching the breast to feed. Though, as Mrs Susman tells me, ‘is it done? No not really. It’s not practical when the baby is feeding every ten or twenty minutes’.

Orthodox and Haredi women are known to have both a higher uptake of breastfeeding and for a longer duration than the broader non-Jewish population, and this is often attributed to the perceived benefits to children, its potential as a contraceptive by way of lactational amenorrhoea, and also religious rationales for nursing infants (see Eidelman 2006; Ineichen, Pierce, and Lawrenson 1997; Wright, Stone and Parkinson 2010). The cosmological impetus to breastfeed is drawn from the Talmud, which advocates nursing throughout the first two years of an infant’s life and also places specific exemptions on nursing mothers in order to preserve their capacity to lactate (see Kassierer et al. 2014).

The rigid expectations and tightly-held assumptions of modesty which demarcate the Haredi social body, lead *frum* women to generally not feed in public with perhaps a few exceptions who choose to cover themselves whilst breastfeeding outside the home. The implication of modesty for public feeding is a point of frustration for some maternity carers, with Mrs Susman stating: ‘I’m a true believer that we all feed. We all eat in public, in restaurants, and we don’t cover ourselves when we’re feeding. Why do our babies have to be covered whilst they’re feeding?’

The perception that breastfeeding in public for some Haredi women can disrupt interpretations of what constitutes *tzniut* is bound up with a deeper discussion of how ‘public’ and ‘private’ space is culturally constructed – and how the maternal body can be entangled between the two. Breastfeeding not only flows across the boundaries of ‘private’ and ‘public’ realms, but also destabilises them, presenting ‘a violation of cultural categories, of the deep-seated taboos which sustain a power structure’ (Maher 1995: 20). Concerns amongst Haredi women of transgressing modesty codes by exposing the breast are comparable to the taboo of breastfeeding in

the broader UK society, therefore challenging the use of relational terms such as ‘secular’ and ‘ultra-Orthodox’, particularly when describing bodily conducts.

Birth Spacing Technologies (BSTs)

With childbearing viewed as the cardinal role of Haredi women, ‘contraception’ is a sensitive area of primary care that is negotiated between Haredi women, doulas, healthcare professionals and religious authorities in Jewish Manchester – as mentioned in Chapter Two. In this section I discuss how the term ‘birth spacing technologies’ (BSTs) can more appropriately frame the way family planning services are used by Haredi Jews as a technique to temporarily space births rather than prevent conception altogether. BSTs are an explicit area of postnatal care for married *frum* women, as opposed to being used as a strategy to prevent conception before marriage and childrearing has begun.

Rabbinical authorities negotiate and grant permission to access BSTs based on their interpretations of religious scripture, and precedents are set in the Talmud for temporary (and in some interpretations, permanent) use of birth control.⁷⁹ The commandment to procreate is an obligation that is interpreted to fall on men which makes any ‘intervention’ to withhold implantation of sperm (such as condoms) a *halachic* transgression. Some forms of female BSTs that also affect insemination – such as the intrauterine device (IUD) – are therefore presented as being unsuitable for *frum* Jewish women. The combined oral contraceptive pill (commonly referred to as ‘the pill’) prevents the ovaries from releasing eggs during ovulation and is therefore an *accessible* form of family planning for Orthodox and Haredi Jews (see Feldman 1992). However, the pill might best be described as permissible rather than acceptable for some Haredim: whilst the ‘oral contraceptive’ can be accommodated in *halachic* interpretations, it remains a moral question, and therefore ‘enjoys the preferred status as the least objectionable method of birth control’ (Feldman 1974: 248). Thus the areas of reproductive and postnatal care that are made *available* to *frum* women through primary care services does not necessarily mean these are *acceptable* to use according to the Judaic cosmology – or authoritative interpretations of the Judaic cosmology.

Mrs Tikvah and Mrs Saunders are *frum* maternity carers who support the increased uptake of BSTs amongst young Haredi families, a trend they have observed over recent years. Mrs Tikvah, in particular, has observed that young *frum* Jewish women are less able

to meet the demands and increasing stringencies of contemporary standards of observance and piety:

Mrs Tikvah: I am happy to say that in the younger, even in the Haredim, they want to take contraception after one child. I'm shocked, not shocked in disgust at them, I'm shocked and pleased to see they do take and it's not inbred in them – that culture – anymore to not take contraception ... I really strongly believe that we are a weaker generation.

BK: Weaker?

Mrs Tikvah: Women don't cope as well; you see something like fasting on *Tisha B'Av*,⁸⁰ yeah? Everybody used to have to do it but there are so many leniencies, even for *Yom Kippur*. I've heard the rabbis say that [pregnant] women can drink a certain amount if they really feel they have to, whereas ten years ago you would never have heard of that. You'd fast and that's it. So this generation is getting weaker, laws are changing.

Mrs Saunders: And the rabbis are understanding that.

It is important to note that the laws and prohibitions concerning BSTs are not changing per se, but the application of *halachah* formulated by rabbinical authorities are becoming more flexible in some areas that can impact maternal health and wellbeing. As Mrs Tikvah and Mrs Saunders claim, this is being engineered by some of the local *rabbonim*, who understand that younger generations are less able to cope with the increasing pressures of living a stringently religious life and are consequently viewing BSTs as a permissible reproductive intervention.

Postnatal depression and the 'cost to a woman's state of mind' has provoked not only a response from religious authorities on the subject of birth spacing, but also an acceptability in some circles, which means 'it's fine to go to your rabbi if you don't cope' (Mrs Tikvah) in order to seek permission to access BSTs. Although some *rabbonim* can be sensitive to appeals for BSTs, the emphasis here, Mrs Susman reasserted, is that 'rabbis don't go to the women, the women have to go to the rabbis'. However, it is not a simple task for a woman to approach a rabbi in order to discuss accessing family planning services, especially as this can challenge prevailing expectations and Haredi norms of women, wives and motherhood:

It takes a lot for a woman to go to her rabbi and say, 'I am not managing'. She feels a failure. There's a lot of pressure to have a number of children in the family. Why that is, I have no idea. I don't know where it comes from. It certainly doesn't come from the *rabbonim*. It's

within the community. It's coming from the women in this culture.
(Mrs Susman)

Although Mrs Susman claims that it is Haredi women who propagate the expectation and preference for large families, it is the *rabbonim* who, in theory, hold the authority to enable women to space their pregnancies.

Interventions to manage and space births are not universally accessible for Haredi Jews, and is perhaps a reason why health material dealing with reproductive health and family planning was seen as inappropriate by Rabbi Silberblatt when describing the need for a 'culturally appropriate' primary care service in Jewish Manchester that was, in a sense, kosher (see Chapter Two). One Satmar *rebbetzin* made clear that BSTs are not acceptable for Hassidish women 'in a community where – for religious and cultural reasons – you do not use any assistance to hold back from having children'. Drawing on her experience as a maternity carer in the Haredi minority, Mrs Susman explained that despite the potential for rabbinical dispensation to access to the pill, 'they [some Haredi and Hassidish Jews] believe your role in life is to have children and children and children'.

A consequence of on-going changes to health policy and practice in England is that GPs have a very limited role in maternity and postnatal care (Smith, Shakespeare and Dixon 2010). Although women usually consult their GP as a first port of call once pregnant (Smith, Shakespeare and Dixon 2010), most postnatal care in England has shifted to the responsibility of Sure Start children's centres. A consequence of this meant that:

A lot of GPs don't even know the women have had a baby; the first thing they know is when women come for their postnatal and they don't always have the time nor the inclination to sit with a woman and say 'how are you actually feeling?' It's, 'You're feeling okay? Fine. The baby's okay? Fine. Bob's your uncle and off you go'. I then take it upon myself to say, 'okay, I saw how you were in the pregnancy. I've seen how you were during your labour. You're struggling. How do you feel about having a short break?' And it's up to me then to help her access the services or else she'd never access them or she'd struggle. Or she'd end up with depression. So my job is really *protection*, giving information, advocating for her with other people.
(Mrs Yosef, emphasis added)

Supporting women with their access to family planning therefore forms part of a protective 'intervention' to oversee postnatal health and wellbeing, due to the perception that mainstream GP services

are unable to appropriately identify how *frum* women cope with the pressures of motherhood. Access to BSTs, as mentioned, is a more complicated issue for some religious minority groups, who have to first navigate consent and acquire support from various religious authorities to obtain a 'break' from childbearing.

Similar to postnatal care in Manchester, Haredi Jewish women in Israel can seek rabbinical dispensation to temporarily space pregnancies (rather than 'contraception') but steps to indefinitely prevent pregnancy would be regarded as unacceptable (Birenbaum-Carmeli 2008). The language surrounding reproductive interventions is an important aspect of how birth control is negotiated as an arena of health and bodily care for religious groups as well as political strategies of population control. Managing populations then takes on opposing values between the state and the Haredim.⁸¹ Whereas the former view 'contraception' as a strategy of population control and providing a degree of autonomy over reproductive lives, the latter view reproduction as a technique to secure and protect the continuation of Haredi Judaism, which consequently sees access to BSTs regulated by male rabbinical authorities rather than healthcare professionals.

As outlined in the Introduction, the UK's Haredi minority are the focus of significant changes in the demographic profile of the overall Jewish population with projections that they will form the majority of the British Jewry by 2050. However, it is the rhetoric and use of language that is mobilised to represent the Haredi reproductive culture and its emphasis on natalism that is of relevance to this chapter. Representations of Haredi Jewish family sizes are relational and formulated against a socially-constructed norm or 'national average', with studies conducted in the UK depicting the Haredim as a population who 'favour large families on religious grounds' (Wright, Stone and Parkinson 2010: 631), and studies in Israel portraying them as being an 'exceptionally pronatalist community' (Birenbaum-Carmeli 2008: 185). Representations of Haredi birth rates in the UK are not only measured against a national average but also interpreted as a challenge to the dominant position enjoyed by the broader Jewish population. Similarly, in the case of Israel, a growing Haredi population is viewed as a threat to the (secular Jewish) body of the nation (cf. Milton-Edwards 2009: 90).

Although the overall Jewish population may appear to have a higher fertility rate than the national average, it has instead been claimed that 'critically, British Jews owe this situation to the presence of the strictly Orthodox Jews in their midst' (Staetsky and

Boyd 2015: 19). Interestingly, this discourse frames the Haredim as being hyper-fertile and perhaps as a challenge to the positioning of Jews who have integrated in Britain. Considering the historical pressures faced by the Jewish minority in England to assimilate and integrate into the body of the nation, it is easy to understand why the mainstream Jewish population would prefer to avoid any threat to its social and economic position.

Discussion

The Haredi cultures of maternity care are bound-up with spiritual, scriptural and social codes of conduct all of which provide a strategy for controlling biological and social reproduction. Criticisms of the Haredi Jewish lifeworld usually focus on its ‘ultra-Orthodox’ socio-religious codes of conduct and self-protective position, but its stringent reality is counterbalanced by an extensive internal welfare system that considerably offsets and buffers the limits of state-provided services (see also Chapters One and Two).

NHS maternity services are viewed by *rabbonim* and most maternity carers as the safer option for Haredi Jewish women to birth in, but are one of the few remaining sites that bring exposure to the external world and cosmologies – and thus constitute the margin in which the *immunity* of the Haredi social body is challenged (cf. Esposito 2015). Exemplary of this encounter is the contest over managing reproduction, which has given rise to antonymic constructions of the term ‘intervention’ in ways that are historically continuous for the Jews of Manchester. Antenatal screening, caesarean sections and ‘contraception’ can present a potentially disruptive contagion to the Haredi cosmology and its governance over Jewish bodies, and thus the reproduction of the social body as a whole. Maternity wards can then be conceived as a frontier area in which cosmologies compete over the guardianship of Jewish bodies, and present conflicting constructions of bodily care that *frum* women are tasked with navigating.

An ‘immunitary response’ (cf. Esposito 2015) has consequently manifested in the form of a self-protective ‘social womb’ (van Esterik 2015) where the entire process of reproduction – from antenatal to postnatal care – can now be influenced by Haredi maternity carers (as well as rabbinical authorities). Haredi doulas oversee the cultural construction of biomedical maternity care and negotiate the delivery of services to Jewish women. NHS maternity services

are acted upon to make bodies kosher, and prevent a diffusion of reproductive interventions or knowledge that are perceived to carry consequences. The Haredi cultures of maternity care in Jewish Manchester illustrate how immunitary defences against perceived contagions ‘must partially and preventively incorporate what negates it’ (cf. Esposito 2015: 56).

The minority group’s relation with the mainstream health-care provider is in fact negotiated and mediated through internal authorities, either by (male) religious leaders or the (female) senior maternity carers. The *frum* maternity carers in Manchester are therefore a prime example of how, as Ecks and Sax put it, marginality involves ‘points of crossing, paths of entry, and potential inversions’ (2005: 208). Moreover, the Haredi maternity carers are significant gatekeepers of the social body, offering local health authorities an opportunity to ‘reach’ the margins of Jewish Manchester and comprehend how health fits into the Haredi worldview. The doulas attempt to negotiate all areas of maternity care in relation to the Haredi worldview, including the ‘choices’ of birthing women in some cases. Understanding how maternal and infant health is not only approached but also contextualised in the broader issue of relations between the Haredi minority and the mainstream health provider provides a point of departure to analyse perceptions of childhood immunisations within Jewish Manchester in the next chapter.

Notes

1. My research participants typically described themselves as doulas. The term ‘birth supporter’ is also widely used in studies of maternity care.
2. *Meyaledet* (sing.) is the Hebrew term for midwife, meaning ‘birther’ or ‘she who brings to birth’.
3. Literally, anointed one (commonly translated as ‘Messiah’ in English) who is descended from the revered King David (also *Mashiach*).
4. *Eretz Yisrael* refers to the Biblical land of Israel, not the Israeli state’s current and contested borders.
5. I also group *frum* doulas and midwives as ‘maternity carers’ in many instances to maintain their anonymity and prevent them from being identifiable. Individuals who feature throughout the book appear under different pseudonyms and particulars in this chapter to avoid their being identifiable.
6. See Nursing and Midwifery Council (2016), a regulatory body in England that sets the standards of education, training and conducts for nurses and midwives.

7. Whilst it is considered more acceptable for *frum* women to pursue undergraduate studies through the Open University (a UK distance learning institute) after marriage, this is not an option for midwifery studies due to the practical work-based nature of the course.
8. Seminaries are generally intended to prepare women for marriage and family-making, though some encourage *frum* young women to pursue a secular education or training after sem.
9. Birth spacing technologies are usually only accessible with rabbinical consent to Haredi married women, which can be withheld by rabbis (see Chapter Two), demonstrating how professional training presents implications for the *halachic* jurisdiction over health and bodily care.
10. Rabbinical authorities interpret the commandment to 'be fruitful and multiply' ([*Tanakh*] *Bereshit*/Genesis 1.28) as applying to men (Feldman 1968), though the expectation of childbearing placed on women can be 'just as forceful' (Bloomfield 2009: 232).
11. Midwives are also concerned with maternal wellbeing but must also monitor foetal health, whereas doulas are concerned solely with the wellbeing of the birthing woman – as Morton and colleagues (2015) discuss in the context of maternity nurses in the US.
12. Thus the historical conception of a doula as holding an honoured and voluntary role (cf. Raphael 1969) closely resembles the Haredi doulas in Jewish Manchester. It is important to reiterate here that Haredi Jewish settlements often have their own internal economies and systems of social support (Chapter One), a structure within which doulas are situated. The doulas of Jewish Manchester contrast studies conducted in the US, where doulas are typically hired as 'paraprofessionals' and remunerated to provide a personal level of care and support that is not standard practice in hospitals in the neoliberal market (Castañeda and Searcy 2015; Hunter 2012).
13. In relation to childbirth, a state of *niddah* commences when one of several stages occur, for instance, when 'bleeding is obvious', when 'strong contractions have started', or 'when she cannot walk unaided'. The *niddah* period only ends after a woman has immersed in the *mikveh* (the ritual bath in which women immerse after each period of menstruation and when postpartum bleeding and discharge end), enabling marital relations and physical contact to resume between a husband and wife. The *niddah* period following the vaginal birth of a boy is seven days, for a girl it is fourteen days. In reality, postpartum bleeding can last much longer than this, thus prolonging the period of *niddah*. According to Judaic teachings, sexual intercourse during the *niddah* period is not only prohibited but dangerous to the social order and disrupts the patriline as the punishment for a Jewish man is *karet* or to be 'cut off' (see Cicurel 2000: 167).

14. Guidance produced under the authority of a local rabbi states that it is 'preferable for the husband not to be present in the delivery suite at the time of birth. According to some opinions this is forbidden'.
15. Childbirth is conceptualised in many cultures as belonging to the female domain, and men often do not participate in labour or, in some cases, are not able to view it (Dettwyler 2011: 149), which illustrates how Haredi Judaism is not unique in circumscribing the role of a husband in childbirth. Attention to birth among Haredi Jews reiterates how the 'ultra-Orthodox' label is an etic identity imposed on Haredi Jews when their conducts can often be similar to a wide range of social groups.
16. Pious Jews call upon Divine aid in childbirth because it is perceived to be a crucial and precarious event, as Sered (1992) has discussed in the context of Mizrahi Jewish women in Israel.
17. MANJM J294. Local hospitals were not conducive to *halachic* observance for émigré Jews at the time (Chapter Two). See Marks (1994).
18. MANJM J276. Hannah (Bashel) Ackstine was born in 1892 in Manchester to Russian émigré parents. She described how her mother made her have a homebirth. Hannah's oral history was recorded in 1979–1980, making her 88 at the time of interview.
19. Dora Black was a Roumanian émigré. See MANJM J294. The preference of émigré Jewish women in Manchester to birth with a Jewish midwife reflects historical birthing experiences in Ireland (see Birzen 2015; Rivlin 2011; also O'Grada 2006).
20. *Heim* (Yiddish: home). MANJM J40 and MANJM J294.
21. MANJM J40. Lou Black was born in 1904 in Manchester's Jewish Quarter.
22. MANJM 1990-51. Dora Black practiced as an 'unregistered midwife' despite changes to midwifery licensing and regulation at the time (see Chapter Two; Beier 2004).
23. MANJM J40. Whilst Lou Black refers to *geld*, the standard Yiddish translation of money is *gelt*.
24. MANJM J294. The term '*heimeshe*' does not translate accurately into English, and itself has multiple meanings and connotations – chiefly a feeling of familiarity or comfort, or a point of reference and commonality within the (nowadays) typically Haredi constituency. In the context of the quotation, I infer the use of '*heimeshe*' as relating to émigrés Jews from Central and Eastern Europe who were typically observant and retaining shared customs and conducts of a way of life steeped in the 'old country' or the '*heim*'.
25. MANJM J294.
26. MANJM J294.
27. See Marks (1994) for a thorough account of how changes in midwifery regulations affected émigré Jewish birth attendants in East London.
28. The booklets make clear that they are not intended to summarise the *halachot* surrounding pregnancy and childbirth, but clarify many

- frequently asked questions put to *rabbonim* – not questions that are put to doulas. This material was produced under the authority of Haredi rabbis in London.
29. Hebrew: Commonly translated into English as ‘prayers’, though lexical differences in meaning remain.
 30. Yiddish: Praying, as above.
 31. Referenced in a publication that was produced under the authority of a local rabbi and circulated to pregnant women in Jewish Manchester.
 32. The guidelines also mobilise references from the *Gemara* when advising women of ‘precautions’ that are associated with pregnancy loss, for instance stepping on carelessly discarded finger or toe nails. The *Gemara* is one part of the Talmud, and forms a compendium of rabbinical commentaries and interpretations (of which the codex of rabbinical law is derived).
 33. This must be done in a different manner (Hebrew, *shinui*) to how one would usually write in the week, for instance, using the opposite hand.
 34. The first trimester can be a precarious time for foetal development and is the period in which around three in every four miscarriages occur (see National Childbirth Trust 2016; NHS 2015).
 35. Congratulations (also *mazal tov*).
 36. See NHS (2014). According to routine NHS maternity schedules, pregnant women are referred for the initial ultrasounds during the period of eight to fourteen weeks (‘dating scan’), then between eighteen to twenty weeks (‘anomaly’ scan).
 37. Mrs Salamon positioned herself as being ‘at the bottom end of the Haredi spectrum’ (but working with families from across the Jewish settlement).
 38. Antenatal screening services are not value-free, and active avoidance of screening services can be contextualised in broader discussions of medicalisation of childbirth and the control of individuals and populations, as has been argued by Oakley (1984: 2),

‘With the definition of all pregnancies as potentially pathological, ante-natal care obtained its final mandate, a mandate written by the medical profession in alliance with the population-controlling interests of the state, and one giving an unprecedented degree of licence over the bodies and approved life-styles of women’.
 39. It should be noted that termination of pregnancies among Haredi women in Israel is not unheard of, with *rabbonim* granting dispensations (or exerting pressure to take dispensation for an abortion) in certain circumstances (Ivry 2009; Ivry, Teman and Frumkin 2011). Examples discussed by Ivry and colleagues include a foetus’ being diagnosed with a fatal disease (e.g. Tay Sachs or a heart defect), or if the physical or emotional health of a woman would be affected by carrying a pregnancy. The sensitivity of abortion among Haredi Jews meant

- that, in some cases, medical professionals would refer *frum* women to a particular rabbi who was considered 'likely to allow pregnancy termination' (Ivry, Teman, and Frumkin 2011: 1,532). Whilst rabbinical authorities might agree that abortion is permissible when the mother's life is in danger, interpretations of what 'danger' actually constitutes are far from uniform (see Ivry 2015: IV). Rabbinical authorities interpret the body of religious texts that inform the Jewish cosmology in relation to an individual's circumstance, and it is this interpretation that formulates a *psak* (ruling of *halachic* law, see Chapters Two and Four).
40. See also McCourt and Pearce (2000: 151) who describe how certain ethnic minority women in the UK value the continual care model, particularly 'because their expectations of support, good communication and care are not being met in conventional services'.
 41. Operational constraints that prevent midwives from providing the quality of care they aspire to see and practice is a major cause of midwives leaving the profession. See Royal College of Midwives (2016a; 2016b) for further information about dissatisfaction among midwives and the pressures they feel.
 42. In 2017 the National Federation of Women's Institutes (NFWI) and the NCT launched a report ('Support Overdue: Women's Experiences of Maternity Services') based on a survey completed by 2,493 women who laboured in England and Wales from 2014–2016 (Plotkin 2017). The report claimed that shortages of midwives were occurring amidst a national 'baby boom', with 100,000 more births registered in 2015 than in 2001. The report argued that 'staffing complements on labour wards are in crisis and that for a significant portion of women, these shortages are leading to unsafe care' (Plotkin 2017: 17).
 43. However, maternity carers in Manchester did not constitute a uniform service and some doulas actively encouraged home births.
 44. The view that home births are not 'cultural' in Jewish Manchester reflects the low levels of home birth recorded in England (2.3 per cent), (see Office for National Statistics 2014).
 45. Hunter and Hurst (2016: 10–12) describe how doulas have been conceptualised as a 'medical "intervention"' in studies assessing birth outcomes, but this analytical stance can stand in opposition to how some doulas regard their own role.
 46. One maternity carer told me how NHS workers have apparently made complaints against certain doulas in the past, which can require mediation by a lead and coordinating maternity carer with the hospital authorities.
 47. The event in Exodus (*Shemot*), where the Red Sea (*Yam Suf*) is Divinely parted to allow the ancient Israelites to escape the charging Egyptians forces.
 48. The link between lack of information (and misinformation) and fear is not specific to Haredi Jews, but has been observed more broadly.

- Lothian and Grauer (2012) have argued how the historical shift from 'home to hospital' has contributed to women's lack of knowledge of birth and their fear. She describes how 'telling birth stories not only provides important information about birth but can help women to be more responsive to that information' (Lothian and Grauer 2012: 126).
49. Women having a caesarean in their first birth (primary caesarean section) in English NHS Trusts are likely to experience a caesarean birth in subsequent pregnancies (Bragg et al. 2010).
 50. Wendland (2007) has critiqued the claim that caesarean sections are, according to evidence-based medicine, the preferred option in cases of breech labour or VBAC – indicating the multiple ways that childbirth can instead be managed safely without the need for surgical intervention. Wendland (2007) argues how studies that mobilise evidence-based obstetrics to advocate for caesarean sections as the preferred and 'safest' course of action can be based on short term indicators that do not consider the long term implications of intervention, such as post-partum pain and recovery, and do not consider the caesarean itself as injurious to the woman, demonstrating how the maternal subjectivity and body 'vanishes' from the construction of knowledge pertaining to obstetric care.
 51. Studies claim that it is not uncommon in the 'developed world' for sterilisation to be discussed with women after the third caesarean, with the opportunity to have a fourth caesarean apparently being rare (Rashid and Rashid 2004).
 52. The incident also indicates how some doulas appropriate biomedical knowledge of birth when attempting to negotiate with healthcare professionals during encounters. Cf. Jordan (1989: 928), who has remarked how training courses expose 'traditional birth attendants' to the biomedical language and cosmology, enabling them to find 'new ways of legitimizing themselves, new ways of presenting themselves as being in league with this powerful system'.
 53. Davis-Floyd has argued that standard obstetric procedures are in fact a ritual of technocracy, which tame, order and control the precarious and unpredictable 'natural process' of birth and so 'reinforces American society's most fundamental beliefs about the superiority of technology over nature' (2003: 2).
 54. Mrs Herskovitz did not provide any evidence to support her claim that the caesarean rate in Jewish Manchester had reduced to three per cent as a result of doula care and intervention. Publically available statistics at the time of research note that England's caesarean rate rose to 26.2 per cent in 2013–2014, amounting to one in four births by operative intervention (see Health and Social Care Information Centre 2015). The WHO (2010) maintains that national rates of caesarean sections exceeding fifteen per cent of all births cannot be medically justified.

55. Most studies of doula care are conducted in the US context and report how continual doula care is also associated with a reduced need for medical intervention during childbirth and improved outcomes for birthing women (e.g. Davidson 2015).
56. Hebrew, *Bechor* is interpreted as meaning first-born who is a male, rather than a first-born child. For the purpose of the *Pidyon HaBen*, a girl who is the first-born child does not constitute opening up the womb.
57. The *Pidyon HaBen* originates from the Judaic narrative of Exodus, where the tenth plague resulted in the massacring of all Egyptian first-born sons (sparing all Hebrew first-born males), which led to the 'exodus' of the ancient Hebrews from enslavement. All Hebrew first-born males were, for a time, consecrated to perform Divine service in the Holy Temple, which later became the prerogative of the priestly casts. Parents were then required to pay a Kohen or Levy a small sum to redeem their *bechor* from service. Although the Holy Temple has since been destroyed, the *halachic* claim on the *bechor* remains in place and parents are obligated to exempt him through the *Pidyon HaBen* ceremony. The *Pidyon HaBen* is not conferred upon a *bechor* if he descends from a priestly lineage.
58. The complexity of *halachic* law can mean, under certain circumstances, that a live 'firstborn' male might not be eligible for the rite (and right) of birth if the mother had previously experienced a miscarriage. Parents are advised to solicit the guidance of a rabbi in such cases.
59. When intervening in clinical encounters to maintain processes of social reproduction, the practices of *frum* doulas in Jewish Manchester confront the few anthropological conceptualisations of doula care (such as Hunter 2012: 316).
60. There is a historical continuity to Jewish communal services that are instituted to meet the limitations of the state and what it provides, particularly to ethnic minority groups (cf. Marks 1994).
61. A pseudonym.
62. Priority is given to women who reside outside of London, primarily because a fee-paying Jewish maternity rest home already exists in the South of England.
63. Perhaps drawing on his own reflections as a father, Mr Attias' description of labour as a 'traumatic experience' is not dissimilar to the broader discourse of paternal reflections of childbirth (see Hanson et al. 2009).
64. GB127.M182/3/1: 1872–1873.
65. GB127.M182/5/2: 1903 quotes from the annual report of the 1901 Manchester and Salford Ladies' Public Health Society.
66. MANJM J143; GB127.C15/3: 1920, 1929. The United Sisters Maternity Society merged as part of 'The Jewish Maternity and Rest Home' in 1925, the 'Jewish Rest Home and Maternity Society' in 1926, and the 'Jewish Holiday Home for Mothers & Babies and Convalescent

- Children' in 1929. There is no definitive record of when the United Sisters Maternity Society was first instituted.
67. According to records from 1925, non-Jewish women were referred to the Jewish service by various 'Child Welfare Centres' in Manchester. The Manchester School for Mothers made a donation of £10 towards the care of non-Jewish women.
 68. GB127.C15/3: 1922.
 69. GB127.C15/3: 1920.
 70. GB127.C15/3: 1922.
 71. C15/3: 1923. The aim of the convalescent home for mothers was to 'restore them to health'.
 72. Williams (1976: 155) notes that the 'United Sisters Charitable and Benevolent Society' was formed in 1847 to relieve poor (married) women 'during their confinement in childbed and sickness'. This was a small-scale charity that does not seem to compare with maternity provisions in London's East End.
 73. See Dulberg (1909) who claims rates of infant mortality in 1907 were lower in the émigré Jewish area of Cheetham compared with neighbouring areas in Manchester.
 74. Marks (1994) also notes that Jewish family diets (rich in Vitamins D and A) would have contributed to lower infant mortality rates compared with the region.
 75. This is likely a reference to the WHO (n.d.) which attempts to encourage mothers to nurse exclusively for six months.
 76. The term often used was *Rov*, denoting a personal relationship with a rabbi or even a learned man who offers spiritual mentorship (also *rav*).
 77. Also *Chatan*.
 78. *Negel vasser* (vernacular), for morning washing of hands.
 79. See Feldman (1974) and Feldman (1992) for a detailed discussion on the *halachah* surrounding birth control.
 80. Ninth day in the Hebrew month *Av*: A twenty five hour fast that commemorates the ancient destruction of the first and second temples, and in some circles the fast as well as more recent calamities such as the *Shoah*.
 81. The broader body of anthropological work illustrates how contraception and family planning form a contested biopolitical 'intervention' for ethno-religious minority groups who are negotiating their presence as migrants in Europe. Émigré women can encounter notions of reproductive rights in Europe that cause established Islamic teachings to be negotiated, yet state contraceptive agendas are also viewed in the broader context of racism and hostility towards minorities, with some women viewing birth control as an institutionalised attempt to restrain their growing demographic (Sargent 2006). As the broader anthropological discourse attests, the bodies of – usually of female, non-white, and poor – citizens are targeted as 'vessels of population

growth' with which 'the world's very survival depends on containing their reproduction' (Kanaaneh 2002: 27). Family planning then serves as part of a political intervention and strategy of 'internal colonialism' (term borrowed from Scott [2009]) when seeking to reach the margins of the state, which become represented as being (over-)populated by migrant and minority groups.

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Archival Material and Oral Histories

Oral Histories, Manchester Jewish Museum (MANJM)

- J40: Lou Black. Date of interview not recorded, by B. Williams.
J143: Margaret Langdon. Date of interview: 1978, by R. Livshin, R. Burman and P. Roberts.
J276: Hannah (Bashel) Ackstine. Date of interview: 5 December 1979 to 2 February 1980, by R. Burman.
J294: Sidney Taylor. Date of interview: 14 July 1980 by J. Emanuel.

Archival Records, Manchester Jewish Museum (MANJM)

1990-51: Dora Black's baby book.

Archives & Local History, Manchester (GB127)

- C15/1/1-5: United Sister's Maternity Society.
M182/3/1-4: Manchester Jewish Board of Guardians for the Relief of the Jewish Poor.
M182/5/2: Manchester Jewish Ladies Visiting Association.

Chapter 4

IMMUNITIES AND IMMUNISATIONS

Mrs Kahn, a Haredi (Litvish) mother of nine, told me the reasons why she chose to delay acceptance of the recommended NHS childhood vaccination schedule for her first six children. In her words, ‘I was never comfortable with it being so early. They were very little. They had immunity from me because I was breastfeeding, so I wasn’t in a hurry’. When Mrs Kahn decided to accept vaccinations for her sixth child, she was distressed by his reaction to the diphtheria, whooping cough and tetanus vaccine (DPT)¹:

I was warned ‘he might have a temperature, keep him on Paracetamol overnight’. I monitored him and it was peculiar for a few days. He broke out in a rash all over; it was like an eczema rash, which didn’t go away for months and months and months. He was inconsolable and had this weird high-pitched cry for days, and days, and days, and he had a temperature on and off for days. I was a bit freaked out by it to be honest and I think I went back to the doctor who said, ‘oh it’s nothing, it’s fine’. So I was very scared ‘coz I thought they’re pushing for something and they’re not being honest, and it really scared me off the whole idea of vaccines.

Mrs Kahn subsequently declined all vaccinations for her seventh child – much to the frustration of her local GP who tried to convince her that complying with the recommended NHS vaccination schedule was important to protect the health of her newborn baby as well as the local population. Mrs Kahn described the pressure and duress she felt to vaccinate, whilst at the same time she doubted the public

health claims of population-level protection that were put forward to influence her decision-making:

I'd been scared by the doctor who said 'you need to give [vaccinations], 'coz if a child gets whopping cough, it's terrible and newborns who get whooping cough, it's life threatening, it could be fatal, and if you don't vaccinate then we're not going to have herd immunity' and really using the hard sell to try and get me to vaccinate. I brought this eight-week-old child in for its check-up, and he wasn't very well, he was full of cold and he had this horrible cough, and they still wanted to vaccinate. Now one of the things I'd read was that you only give a child who is in good health a vaccine, and he was still pushing to give it though he was poorly. So I said, 'no I might do it, I'm still not convinced, but I'm not gonna immunise if he's not well'. Anyway he got worse and worse and I took him to the hospital. He had whooping cough. So even if I had wanted to vaccinate him at eight weeks old, he wasn't well enough. And he had whooping cough already, so herd immunity hadn't worked anyway – this whole fallacy.

Unsettled by this experience, Mrs Kahn subsequently viewed NHS health information around vaccinations with mistrust and withheld vaccinations for her eighth and ninth children. When I asked whether she also drew on Judaic teachings to inform her vaccine decision-making, she clearly stated 'there's no religious anti-sentiment to vaccines, on the contrary. If it's the right thing to do, you must do it. This was nothing to do with religion at all, this was just watching a child who reacted'.

Mrs Kahn's experience around childhood vaccinations gets to the heart of this chapter on how perceptions of immunity and immunisations influence vaccine decision-making among Jewish parents in Manchester. Low uptake of childhood vaccinations appears to be one of the main reasons why Haredi Jews are portrayed as being 'hard to reach' in public health discourse, and their 'non-compliance' with routine childhood vaccination schedules is often attributed to 'culture' or religious 'belief'. Some parental responses to vaccinations reflect a broader preference to negotiate maternity care and child health services due to opposing interpretations of bodily protection – as put forward by the Haredim and public health authority. Yet parents in Jewish Manchester hold diverse standpoints on vaccinations that range from outright refusal to cautious, selective, delayed and complete acceptance, which illustrates how there is no blanket culture of opposition to childhood vaccinations (as the 'hard to reach' accusation implies).

Whilst vaccines are one of the most effective public health interventions available to prevent and arrest the transmission of certain infectious diseases, ‘compliance’ with vaccination campaigns in the UK has been undermined by safety concerns and mistrust in government recommendations. Parents across the UK are known to negotiate acceptance of childhood vaccinations, which resonates with the broader experience of *frum* parents in Manchester and suggests that entire ‘ultra-Orthodox Jewish communities’ are unfairly stigmatised and targeted for their responses to an area of child health that is commonly viewed as sensitive. Local concerns for vaccine safety should therefore be viewed in the context of Haredi Jews being a minority group in the UK.

This chapter explores childhood vaccinations through three main pathways: firstly by discussing ‘immunity’ as a social construction, then by juxtaposing a brief historical account of how émigré and poor Jews were the target of vaccination policies during the nineteenth and twentieth centuries alongside current representations of the Haredim as being ‘hard to reach’, and finally moving on to frame the views and concerns surrounding vaccinations in Jewish Manchester today.

Social Immunities

The NHS childhood vaccination schedule (detailed in Appendix) is a state-funded programme that requires consistent engagement until children reach pre-school age, around three-to-four years old. Government sanctioned vaccination campaigns are ‘political projects’ to immunise the body of the nation, demanding a state of ‘compliance’ that is not always volunteered willingly by the intended targets of public health interventions (Greenough, Blume and Holmberg 2018). A public health philosophy can conceive vaccinations as an obligation – a *gift* to preserve life – that must continuously be circulated without disruption between individuals in order to protect the population (through the mechanism of social immunity).² Parents who decide to exempt their children from the citizenly responsibility to accept childhood vaccinations according to NHS schedule are dispersed across the state, as variation in UK vaccination coverage rates imply. Yet it is seemingly the case that Haredi Jews are singled out for low-level uptake perhaps because they are identified (and identifiable) as a target for intervention. In so doing, a social history saga continues to frame Jewish minorities

as being disruptive to the body of the nation's health (Introduction, Chapter Two).

The Haredi social body is maintained by a preference for self-protection and a pursuit of *immunity* from the external world – an exemption that preserves its own social life, but has implications for how healthcare services are used. The strategies of self-protection and immunitary reactions employed by the Haredim demonstrate how, as Haraway has argued, 'the immune system is a plan for meaningful action to construct and maintain the boundaries for what may count as self and other in the crucial realms of the normal and the pathological' (1991: 204). The representation of Haredi Jews as being 'hard to reach' and 'non-compliant' with the citizenly ideals propagated by the state evokes a historically contiguous issue of how the Jewish social body is positioned vis-à-vis the body of the nation, and how they position themselves.

'Social immunity' describes the threshold of a population that must be immunised in order to arrest and resist the transmission of vaccine-preventable diseases (VPDs).³ If a certain proportion of a population are vaccinated against an infectious disease, protection *may* be afforded to susceptible and vulnerable bodies who cannot be vaccinated for reasons of medical exemption (such as foetuses, newly-born babies and pregnant women) – thus offering a degree of protection to the body of the nation. However, the protection that would be afforded to individuals with medical exemptions through social immunity is left vulnerable if threshold levels of vaccination coverage are not maintained.⁴ Thus the logic of social immunity rests on the continued uptake of vaccines, especially those routinely recommended during childhood.

Statistics of national vaccination rates are not an accurate indicator of social immunity at local levels, largely because vaccination coverage is not spread evenly across the entire UK population and has varied significantly in recent years.⁵ The threshold level of the immunised population in relation to the non-immunised is, in reality, not static, but constantly shifts with the movement of individuals.

Common conceptual references for social immunity include 'herd immunity', 'health protection target', and 'community immunity', the latter of which emphasises the human value of protecting vulnerable groups in a shared environment.⁶ However, 'community immunity' conflicts with my aim of problematising the use of 'community' in public health discourse because of the idealised or imagined participation that this term implies, particularly as *frum*

Jews do not share a common standpoint on vaccinations and would not always ‘comply’ with the views of rabbinical authorities when it comes to uptake of vaccinations (discussed in this chapter). The term ‘community immunity’ is also at risk of obscuring how the UK population does not share a homogeneous view on vaccinations (as regional variation in coverage rates might suggest). For these reasons I instead advocate the term ‘social immunity’⁷ as an attempt to realign the public health language with the socio-cultural context in which health conducts and interventions are always embedded and entangled within.

It is in this conceptual perspective that the complex and antonymic relation between *immunitas* and *communitas* (Esposito 2015) can be applied to the social tensions of individual and public bodily protection within which vaccinations are embedded. At the heart of understanding the relation between immunity and the ‘community’ is the Latin etymological root of *munus*, which denotes an obligation or gift that must be repaid. In other words, it is a contractual obligation. The power of *communitas* lies in its construction ‘around an absent gift, one that members of community cannot keep for themselves’ (Campbell 2008: X).

Whereas *communitas* marks those ‘who support it [the obligation] by being its bearers’, *immunitas* is the privilege of exemption and is fundamentally a state of ‘difference from the condition of others’ (Esposito 2015: 6). The crux of *communitas*, or being inside the ‘community’, is to be bound by an obligation (*munus*). To be immune is not only to be relieved of the *munus* and be placed ‘outside the community’, but also to *disrupt* the social circuit itself (2015: 6). By relieving oneself of an obligation ‘and placing himself or herself outside the community ... they become constitutionally “ungrateful”’ (2015: 6) – or what public health discourse would describe as ‘non-compliant’ in the context of opposition to vaccines and the subsequent interruption to social immunity levels.

The antonymic relation between *communitas* and *immunitas*, as Esposito argues, ‘can happen in mutually opposing forms that bring into play the very meaning of biopolitics: either the self-destructive revolt of immunity against itself or an opening to its converse, community’ (2015: 141). Whilst Esposito argues this in relation to the body of the nation, it is my view that the phenomenon can also be observed from the perspective of the Haredim. For Haredi Jews, the resolute and increasingly stringent pursuit of *immunity* and protection results in a vulnerability that can have the potential for the social body to be threatened from within (Chapter Two). What is

common to these antonymic instances of preserving the lifeblood of the state and the social body is a need to identify and target the location in which contagions manifest – the border between what is positioned as internal and external, or perhaps purity and danger (cf. Esposito 2015; Douglas 2002).

Framing Opposition

Vaccination hesitations and oppositions cannot be understood as a universal phenomenon and should instead be viewed as part of broader socio-cultural conceptualisations of the body and immunities.⁸ Objections to vaccinations are all too often reduced to a ‘lack of knowledge’, ‘cultural factors’, or ‘religious beliefs’ in public health discourse, yet little attempt is made to describe what these ‘beliefs’ actually entail or the processes in which they are formulated.⁹ This tendency to gloss over opposition to immunisations raises the question of whether such ‘beliefs’ happen to be held by religious people, or whether they are based on cosmological interpretations that are propagated by religious practitioners. How religion becomes a reason and rationale for religious individuals to *not* vaccinate is rarely discussed (Hobson-West 2003).¹⁰ A resolve of this chapter is to illustrate how *frum* Jews navigate the process of deciding to immunise or *not*, and how vaccine decision-making strategies are shaped in relation to the Haredi lifeworld.

A ‘belief’ implies that perceptions of health and the body are malleable and not based on authoritative knowledge, when health conducts are instead grounded in a worldview or ‘cosmology’ (as the Haredim demonstrate). Moreover, culture or ‘cultural resistance’ is often positioned as a barrier to biomedical interventions and thus the emphasis is placed on the target group alone – also sweeping aside the structural, socio-economic, or socio-political constraints at play (Fassin 2001; see also Parker and Harper 2006). Cultural reductionism in public health discourse positions ‘*the culture of the Other insofar as it is different*’ without attention to what might be similar (Fassin 2001: 300 [emphasis in original]). Positioning culture as the target of intervention obscures how safety concerns held by parents in Jewish Manchester can factor strongly in responses to public health interventions (which are not exclusive to Haredi Jews).

Vaccine refusal can be intimately tied to socio-political relations between the state and minority groups, particularly when the latter fear being the targets of contraceptive control, virulent pandemics, or unsafe global public health interventions (Renne

2018: 301).¹¹ Global concerns that vaccinations are, for example, used to control population size are often positioned as ‘unusual theories’ or dismissed as ‘conspiratorial claims’ in need of defusing (Davies, Chapman, and Leask 2002: 24; Kata 2010: 1712–1713). However, relegating vaccine refusal to the realm of ‘unusual theories’ or ‘conspiratorial claims’ points to a broader issue of how the concerns held by the intended beneficiaries of vaccination campaigns are handled and addressed by global public health bodies, which is necessary to promote and protect public trust in immunisations.

Compliance and Coercion over Time

Juxtaposing archival and ethnographic material demonstrates how compliance with vaccination policies (to increase uptake) has been cultivated over time, firstly among émigré Jews, and now among the Haredim. Looking at vaccination practices across historically-situated lifeworlds also generates an important discussion on engaging minority groups with vaccination campaigns and how responses (which are not in the manner of ‘compliance’) should be interpreted. Public health formed part of a historical strategy to assimilate difference (Chapter Two), and émigré Jews during the nineteenth and early twentieth centuries were coerced into accepting vaccinations against smallpox by the established and anglicised Jewish social body.

Smallpox was a reoccurring threat during the nineteenth century, and the Medical Officer employed by the Jewish Board in Manchester implemented rigid and ‘proper’ childhood vaccination policies to counteract the risk of exposure in the Jewish slum areas and neighbourhoods. It was the view of the Medical Officer at the time that his enforced vaccination policies led to the ‘exemption [of the Jewish poor] from this fatal disease’ – probably by granting collective protection through social immunity.¹² The Board consequently did not have to report incidences of smallpox contagion to the local authorities due to the absence of infectious outbreaks in the Jewish neighbourhoods.¹³ When attempting to enforce a state of ‘compliance’ with health interventions amongst the Jewish poor, the Board would use its economic relief as leverage when implementing vaccination and re-vaccination policies.¹⁴ Policies of coercion were associated with epidemics and outbreaks of smallpox, and in 1876 the Board warned that aid and the provisions of religious

imperatives such as *matsos*¹⁵ would ‘be absolutely stopped’ in all cases of ‘non-compliance’.¹⁶ Thus émigré and poor Jews who were ‘non-compliant’, or who sought exemption from the obligation to be immunised, were threatened with exclusion from important sources of culturally specific welfare support.

The Jews’ School on Derby Street was an institution not only of education but ‘powerful assimilatory pressures’, where speaking Yiddish was a punishable offence in the classroom as well as the playground (Williams 1976: 295; Null 2007). Children attending the school in 1878 were examined for evidence of vaccination or those performed ‘imperfectly’ – defined by ‘having less than two good marks’ – as the body proved its compliance with public health orders. Moreover, the Jewish school, situated in the heart of the slums, worked in collaboration with the Board to implement blanket vaccination strategies. In fact, teachers provided the Board with the names and addresses of pupils whose parents were thought likely to apply for assistance, ‘so that pressure may be put on such parents to have them [children] vaccinated when not already so, – or revaccinated where the vaccination is only imperfect’.¹⁷ Access to essential relief for the Jewish poor therefore became dependent on compliance and submission to the dominant Jewish body as a proxy of the state.

Foucault’s theoretical paradigm of ‘governmentality’ can be used to analyse the attempts of authoritative Jewish institutions to coerce ‘alien’ Jews into complying with vaccination policies against smallpox. Forced vaccination policies can be situated as part of a historical pursuit of capitalism, within which modern preventive medicine was cultivated as a technique of subtle subjugation – epitomised by the term ‘intervention’ (rather than ‘service’). Compulsory vaccinations programmes can then be interpreted as an imprint of political or economic demands on citizens, and featured prominently in colonial campaigns to convert local populations into ‘governable subjects’ and thus control their economic production.¹⁸ Vaccinations form part of the state’s apparatus to survey and control its subjects, but ‘state authority and power in implementing public health measures is all the more amplified when it is applied to marginalised populations, often consisting of ethnic minorities and migrants’ (Davidovitch 2013: 151). When ‘alien’ and ‘foreign’ bodies are pathologised as a potential biological risk to the body of the nation, public health interventions are deployed as an immunary reaction to assimilate difference (cf. Esposito 2015; Chapter Two).¹⁹

'Non-compliant Communities'

The historical attempts to coerce émigré and poor Jews into 'complying' with vaccination policies is contiguous with current representations of Haredi Jews in public health discourse as 'hard to reach', and the target of intervention for the protection of all. Low-level vaccination coverage among certain Haredi neighbourhoods in North London has resulted in persistent outbreaks of VPDs (Public Health England 2016). Low-level vaccination coverage within 'hard to reach' or under-served 'communities' (such as the Haredim) is not only framed as a national concern for Public Health England, but also 'threatens to jeopardise progress towards disease elimination and allow VPDs to re-emerge in the European Region' (Public Health England 2016: 6).²⁰

Over the past decade recurring outbreaks of measles in the European region (as a hindrance to overall control) have been linked to low vaccination coverage in the 'Orthodox Jewish community' or 'extremely ultra-Orthodox groups' who are portrayed as 'sectarian', 'specific sub-populations', or 'non-compliant communities'.²¹ A strategy of European public health bodies has been to consequently identify and target specific areas and populations who remain 'at risk for measles' (read: those with low vaccination coverage) and to tailor health information and preventive services accordingly (Steffens, Martin and Lopalco 2010). The overall objective is to increase 'compliance', which resonates with claims that consider public health surveillance as an opportunity to control and contain populations as much as infectious diseases (Foucault 2006; Briggs 2003).²²

Following this line of enquiry, the UK's Orthodox and Haredi Jewish populations can then be framed as a *specific* group targeted for intervention because of low vaccination coverage – despite considerable variation at the national level. Put together as the 'ultra-Orthodox Jewish community', Haredi minorities can be viewed as a threat to ambitions of measles elimination held by Public Health England (also hindering its responsibility to contribute to the protection of the European 'community'). Constructing an image of the 'ultra-Orthodox Jewish community' as one that is 'hard to reach' has the side effect of explicit stigmatisation, particularly as the safety concerns and hesitations held by some Haredi mothers in Manchester are similar to those observed in the broader UK population.

Prevailing representations of Haredi Jews in public health discourse can be embedded in a deeper discussion of the attempts made

by minority groups to settle at the resistive margins of the state, which become justified sites of 'intervention'. The language used to frame Haredi Jews and the consequent ingress of public health epitomises how power is exercised not only across territories but also on the bodies and 'the subjects who inhabit it' (Foucault 2006: 135). Thus vaccinations can be read as leaving a mark of intersecting powers on the body and imprints of the custodianship sought by socio-religious, political as well as biomedical authorities over individuals. The Haredi population is emblematic of this contest, for whom the preference to be self-protective is a preventive measure against external influences that are viewed as being a virulent threat to the established socio-religious order. It then becomes clear how vaccinations and public health interventions point to a strong conceptual reference in a minority such as this, for whom maintaining a sense of social *immunity* from the outside is paramount to collective endurance and survival. Attempts by the public health authority to improve coverage should therefore be handled sensitively, but are arguably (and evidently) not.

In order for public health authorities to target Haredi minorities they must first be constructed and represented (or re-presented) as a 'community' in need of intervention or protection, and then 'reached' through tailored information and services (Figure 4.1). Some preventive health programmes can actually *misrepresent* the Haredi minority, which indicates a conflict between how the Haredim are viewed by public health campaigns and how they view themselves (Chapter Two). The way in which public health discourse constructs target populations can equally mean that 'differences between populations in terms of their relationship to the circulation of health-related information can be crucial determinants of their citizenship status – at the same time that it shapes understandings of the state and state power' (Briggs 2003: 292). Public health, as an institution of the state, can therefore be seen as strategic to formulating and circulating ideals of citizenship through its discourse, with the targeted group then assimilating these citizenly responsibilities into their daily lives. When studies and public health discourse constructs the 'ultra Orthodox Jewish community' as an 'at risk', 'underserved' or 'hard to reach' population, intervention is legitimised and paves the way for the ingress of public health and the incorporation of minority groups into the nation.²³

The right of an individual to receive routine and recommended childhood vaccinations is enshrined in the NHS Constitution (2015), which can be read as a gift from the state that is returned



FIGURE 4.1 Translated information leaflets for Haredi families in North London. © The Queen's Nursing Institute. Published with permission.

or repaid by immunising the body of the nation. Strategies to encourage acceptance of vaccinations in the UK are (in theory) persuasive, as there are no formal laws or punitive measures which force parents to immunise their children.²⁴ In this sense, the health authority attempts to convince the public body of the need for vaccinations as a technique to govern and protect their own health as well as the health of the nation.²⁵ Parents are nonetheless encouraged and expected to ‘comply’ with routine vaccination schedules (Hobson-West 2003), leading to social expectations to conform with norms of ‘responsible’ and ‘good’ parenting. Parents who ‘deviate’ from recommended child health guidelines are consequently represented as fuelling the increasing incidences of vaccine-preventable diseases (see Conis 2015), or as Esposito (2015: 6) might say, they disrupt the ‘social circuit of reciprocal gift-giving’ (social immunity).

Parental Perspectives on Vaccinations

Past studies of primary care coverage in Haredi settlements report conflicting responses to vaccinations, indicating how representations of Haredi Jews in public health literature should be viewed with a critical lens.²⁶ Whereas many studies claim that there is a lower than average uptake or coverage of vaccinations among Haredi Jews, there are past counter-narratives which detail how there are no significant differences when compared with neighbouring non-Jewish populations.²⁷ It has been argued that English health authorities possess a misconceived (and perhaps inaccurate) understanding of the views of Haredi Jews with respect to preventive health services (Cunninghame, Charlton and Jenkins 1994).²⁸ How Haredi Jews *actually* respond to vaccination campaigns can conflict with the way in which public health authorities *imagine* them to fear immunisations.²⁹ Haredi minorities are arguably singled out unfairly for low uptake in public health discourse, particularly as vaccination coverage varies significantly across the UK.

The reasons that apparently underlie low-level acceptance of vaccinations amongst the Haredim also remain unclear and conflicting. Infectious outbreaks are recorded (or portrayed) as spreading like ‘wildfire’ in Haredi settlements, largely because of family sizes, under-immunised child populations, domestic overcrowding and the international network that comprises the so-called Jewish ‘community’. Public health authorities have remarked on the association

between large family sizes and the likelihood of multiple non-vaccinated children in Israel as well as Jewish London (Ashmore et al. 2007; Muhsen et al. 2012), but other studies in London have instead claimed that large family sizes are not implicated in the immunisation practices of Haredi Jewish mothers (Henderson, Millett and Thorogood 2008).

International travel between Haredi settlements is associated with the importation and exportation (or transmission risk) of infectious disease in public health discourse.³⁰ Yet this is a claim that is recurrent over time considering the use of ‘quarantine as a medical rationale to isolate and stigmatise social groups reviled for other reasons’ (Markel 1997: 4), such as émigré Jews to the United States. Public health bodies compare and make inferences between outbreaks of infectious diseases or low immunisation coverage in Jewish London with other Haredi contexts in Europe, the United States, as well as Israel (see, for instance, Anis et al. 2009; Muhsen et al. 2012). However, public health discourse should not misconstrue Haredi Jews as belonging to a global ‘community’ that is either monolithic or a monocultural, instead, outbreaks as well as vaccine hesitations should be analysed in each individual context.³¹

Blanket claims that Haredi Jews respond to vaccination campaigns with low-levels of ‘compliance’ shields the multiplicity of views surrounding immunisations held by parents, as is shown by responses in Jewish Manchester. Vaccinations are not forbidden under *halachic* law (Loewenthal and Bradley 1996: 224), and there were attempts by some rabbinical authorities to promote them as a means of protecting infant health (based on their interpretations of the Judaic cosmology). Promotion of vaccinations by public health officials or certain Haredi-led initiatives within Jewish Manchester took various forms, and were sometimes circulated by specific Haredi institutions or underlined by making references to authoritative personnel. One example is a culturally specific health periodical, ‘*Zei Gezunt*’, which collates and selectively screens public health messages from the wider biomedical and therapeutic network for distribution to approximately 2,700 Jewish homes.³² The periodical was used to raise the profile of vaccinations following the 2014–2015 multi-state outbreak of measles in the United States, endorsed with the views of rabbinical authorities. Of particular interest are the ways in which preventive health messages are made relevant to Haredi worldviews by drawing on the authoritative knowledge of *poskim* – arbiters of *halachic* law in cases where a situation or dilemma is ambiguous, contentious or without precedent:

The consensus of most *poskim*³³ is that the vaccination of children to protect them from disease, and that the vaccination of children who can be medically vaccinated, is absolutely the only responsible course of action.

In the absence of a supreme religious authority (such as the Pope and the Roman Catholic Church), the notice asserts the view that *most* (and thus not all) *poskim* advocate that vaccinations are a kosher preventive measure. Claiming that parents have a responsibility to accept vaccinations based on the judgements of *poskim* suggests that cautiousness surrounding vaccine uptake are related directly to issues of *halachic* permissibility, when Jewish parents engage in vaccine decision-making through a range of influences and considerations.³⁴ Whilst some vaccine-hesitant parents would indeed obtain a *psak halachah* (judgement of law), others did not see this as a necessary course of action – especially if it would have the potential to conflict with their own interpretations of vaccine safety.

Although the *Zei Gezunt* advertisement is broadcast directly to the settlement through an established channel, other sources of authoritative knowledge were dispersed through more international as well as peripheral lines of communication (Figure 4.2).³⁵ The missionary strategies employed by Chabad Lubavitch in Jewish Manchester is one example, with immunisations referenced positively in a weekly publication that is freely delivered to local homes.³⁶ One edition of the circular raised the issue of immunisation for the purpose of travelling to Israel, which made clear and offered reassurance that vaccines are safe and should not be a source of anxiety.³⁷ Through this circular it would seem that immunisations are viewed favourably and without risk amongst the Chabad movement. However, this positive view of immunisations may not be upheld by individual followers and it is worth reiterating that despite the prominence that Chabad enjoys as a Haredi Jewish outreach service, they are just one of many Haredi groups. The internal diversity of Jewish Manchester means that the dissemination of pro-immunisation messages by some authorities or circuits of authoritative information may not resonate amongst others.

The view that Jews are mandated to preserve their health and body (Chapter Two) was mobilised to justify uptake of vaccinations as a parental responsibility. Mrs Tananbaum, a *frum* mother of four, explained that, '*halachically*, one should do everything in their power to put themselves in a good position to protect themselves. Because you're supposed to live Torah, not die. If you're dead, you can't do

any of the Torah *mitzvos* [commandments]'. In this view, vaccinations are (or should be) sanctioned as they enable Jews to maintain their health, and fulfil religious commandments. Mrs Tananbaum interpreted vaccinations as being an imperative conduct, and part of the social contract between the Jews and their Divine authority:

You have to protect your children, you have to do everything in your power to protect your child and if that is to vaccinate your child, you should. At the end of the day, God forbid something happens, who are you going to blame, God? You can blame God but He put you in the world, and if He gave you facilities to protect your child, you should, to save a life.³⁸

Vaccines are then conceived as being bestowed by God as a protective mechanism to preserve life (*pikuach nefesh*). The claim that vaccinations enable Haredi Jews to observe the obligation (*mitzvah*) of preserving the body is consistent with broader ideas of health and the body in the Judaic cosmology and coheres with the view of a local Haredi (Litvish) rabbi I met. In the context of nutrition and preventive health, he told me that:

The vehicle for all of this [performing *mitzvot*] is our body. Yes, we are here to attain the world to come by doing *mitzvot*, but we are not spiritual souls, spiritual souls would be the equivalent of angels who don't have bodies. We are not angels. We are here in bodies. The *mitzvot* you actually do with your body, and if your body is not healthy, well you just aren't going to be as able or energetic or as well to do the *mitzvot* that you should be doing. (Rabbi Raphael)

It is equally the case that there is no authoritative ruling in the Judaic cosmology to proclaim that vaccinations are compulsory. Rather than opposition to vaccines being an issue of 'culture' or religious 'beliefs', anxieties and responses to vaccines emerged as a fraught area of childhood and child health for Haredi parents that needs to be carefully and continuously negotiated. Religious teachings were, for instance, interpreted as a reason *not* to immunise by Mrs Lisky, a local Hassidish mother. She drew on a Talmudic decree to underline her decision to decline the further course of routine vaccinations that her daughter was offered:

Mrs Lisky: In the *Gemarah* it says that it is worse to do something dangerous than to do something which is forbidden.

BK: What do you mean by that?

Mrs Lisky: It comes from a fear that it is worse to do something dangerous than to do something which is forbidden. And that's the

Jewish law – you can see from there it is possible that punishment is allowed for danger and that is even worse than something that is forbidden.

The decision Mrs Lisky made to not vaccinate her daughter is therefore situated in relation to her own legal interpretations of how the body and soul is governed in Judaism. Even though vaccinations are *halachically* permissible and not forbidden, the danger that she perceived them to hold would consequently put her at risk of Divine punishment exceeding that of a *halachic* transgression. Child health appears to be highly prized and protected, requiring negotiation as well as intervention in ways that parents can view as antonymic to public health philosophies (similar to areas of maternity care, see Chapter Three). The decisions that some Haredi parents formulate might then involve a sensitive process of juxtaposing the danger against the *halachic* permissibility of biomedical technologies; also demonstrating how religious scriptures are interpreted by individuals and applied to suit healthcare-related encounters.

These examples illustrate how Jewish legal frameworks offer plural and opposing interpretations for parents deciding whether to vaccinate or object to vaccinations, yet each might be seen as taking a ‘leap of faith’ from the other’s perspective. Studies that cite religious rationales or ‘beliefs’ for objecting to vaccinations often fail to clarify what these actually entail, and the case of Jewish Manchester demonstrates the complexities for Haredi Jewish parents when consulting Judaic teachings to inform healthcare-related decisions.

Maternity carers held a range of opinions on how vaccines were viewed in Jewish Manchester, with some claiming that the ‘Haredi community do not believe in giving immunisations until a bit later on’ – rather than this being an issue of outright refusal. The number of Haredi parents who actively refused vaccinations was apparently a ‘very small percentage’ of Jewish Manchester (Mrs Cohen). Many of the midwives and doulas told me that providing vaccine information did not fall in their remit, and this was instead viewed as the responsibility of a local Haredi-run family and child welfare centre.³⁹ One doula made a conscious decision to avoid promoting vaccines in her maternity care work, partly because she viewed immunisations as a responsibility for GP surgeries but also because this particular biomedical intervention is entangled with broader political and economic relations:

I don't really try with immunisations. I try to keep out of it, because it's a very sticky subject. I know a lot of GPs are paid; the way that the GP now gets his funding or her funding is through targets. They've got targets to get to, so part of it is the targets for immunisation. I wouldn't want to take away somebody's, you know, you know [smiles], salary because [of what] I've said to people. So I try not to get involved with immunisations ... it's a bit more sticky, and it's medical, so I really would try to keep out of that. (Mrs Susman)

Mrs Susman actively refused to interfere with the issue of promoting vaccinations, which she viewed as an invasion into a terrain of medical jurisdiction or perhaps an area that her infant care work reluctantly overlaps with. Mrs Susman does, however, recognise the possible implications of her advice: if her guidance should conflict with that provided by medical professionals, they would then incur a financial penalty due to lower than anticipated immunisation coverage.

GP surgeries in England have financial incentives to meet childhood immunisations targets, which complicates the relationship between healthcare professionals and patients. Similar to other areas of preventive healthcare, this creates a situation where healthcare professionals are under pressure to improve the uptake of 'interventions' (such as cervical screening) in order to achieve coverage targets that are tied to financial reward or remuneration (see Berjon-Aparicio 2007). Provision of immunisations in primary care then presents particular 'side-effects', given that advice from general practitioners is viewed as partial or untrustworthy by parents because of their institutionalised financial incentives to immunise children (see Petts and Niemeyer 2004; Poltorak et al. 2005).

NHS GP surgeries in England have previously deployed conscious strategies to avoid financial penalty by manipulating vaccination coverage levels. Tactics have included the temporary exclusion of children from patient registers if their parents object to immunisations – by removing these children from immunisation target groups, they would thereby also be excluded from calculations of uptake levels and present the illusion that immunisation coverage is higher than it actually is (Scanlon 2002). The manipulation of statistics to create the illusion of higher coverage levels for the purpose of securing economic incentives offers a backdrop to understanding why some maternity carers may be hesitant to promote vaccines (which in some cases they appear to lack confidence in). It is therefore worth critically engaging with the statistics that are deployed as authoritative knowledge in public health discourse – or

the *culture* in which authoritative knowledge is constructed – to represent vaccination coverage, especially when seeking to understand the dynamics of vaccine hesitancy. Against the political and economic context within which vaccines are delivered, maternity carers like Mrs Susman felt they had good reason not to actively circulate pro-immunisation advice.

Vaccine cautiousness among parents in Jewish Manchester usually centred around the fabricated and long-refuted claims that the triple-antigen measles, mumps and rubella (MMR) immunisation may be causally associated with autism (Wakefield et al. 1998). Mrs Susman considered this a lingering anxiety in Jewish Manchester because of the prominent place that the alleged dangers of the MMR immunisation once held in the public domain, which:

Petered through the system to the Jewish community, but they're not up to date with it. They're still maybe ten years behind with what has gone on with the MMR. They're not up to date with the recent research that shows that MMRs are safe, well, *supposed* to be safe. (Emphasis added)

Although Mrs Susman notes that Jewish Manchester is not up to date with recently published research, this is not to say that public debates about health do not 'reach' the constituency at all. Advice and authoritative knowledge that is intended to counter vaccine cautiousness certainly do circulate through information sources that are viewed as approved and authoritative (such as *Ze' Gezunt*, but also Haredi newspapers and lifestyle magazines, as well as independent Internet research). Mrs Susman appears to doubt the safety of the MMR vaccine despite the access she would have to current authoritative knowledge circulated by public health (through her maternity and infant care work). If Haredi Jews in the UK have a residual concern with the MMR vaccine then this should also be viewed in the broader context of their being a minority group in the UK, where reactions to the MMR controversy were widespread.

Some maternity carers also told me that a significant number of local parents continued to be convinced that vaccines were associated with autism and atopic or allergic conditions (such as asthma or eczema) developing in their children. Concerns relating to MMR safety (and the implications for uptake) are not specific to Haredi mothers in the UK, despite the general population not being insulated from flows of information in the mainstream media. Levels of MMR coverage have consistently struggled to reach those attained prior to the 1998 Wakefield affair, often triggering outbreaks of



FIGURE 4.2 Promoting vaccinations in international Haredi newspapers. Photograph by Thomas S.G. Farnetti. © Wellcome Collection. Published with permission.

measles, and the public distrust that underlies lower-level MMR uptake has also shaped responses to subsequent immunisation campaigns (see Stöckl 2010; also Thompson 2009). Lower MMR coverage and the implications for how childhood vaccination campaigns are viewed in England then suggests that the self-protective stance of the Haredim (which, according to Mrs Susman, makes them less ‘up to date with the current research’) cannot solely account for mistrust in the MMR amongst *frum* circles.

Negotiating Recommended Childhood Immunisation Schedules

Jewish mothers in Manchester often preferred to accept childhood vaccinations at their own pace rather than follow NHS schedules. Delayed uptake can be read as parents choosing to negotiate acceptance of vaccinations, and illustrates how parental vaccine decision-making is poorly understood when viewed in binary terms of ‘compliance’ and ‘non compliance’.⁴⁰ Blanket representations of low-level of vaccination uptake or ‘compliance’ among Haredi neighbourhoods do not accurately reflect the *process* in which individual parents navigate child health decision-making.

Having a growing family led Mrs Tananbaum to change her views on vaccine acceptance over time as opposed to holding a static position on uptake. She recalled how she was exclusively breastfeeding

and caring for her firstborn son at home (instead of sending him to a communal nursery), which led her to delay uptake of primary vaccinations. Her process of vaccine decision-making later changed when caring for multiple children:

My gut feeling is, 'he's not in nursery, so he's not exposed to other children and I'm still fully breastfeeding him. I think he's protected enough at this moment in time so I want to delay it until her own immune system is strong enough to be able to cope with the vaccines'. Whereas, with my second, I immunised her a bit earlier than my first because I was thinking my eldest is now going to nursery; he's coming home with goodness knows what and exposing it to our newborn. So it [her rationale that underlies vaccine decision-making] changes as the situation changes. Nothing is rigid.

Delayed acceptance of vaccinations must then be understood in relation to broader decision-making strategies surrounding child health and care. Mrs Tananbaum claimed that *frum* mothers delayed uptake because they apparently feared newborns are 'too young at six weeks to get a cocktail of vaccines', with some placing a greater value on exclusive breastfeeding as a conscious strategy of bestowing immune-protection during infancy.⁴¹ Conflicting perceptions of 'protection' can be observed between *frum* mothers and NHS routine immunisations, particularly because preventive health interventions that are designed to guard the broader population by way of social immunity are perceived as potentially virulent to individual bodies. In advancing Esposito's (2015) notion, Haredi women can be understood as claiming exemption from the obligation to vaccinate according to the NHS schedule (and thereby possibly disrupting the protective circuit of social immunity), as an attempt to avoid what they perceive as a disruption to their own children's health and welfare. The view that routine vaccination schedules are a universal technique of protection is therefore not always an interpretation shared between the state and citizens (read: the targets of vaccination campaigns).

Parental assessments of their children's immune systems were common amongst the Haredi mothers I encountered. Mrs Kelner explained that the inclement climate in Manchester meant that she had to carefully decide when to accept childhood vaccinations, and delay uptake when necessary:

Because the weather is so bad here I don't like them to have their jabs when they have a cold or when they are poorly of any sort, and it's really hard to get those months in. *I don't like the idea of giving them*

something that isn't good when their immune system is down a touch.
(Emphasis added)

Mrs Kelner viewed vaccinations as a possibly harmful – rather than protective – intervention, and vaccines had to be balanced against the climatic context of Jewish Manchester to avoid assaulting her children's immune systems. The decisions that these particular Haredi mothers formulate are similar to those observed in the broader UK population, where parents often view their children's immune systems as highly individual and 'at odds with a logic of vaccination among public health institutions premised on homogeneity' (Leach and Fairhead 2007: 46).

Trust in a Time of Conflicting NHS Advice

Past vaccine safety-scares in the UK prompted mothers in Jewish Manchester to cross-examine NHS advice by engaging with broader information sources and social networks. When reflecting on the experience of being a mother during the MMR controversy, Mrs Kelner told me:

I didn't think we were treated fairly as parents. We were given conflicting information even by the government. The NHS didn't seem to know where it stood, and if you can't rely on those who are meant to be giving you the right information then what do you do? What do you base your judgement on?

BK: Does this affect the way you see NHS health information?

Mrs Kelner: In general no, when it comes to immunisations yes. I won't take it as written in stone, definitely not. I will chat it through with people or look it up online.

The perception that the NHS had allegedly failed to reassure parents during the MMR scandal has had the implication of breeding a continued mistrust in government recommendations concerning vaccinations, pushing Haredi parents such as Mrs Kelner to scrutinise health recommendations. Mrs Kelner's claim that the NHS and healthcare professionals were previously ambiguous in their position on MMR safety reflects the views of parents in England more broadly (Petts and Niemeyer 2004: 12).⁴² Any evaluation of how Haredi Jews respond to vaccination campaigns should then consider their status as a minority group in the UK, which shapes both their trust in the state and its health authority.

The decision to 'give' vaccinations can involve a process of researching and negotiating the benefits and risks to the individual and social body, the latter of which can be seen to play a

significant role in parental decisions. One Haredi mother described the challenges involved in vaccine decision-making strategies, as the appreciated benefits are counterbalanced by their perceived toxicity:

I think immunisations are extremely *toxic* and it's a very hard decision to know whether to immunise your children or not. I did give them immunisations but I would have preferred not to. I haven't researched this hugely, but I think that they contribute a lot of heavy metal poisoning in the body. Why take a healthy body and inject it with an outside virus? But I know that it can save lives, and I know that if my child caught measles and was exposed to somebody with a compromised immune system then it could kill the person if they caught measles. So it wasn't only for my children it was for the whole community. (Mrs Schmidt, emphasis added)

Mrs Schmidt acknowledged the benefits of childhood vaccinations but accepted her own children's vaccinations reluctantly. Thus 'compliance' with vaccination campaigns does not mean that parents accept them without any concern. The reluctance of this mother to vaccinate her child again echoes findings from the broader UK population, for whom consenting to vaccination does not equate with public trust in healthcare and the medical authority (Casiday et al. 2006).

Haredi mothers who delay uptake of vaccinations viewed themselves as employing a deliberate strategy to avoid administering a 'cocktail' of immunisations until their infants are relatively older and perhaps then more able to withstand preventive interventions that have the potential to be 'toxic'. In Mrs Tananbaum's case, this was carefully decided upon through her own analysis of risk and bodily protection. Views that the immune systems of children might not sit in accordance with NHS recommended guidelines are not specific to Jewish Manchester, and these concerns are not an issue of 'culture' or 'religious belief'. The views of these *frum* mothers instead resonate strongly with long-established anthropological debates, wherein 'accepting vaccination means accepting the state's power to impose a particular conception about the body and its immune system – the view developed by medical science' (Martin 1994: 194).

The decision to accept or refuse vaccinations is made by parents and imposed on their infants, the latter of whom bear the implications of contracting a VPD or any adverse reaction that could result in vaccine damage.⁴³ The decision not to vaccinate children is also

understood by parents as putting the social body at undue risk. Childhood vaccinations then become the point where competing risks and responsibilities intersect, entangling the bodies of the individual, the social and that of the nation.⁴⁴

A minority of parents wanted their children to benefit from social immunity without having to vaccinate them, who Mrs Tananbaum described as being 'a little bit of a cheat'. The strength of social immunity rested in the willingness of individuals *to* vaccinate:

A kid might not get meningitis because everyone else around him is vaccinated; they're just jumping on that free boat. Whereas I would question this lady and say, 'if no one else was vaccinated, would you still not vaccinate your kid?' So there's more chance that the child would get meningitis, whereas if everyone is vaccinated it's a very small chance that you would get it. (Mrs Tananbaum)

Ms Meyer was a local mother who defined herself as Orthodox Jewish. She objected to vaccinations for many reasons, and described how high vaccination coverage would (in theory) protect her non-vaccinated child:

If ninety-five per cent of the population is vaccinated that means there's no chance of the disease [circulating] and then therefore the five per cent [that are not vaccinated] are protected anyway. So there's no need for the five per cent to be vaccinated if the majority vaccinate anyway. It's just common sense.

However, Ms Meyer's willingness for her child to rely on social immunity for protection indicates a partial appropriation of biomedical information (authoritative knowledge) when formulating her refusal of vaccinations. Coverage levels, as I discussed earlier, vary from place to place. Some Haredi neighbourhoods in London do not achieve the required threshold to confer social immunity, judging by outbreaks of VPDs (Public Health England 2016). When vaccination coverage is not constant across the country, protection circulates amongst those who are immunised but not those who claim exemption from the social immunity circuit. Whilst individuals like Ms Meyer appropriate biomedical knowledge to inform and justify opposition to childhood vaccinations, it is equally the case that she does not fully consider that her local context might not secure the required threshold of social immunity: the logic that her child might form the protected five per cent only works if vaccinations are accepted by the ninety-five per cent who comprise her neighbourhood.

Toxic Interventions and Adverse Reactions

Anxieties surrounding vaccine toxicity and the risk of bodily contamination informed the opposition of some parents in Jewish Manchester. Mrs Lisky claimed that vaccinations contained animal-derived cells, which she viewed as being a potential reason that her daughter was mute:

My daughter is a bit autistic, she doesn't speak. The paediatrician asked if I was up to date with the immunisations and I said I wasn't giving her the last ones. She asked, 'why not?' So I said, 'I feel the MMR immunisation made her autistic'. She was very angry. They [medical professionals] were all very upset, she and some other people were shouting at me. I said, 'I know for a fact that they make it [immunisations] out of diseased flesh from dogs and cats and rabbits, and then they put it into the body. Not everybody can take dog flesh or aborted flesh; maybe there are sensitive people. Animals can't speak and maybe that's why my daughter can't speak'. (Mrs Lisky)

This Hassidish mother's opposition to vaccinations was embedded with grave concerns about safety and the potential for her daughter's body to not only be contaminated with animal matter – but for her to acquire non-human attributes from the method through which vaccines are cultured.⁴⁵ The possibility for human bodies to be contaminated or damaged by vaccinations that are cultured with animal-derived tissues was a concern for other mothers in Jewish Manchester, and further demonstrates how bodies were seen to need protection and fortification in ways that conflict with the public health philosophy of vaccines.

It is here where we begin to see contests over the guardianship of the body between the Judaic and biomedical cosmologies, the latter of which has been described as producing bodies in a powerful terrain of 'cultural and material authority' (Haraway 1991: 204). Anxieties surrounding the cross-species transfer of tissues demonstrate a permeation of embodied boundaries that is made possible by biomedical interventions. Through adverse reactions,⁴⁶ vaccine-damaged children are viewed as acquiring animal traits or what might be described as conceptualisations of the 'monstrous'.⁴⁷ Biomedical interventions that bring the 'external' into the 'internal' are refused as an attempt to protect and preserve the body in both its physically and socio-culturally constructed boundaries. The notion of 'immunity' then acquires a paradoxical meaning for this Hassidish

mother, as that which is meant to preserve life is counterbalanced by the potential to endanger it (cf. Esposito 2015). Indeed Ms Meyer and her family voiced outright opposition to vaccinations for similar reasons:

Ms Meyer: You're injecting a healthy body with things that come from animals. That's what the injections are, and we're against that for moral reasons, to put that into your child.

BK: What are your main concerns about immunisation safety?

Ms Meyer: First of all its safety for sure, what if [interrupted]

Ms Meyer's parent: It's cowpox, isn't it, vaccinations?

Ms Meyer's sibling: I don't know what the ingredients are but I've heard various things, it comes from monkeys, it's lots of toxic drugs. It's a cocktail of stuff, you know, the ingredients, but yes that's the main priority and then is it actually kosher? I'm not sure that all the ingredients can be kosher.

The cowpox that Ms Meyer's relative had claimed vaccinations were derived from played a historical role in the development of vaccinations against smallpox rather than contemporary ones. These anxieties surrounding the safety status of vaccinations point to a partially appropriated and incomplete knowledge of the intricate process through which these biomedical interventions are produced and cultured.

Viruses for some routine childhood vaccinations are pharmacologically 'incubated' or processed using human or animal cell-lines (Oxford Vaccine Group).⁴⁸ Cell-lines have become a biomedical technique of culturing and immortalising life over short and continued periods of time, where human and animal tissues are extracted and grown independently of bodies for the purpose of mass-reproduction and the development of therapeutic interventions, including immunisations (Landecker 2007; Lock 2007; Lock and Nguyen 2010).⁴⁹ The initial trace of human and animal cell-lines are removed when being 'purified' intensively, which means there is no demonstrated risk of transmitting disease through the manipulation of animal cell-lines for the use of human vaccines. However, ethical issues remain in the fact that human cell-lines are derived from foetuses that were voluntarily aborted in the 1960s but continue to sustain the development of immunisations (see Oxford Vaccine Group 2018).⁵⁰ The concerns of Mrs Lisky should not be dismissed as conspiracy, since at the core of her refusal to not complete the course of childhood vaccinations is a complexly woven debate concerning the pharmaceutical manipulation of foetal and

animal tissues and the moral challenge this has raised for religious practitioners from a range of cosmologies.

Adverse and Averse Reactions

Opposition to vaccines was often described by parents as arising from what they considered to be past experiences of a 'side-effect' or an 'adverse reaction'. Health professionals are, in theory, mandated to log any adverse experiences to vaccinations in patient records.⁵¹ Yet there was a concern amongst Haredi mothers that this does not always occur in practice, which can be viewed as one of the several signs of mistrust in childhood vaccinations and the medical establishment. When recalling her son's adverse reaction to the triple-antigen DPT vaccine, Mrs Kahn described how she felt healthcare professionals handled the situation and her hesitations poorly:

I spoke to the doctor about it, I said, 'look, it seems to me that my son had a vaccine reaction and I think it needs documenting'. And he said, 'Yes, we'll document it. Don't worry'. And he didn't. It bothered me. I said, 'it was clearly a vaccine reaction' because he was trying to persuade me that the statistics for having negative reaction were not that high, but the statistics if you didn't [immunise] were high, and using a lot of emotive language like 'I've seen children with measles in hospitals and if only you'd seen, statistically it's safer to give than not to give'. I said, 'but you've not recorded him as a vaccine reaction. If you've not recorded him as a vaccine reaction then how can you say the statistics are fair?' (Mrs Kahn)

What is interesting is that Mrs Kahn challenged the view that statistics were an accurate representation of vaccine safety, because she felt that her son's lived experience of an adverse reaction was being excluded from the process of constructing biomedical knowledge (which was presented to her as indisputable). Whilst Mrs Kahn told me how she confronted healthcare professionals on the issue of statistical transparency, other Haredi mothers did not formally report their children's experiences of adverse reactions. Mrs Dreer held particular reservations about the pertussis vaccine despite 'complying' with the recommendation from her GP, but her son subsequently experienced what she interpreted to be an adverse reaction:

Mrs Dreer: I was very nervous about giving the whooping cough vaccine because I've heard stuff, and I said to the doctor, 'should I give it?' He said, 'you'd be a negligent mother if you didn't'. So I gave it, and he was so ill. He had a terrible reaction, *terrible*. I didn't

get any support from the hospital at all. I said this kid is burning up with fever, had ulcers in his mouth. He was dreadfully ill. [Emphasis in interview]

BK: So when you reported it to your [question interrupted]

Mrs Dreer: They weren't bothered, they just said "don't bring him in, he'll just get iller [sic] in hospital."

BK: Did you log the reaction?

Mrs Dreer: No, no. I just told them about it [the reaction], but they weren't interested.

After experiencing what they saw as adverse reactions to routine vaccinations, these Haredi mothers often chose to delay or withhold vaccinations for subsequent children. Mrs Kahn, as mentioned at the beginning of this chapter, withheld all recommended vaccinations for her seventh, eighth and ninth children. Mrs Dreer delayed the age at which her subsequent six children received all recommended vaccines, but selectively excluded the pertussis vaccination.⁵²

Mrs Kahn and Mrs Dreer both felt that healthcare professionals dismissed their concern that adverse reactions had occurred. Mrs Kahn, in particular, felt like healthcare professionals were treating her as a 'paranoid stupid mother who is just being ridiculous'. When I discussed the issue of vaccine safety concerns with a local *frum* GP, I was told that only a small minority were averse to vaccinations and they were allegedly 'just bonkers or people with bonkers ideas'. He went on to remark that parental anxieties could be attributed to 'crazy discredited research or there may be some *meshugenah* [Yiddish, crazy person] in the family who is against immunisations'.

One afternoon I accompanied Mrs Goldsmith as she visited a nearby Hassidish neighbourhood to promote an upcoming ladies' health event arranged by *Gehah* (Chapter Two). When she approached Mrs Lisky with a flyer, the two soon became engaged in an awkward stand off. The Hassidish mother challenged Mrs Goldsmith on the perceived risks of vaccinations, who then responded by asserting the status of her role as a healthcare professional to counter the claims. Meanwhile, I stood nearby not knowing what to do, but seized the opportunity to meet with Mrs Lisky and discuss her anxieties in greater depth.

When we met a few days later, Mrs Lisky expressed her concern with the willingness of healthcare professionals to promote childhood vaccinations without actually being able to explain the process of the vaccine's production. The contradiction she saw subsequently fuelled her mistrust in vaccine safety, but also in the nexus connecting the state, the health authorities and the pharmaceutical industry:

I asked the top paediatrician who has been working here [local hospital] to tell me exactly what was inside injections and she didn't know. All she said was, she was told that it was safe so she knew it was safe. She didn't know it herself. How can you just believe people when you are putting things into tiny babies? It is top *secret* what they put into it. They want to make sure that everybody gets it [immunised] and they get their money. They aren't telling you that it is safe [because] they can't know that it is safe. (Emphasis added)

These Haredi parents viewed vaccinations with suspicion because of conflicting positions on authoritative knowledge and transparency: whilst they accepted the potential for vaccinations to cause adverse reactions and damage to their children, they claimed that physicians did not. The process through which authoritative knowledge concerning vaccine safety is produced and presented to parents underlines this issue of public confidence, as several mothers in Manchester interpreted the information they received with varying degrees of mistrust.⁵³

The safety concerns held by Haredi mothers in Manchester accord strongly with previous explorations of vaccine confidence and trust in the government, as well as medical and public health authorities. A past study conducted in England found that a significant number of parents (who refused the MMR) felt that healthcare professionals were quick to dismiss their anxieties regarding 'side-effects' or adverse reactions, with parents often trusting their own family doctors to take concerns more seriously than the medical establishment as a whole (Casiday et al. 2006: 183). Moreover, as has been explained elsewhere, public confidence in vaccinations is vital to secure sufficient coverage for social immunity, and vaccine hesitations might be alleviated if parents were more aware of the existing processes for surveying the safety of pharmaceuticals and official lines to report adverse reactions (see Casiday and Cox 2006).⁵⁴ Not being seen to record adverse reactions presented by parents can run the risk of fuelling speculation that serious incidences are being 'overlooked, or even worse, covered up by the medical establishment' (Casiday 2007: 1067).

'Power of the Mouth'

Some Haredi locals in Manchester would circulate advice contrary to public health opinions, particularly recommendations to avoid certain vaccinations because of the perceived risks and toxicity. Mrs Lisky told me:

Mrs Lisky: Today I had an argument because somebody went to have a rubella injection and I said to her she shouldn't go.

BK: You advised her not to go for the immunisation?

Mrs Lisky: Yes, because a lot of people who have the rubella immunisation still have low immunity ... and there is a very, very, small risk of having rubella when you are pregnant because most people don't get it and certainly not when you are pregnant. It happens to one in a million people.

Although Mrs Lisky is perhaps correct in alluding to the fact that rubella (also known as German measles) is a rare condition in the UK, the overwhelming reason why rubella is not widely circulated is because of high MMR coverage. Low circulation, however, cannot always be taken for granted because, as mentioned, vaccination coverage varies throughout the UK.⁵⁵ Rubella is a highly contagious viral infection that is relatively mild, but can have serious implications if contracted by a pregnant woman. Vaccinating children against rubella, therefore, has less to do with protecting the body of an individual and more with the body of the nation, and how this is reproduced. Congenital rubella syndrome (CRS) occurs when the infection passes through the placenta to the foetus, and can result in pregnancy loss as well as acute foetal disabilities, especially during the first ten weeks of pregnancy.⁵⁶ Whereas pregnant women are routinely offered a blood test to check for rubella immunity as part of NHS antenatal care (usually at the eight to twelve week stage of gestation), some Hassidish women evade these initial antenatal screening services (Chapter Three).

Vaccine safety concerns are circulated by the 'power of the mouth' in Jewish Manchester, as one participant put it.⁵⁷ Yet vaccination campaigns and public health interventions will not be successful without addressing the anxieties held and shared by intended beneficiaries. The tendency to frame public opposition to preventive interventions, such as vaccinations (measured by low uptake), as arising from 'apathy' or a 'misinformed culture' (such as Oldstone 2010: 9) fails to grasp how antipathy is often rooted in safety anxieties and quests of bodily protection. Vaccine cautiousness in the UK more broadly (and their circulation through the 'rumour mill') reveal intense mistrust of government recommendations relating to science and technology, even amongst parents who otherwise cautiously accept vaccinations (see Cassell et al. 2006; Poltorak et al. 2005). Rather than dismissing rumours that are circulated among minority groups, public health authorities should attempt to understand the underlying causes of mistrust and local contentions that

provoke immunisation anxieties, such as those held and proliferated by Mrs Lisky.

Consulting and Circumventing Rabbinical Advice

The importance with which the preservation of health and *pikuach nefesh* is viewed in the Judaic cosmology means that some Haredi parents approach local *rabbonim* with a *shailah* concerning vaccinations,⁵⁸ especially if they have concerns over safety or had previously experienced what they considered to be an adverse reaction (Figure 4.3). Rabbi Levy leads one of the Hassidish constituencies, and locals from across Jewish Manchester (including those who are not Haredi or not observant) solicit his authoritative guidance and rulings. Mrs Kahn regarded him as ‘an extremely holy man’, and described how she approached him with the question of whether to accept vaccinations for her children.

Rabbinical authorities are often consulted in healthcare-related decisions, and their guidance is considered binding (Chapter Two). The particular rabbi who Mrs Kahn approached had apparently said it would be in her interests to consult a *frum* Jewish physician who would still have that ‘health perspective’ to hear and allay their concerns. She then committed herself to acting on his ruling:

I had to take the view that if I’ve gone to ask then I have to abide by what he’s saying. I really do. So I took them [her children], except for the young man who had the reaction [to the pertussis]. I didn’t do [immunise] him then. I was too scared, I really was. So I did the rest of them, I did the whole vaccine programme and got them all up to date. I left him, I just couldn’t bring myself to do it. (Mrs Kahn)

The contractual agreement which consulting a rabbinical authority involves, underlined the reason why Ms Meyer was hesitant to solicit an answer on the specific issue of vaccinating her child. Yet she was partial to procuring rabbinical guidance if she could circumvent any obligation to act on the authoritative advice given:

Ms Meyer’s relative: The thing is, if you ask him [the rabbi] a question and you want a *psak halachah* [judgement of rabbinical law] and you’re not going to follow it, there’s no point in asking because if a rabbi did say ‘you have to vaccinate’, we wouldn’t vaccinate. There are lots of issues, well we feel it’s religion too, but we haven’t investigated that as in depth ... as the moral, or the safety. The

issue, you know, we haven't really examined it from the [religious/*halachic*] point of view. There are things permitted in *halachah* that we wouldn't do.

Ms Meyer: I thought about it, but if you ask him and he says, 'you have to', then you really have to follow it through. Don't ask if you can't do it. We could find out what he feels about it in a *roundabout way* without asking him directly 'what should we do', we could get somebody else and if we find out that he's open minded then we could approach him. It's worth thinking about, but in a roundabout way, so that way we don't have to do what he says if we don't agree with it. (Emphasis added)

Thus Ms Meyer's inclination to obtain rabbinical advice in a circuitous way indicates how the *rulings* of religious authorities might be less sought after than their *views*, particularly if this is to reinforce their individual oppositions to vaccinations. The family viewed *halachah* and rabbinical authorities only as a possible source of consultation, particularly if this could reinforce their current objections to immunisations.

Previous studies have illustrated that Haredi Jewish women often look for specific qualities in the rabbinical authorities they consult regarding biomedical interventions, such as their being an accurate interpreter of the Torah or *halachich* law (Coleman-Brueckheimer, Spitzer and Koffman 2009). However, it might also be the case that such rabbinical authorities are selected for their potential to be amenable to the concerns presented, and that people might even consciously evade rabbinical figures who hold a contrary opinion.

Media coverage of vaccinations in the UK *Jewish Chronicle* recently pointed to collaborations between Haredi religious and public health authorities, with the former agreeing to endorse immunisations in their constituencies in response to rising incidences of measles (see Kolirin 2017; Winograd 2013). Yet rabbinical endorsement of healthcare delivery strategies does not necessarily mean that Haredi Jews themselves will be convinced of the need to act accordingly (see Coleman-Brueckheimer and Dein 2011).⁵⁹ Public health discourse that represents Haredi Jews as being 'non-compliant', 'resistant' or 'hostile' to preventive health services does not fully account for the complex terrain that religious authorities and parents themselves navigate when dealing with vaccinations. Haredi individuals evidently do not always respond with 'compliance' to the dictates of religious authorities, which underlines my broader argument that Haredi Jews should not be reduced to a monolithic 'ultra-Orthodox community'.⁶⁰



FIGURE 4.3 Authoritative knowledge. Photograph by Thomas S.G. Farnetti © Wellcome Collection. Published with permission.

Discussion

This chapter has critically engaged with the ‘hard to reach’ trope that has been imposed on Haredi Jews, by exploring how immunities are a social construction within which contrasting ideas of bodily protection are at play. While the state views social immunity as a technique to protect the body of the nation against the threat of infectious diseases (as well as ‘contagious communities’),⁶¹ the survival of the Haredi social body is made possible by maintaining *immunity* from the external world and its potential dangers – which can include areas of healthcare. By applying Esposito’s (2015) conceptual analysis to the ‘hard to reach’ designation, it can be inferred that the Haredim are framed in public (health) discourse as claiming *immunity* from the citizenly obligation to accept immunisations and protect the body of the nation – which, in turn, disrupts the reciprocal circuit of social immunity (or *communitas*).

Vaccinations are a lauded public health and protective intervention used to arrest the transmission of certain infectious diseases at a population level. Haredi parents in Manchester prefer to negotiate uptake at an individual level; vaccinations are accepted broadly but cautiously, selectively and on their own terms to avoid danger or

harmful assaults on the immune systems of children. Portraying opposition to vaccinations as being an issue of ‘culture’ or ‘religious belief’ fails to grasp how responses to health services (that to do not adopt the desired manner of ‘compliance’) may result from a contest of guardianship and protection over the body and soul, which also intersects with constructions of risk and bodily damage. Only a minority of the *frum* mothers in Manchester opposed immunisations on the grounds of cosmology, although they would mobilise their interpretations of Judaic teachings to underscore their decisions. Vaccine hesitations based on safety concerns might occur across the UK, but in Jewish Manchester the process and influences on vaccine decision-making can take on nuanced forms. While public health discourse and studies are quick to claim that there is no religious or *halachic* basis for Jews *not* to vaccinate their children (such as Stewart-Freedman and Kovalsky 2007), the concerns held by Haredi Jews in Manchester were overwhelmingly about safety and parental responsibility to protect their children.

Mistrust in vaccine safety as well as the state–NHS–pharmaceutical nexus often led *frum* mothers in Manchester to negotiate routine vaccination schedules rather than refuse them altogether. Haredi Jewish parents in Manchester do not accept childhood vaccinations without careful consideration of the risks they can present, which demonstrates how ‘compliance’ with health interventions is not an indicator of the extent to which parents trust Public Health England or the NHS to care for Jewish bodies. The MMR jab became a particular source of angst for *frum* mothers, and in this respect the Haredim are comparable to the broader non-Jewish population in the UK (see Cassell et al. 2006; Casiday 2005, 2007; Gardner et al. 2010; Petts and Niemeyer 2004; Poltorak et al. 2005). The issues that underlie Haredi responses to childhood vaccinations should therefore be discussed in the context of their being a minority group in the UK, as opposed to being a minority group with religious ‘beliefs’ that are obstructive to public health services.

Haredi minority groups emerge from this discussion as a group unfairly stigmatised as ‘hard to reach’ in the context of vaccination coverage and the target of intervention, probably because they tend to live in a particular geography rather than being dispersed throughout the state (as others who object to vaccinations might be, and as national variation in vaccination coverage indicates). Being portrayed as ‘hard to reach’ evokes a historical issue of positioning for the Haredim of Manchester. The juxtaposition of archival and ethnographic material in this chapter further demonstrates

how Jews in England have been the particular targets of public health debates and interventions in ways that are contiguous over time, which should not be ignored in current representations of the Haredim.

Notes

1. Mrs Kahn recalled that her son was administered the triple-antigen DPT vaccine in the early 2000s, though protection against these conditions is now offered in a six-in-one vaccine (see Appendix for current NHS childhood vaccination schedule).
2. Immunity, as expressed previously in this book, is a reaction (or intervention) to protect the body of the nation and its attempt to resist or incorporate foreign bodies, which Esposito (2015) frames as central to biopolitics.
3. Not all VPDs work according to social immunity (such as tetanus). VPDs require particular thresholds of social immunity. The threshold for measles, for instance, sits at 90–95 per cent, whereas rubella needs approximately 82–87 per cent of the entire population to be vaccinated (Milligan and Barrett 2015: 313).
4. Coverage 'is defined as the number of persons immunised as a proportion of the eligible population' (see Health and Social Care Information Centre 2014: 14).
5. Measles, mumps and rubella (MMR) coverage in England (2013–2014) for children reaching twenty-four months of age was 92.7 per cent (Health and Social Care Information Centre 2014), which falls short of the threshold of 95 per cent advocated by the World Health Organization (WHO). Whereas 59 out of 149 local authorities in England reached the threshold MMR coverage of 95 per cent and above, 68 varied between 90–95 per cent, and 40 local authorities failed to reach 90 per cent; two of which recorded coverage of less than 80 per cent (Health and Social Care Information Centre 2014). Coverage of all routine childhood vaccinations in 2013–2014 (when measured at one, two, and five years of age) was lower in England than all other countries in the UK (Health and Social Care Information Centre 2014). The stark variation in coverage across the UK in recent years raises the question of how responses to vaccination campaigns among 'hard to reach' groups compare with parts of the broader or 'general' population.
6. It has been argued that the term 'herd immunity' can be counter-productive for social groups who defined themselves by 'going against the herd' and leading an 'alternative' lifestyle which challenges the status quo (Sobo 2015: 395). For an example of 'health protection target' see Petts and Niemeyer (2004: 8). See Sobo (2015) for an example of 'community immunity'.

7. 'Social immunity' also appears in Leach and Fairhead (2007: 5), but with no elaboration on how the authors interpret this term.
8. As Larson and colleagues (2011) note, vaccine decision-making is influenced by a diverse range of factors, which need to be taken into consideration by those responsible for public health delivery strategies.
9. For examples of studies that discuss or attribute low vaccination uptake in relation to 'cultural factors' or 'religious beliefs', see Lernout et al. (2007); Lernout et al. (2009); Top (n.d.); Wineberg and Mann (2016).
10. International public health studies present conflicting reports between religious motivations and objections to vaccinations amongst Haredi Jews, with this being observed, for example, in Haredi settlements in Israel but not in Antwerp (Lernout et al. 2009; Muhsen et al. 2012).
11. Global health and media discourse widely circulate the view that Nigerian Muslim groups are resistant to international public health interventions because of antifertility anxieties, yet anthropological research demonstrates how parental objections in the context of Nigeria are actually much more complex than this single explanation suggests. Attributing vaccine refusal solely to antifertility anxieties obscures the broader concerns of safety held by parents as well as their feelings of being disenfranchised by top-down government interventions (Renne 2006, 2009).
12. See GB127.M182/3/1: 1871–1872; also 1875–1876; M182/2/: 1877–1878; M182/3/2: 1887–1888.
13. It can be inferred that the Board had to report incidences of particular infectious diseases from a Medical Officer Report 1893–94, 'the poor were singularly free from infectious disease necessary to report to the authorities' (M182/3/3).
14. 'Children of every recipient shall receive instruction, or else relief is suspended' (see M182/3/1: 1874–1875). This illustrates how ambitions for anglicisation were fixed on the children of immigrant parents through educational policies, which had the hope of 'raising them in the social scale'.
15. Also *Matzot*. Unleavened bread, which Jews are mandated to eat over *Pessah* (Passover).
16. GB127.M182/3/1: 1876–1877.
17. GB127.M182/3/2: 1887–1888.
18. As demonstrated by European colonial history, including the French colonial occupation of Cambodia (Ovesen and Trankell 2010).
19. The strategies of health surveillance conducted by the Jewish Board of Guardians should be understood in its own submissive position to state authorities, and its own ambitions of anglicising 'foreign' Jews.
20. The UK sits in the WHO European region, which forms one of the six regional WHO offices. See WHO Regional Office for Europe (2013); European Centre for Disease Prevention and Control (2015) for further

- information on measles and rubella distribution and elimination in Europe, and failure for reaching the 2010 and 2015 targets.
21. For examples of the language styles used to frame Haredi Jews and 'hard to reach groups', see Ashmore et al. (2007) and Cohen et al. (2000). For similar examples in the context of Israel, see Anis et al. (2009) and Stein-Zamir et al. (2008).
 22. Emblematic of Foucault's aforementioned concept of 'governmentality', populations (and particular groups within a population) are cultivated and constructed as defined targets of subjugation and control, especially through institutions of surveillance, such as public health.
 23. For examples of the language used to frame Haredi Jews, see European Centre for Disease Prevention and Control (2012); Henderson, Millett and Thorogood (2008); Lernout et al. (2009); Local Government Association and Public Health England (2013); Public Health England (n.d.); WHO Regional Office for Europe (2013, 2016).
 24. Debates about compulsory vaccinations raise ethical questions about individual versus collective rights to protection. As Petts and Niemeyer (2004:9) note, 'compulsory immunization of an individual may be regarded as unethical. However, given the public good component of vaccination, so too may a decision not to immunize'.
 25. Prevention of vaccine-preventable disease cannot be sustained without a culture of immunisations, indicating how this public health intervention forms part of a 'technocracy' (Leach and Fairhead 2007). Here, various techniques are deployed to increase 'compliance' or 'uptake' and have the ultimate aim of 'instilling vaccination as a habit, and inculcating a desire for it' (see Leach and Fairhead 2007: 9).
 26. Jewish Manchester experienced an outbreak of measles in 2000 (in the aftermath of the 1998 MMR debate) largely because of a low MMR coverage by two years of age, falling short of the regional and national average (Cohen et al. 2000). However, Cohen et al. (2000) do not discuss the reasons for low acceptance of the MMR vaccine. Greater Manchester (including its Jewish settlement and the broader population) later experienced a prolonged outbreak of measles from October 2012 to September 2013. A large proportion of the 1,073 suspected cases of measles were observed in children and youths aged ten to nineteen, this group was reported as having low uptake of the MMR because of previous (and falsified) claims that the triple-antigen immunisation was causally associated with autism (see Pegorie et al. 2014).
 27. See Baugh et al. (2013); Loewenthal and Bradley (1996); Purdy et al. (2000) for the former. See Cunninghame, Charlton, and Jenkins (1994) for the latter.
 28. This study should be viewed in its historical context, being published before the controversial (and falsified) claims by Wakefield et al. (1998). Andrew Wakefield, a British gastroenterologist, was the lead author of

the 1998 *Lancet* article that claimed the triple-antigen MMR vaccine may be causally associated with autism. The controversy sparked widespread vaccine hesitations and public distrust of the MMR vaccine, resulting in lower-level uptake across the UK with coverage levels falling short of social immunity thresholds. The research underpinning the 1998 article was highly flawed and in 2010 *The Lancet* formally retracted the article, and Wakefield was struck off the medical register by the GMC.

29. See Wineberg and Mann (2016: 4), who relay how the 'NHS thinks Jewish community fears immunizations, when majority of parents cooperate'.
30. See Cohen et al. (2000); Lernout et al. (2007); Lernout et al. (2009); Stein-Zamir et al. (2008); Stewart-Freedman and Kovalsky (2007), also Baugh et al. (2013).
31. Extrapolations between Haredi groups in Israel and the UK should be viewed with caution. It is widely accepted that particular Haredi minorities in Israel (such as the Satmar and Neturei Karta) do not recognise the authority of state institutions, which might underline their lower levels of immunisation uptake compared with other Haredi groups (see Stewart-Freedman 2007). These state–minority relations are specific to Israel due to opposition to Zionism, and neither Haredi nor Hassidish parents in Jewish Manchester described such anti-establishment views in relation to vaccine-decision making. It is also essential to bear in mind that relations between some Haredi minority groups and the Israeli State are fraught and fractious, with public health authorities viewing some Haredi Jewish groups as being apathetic 'toward preventative healthcare measures' and as responding with 'hostility toward services provided by the public health system' (Anis et al. 2009: 256). It has therefore been claimed that outbreaks of infectious disease require a 'culture-sensitive approach', especially among groups such as the Haredim, who experience 'implicit or explicit stigmatisation [... and] are judged as being difficult to treat and obstructive to the ingress of public health personnel' (Stein-Zamir et al. 2008: 3). Contentions and confrontations in Israel that entangle the Haredim with the body of the nation extend beyond healthcare in to other areas of civic life such as military drafting and political autonomy.
32. *Zeï Gezunt* (a pseudonym) is funded by a local health authority and produced by a Haredi organisation, which claims, among others, to be representative of the Orthodox Jewish population in Manchester. It is typically delivered to homes with a *mezuzah* (an encased parchment from the Torah) attached to the doorpost, signifying that Jews lived in that house.
33. *Posek* (sing.), *poskim* (pl.). One can approach a *posek* or rabbinical authority for a *psak halachah* (judgement of law).
34. Rabbinical interpretations of medical risk and danger are central to how *halachic* rulings on vaccination acceptance are formulated, for

- ‘medical science is key to the religious determination’ (Turner 2017: 2). This chapter instead focuses on how parents engage in vaccine-decision making based on *their own* interpretations of vaccine risk, rather than the risk analysis of religious authorities.
35. US-based lifestyle magazines and newspapers catering to *frum* and Haredi Jews published a range of articles on vaccinations in 2015 following the US multi-state outbreak. These magazines and newspapers were nuanced in how they addressed issues from social, political and international events, but were not considered acceptable by all Jewish locals in Manchester. The magazines and newspapers were widely available in Jewish Manchester, demonstrating the flows of communication around health issues (Figure 4.2).
 36. Chabad Lubavitch are actively involved in missionary work to increase religious observance amongst Jews, but not to attract non-Jews to Judaism (see Dein 2004). The pamphlet is intended to circulate Chabad interpretations of religious and philosophical teachings.
 37. ‘As for the question of vaccination, etc., which you would require if you make the trip [to Israel] in November, there is no basis for any anxiety in that respect’, Chabad Lubavitch *L’Chaim* (issue 855, 23 May 2014). This article was likely written in response to traces of polio discovered in multiple sewerage sites in Israel and the Occupied Palestinian Territories, prompting Public Health England to promote polio immunisation amongst travellers to these regions (Public Health England 2013a).
 38. Mrs Tananbaum clearly views vaccinations as an essential area of child health and a religiously binding conduct, but I later discuss how she preferred to negotiate the point at which her children were vaccinated (as opposed to refusing routine vaccinations altogether).
 39. Not all Haredi parents in Jewish Manchester were convinced of the efficacy of this centre for disseminating child health and development messages to the constituency. Mrs Albala, who described herself as being ‘at the bottom end of the Haredi spectrum’, was sceptical of whether health communication was reaching Haredi parents via the Centre, who instead viewed it as being used as a ‘cheap baby-sitting service’. Moreover, the local NHS health visitors who serve the in-house baby clinic were seen to be used only by parents occasionally, ‘when they need to use the health visitors, they do the odd injections but otherwise no. What it is meant to be, is not what it is getting used for’. I was also told that many Hassidish mothers did not view this centre as an acceptable space for their children.
 40. The term ‘underutilisation’ has also been used to describe parents who delay or refuse vaccinations (Muhsen et al. 2012), but I would instead argue that delaying the stage in which vaccines are accepted does not mean they are under-utilised, but utilised according to the judgement of parents.

41. What is also interesting is the language that Mrs Tananbaum used to describe her son's immune system (as needing to be fortified). When depicting an image of battling entities that are far removed from her child, Mrs Tananbaum can be understood as internalising and assimilating biomedical discourse of immune responses in her perception of the body (cf. Martin 1994).
42. Parents across England have viewed information provided by the government, public health authority, or healthcare professionals with distrust or as being conflicting (see New and Senior 1991; Evans et al. 2001; also Casiday 2005; Gardner et al. 2010). The view that parents received conflicting information surrounding the MMR can be situated in a broader socio-historical context in the UK, when 'public trust in government pronouncements on science and risk had already been severely tested' (Stöckl and Smajdor 2018: 242).
43. I use the term vaccine damage as a reflection on the UK Government's 'vaccine damage payment', which offers compensation if severe disability occurs following a vaccination.
44. It is here that we see most clearly how 'the interplay between individual-level and population-level risk highlights a point of tension in society between state public health interests and the individual "right to choose"' (Casiday 2007: 1067–1068).
45. Mrs Lisky's concern for cross-species contamination can be situated in a historical context of vaccine opposition. Formative vaccinations to prevent smallpox attempted to induce immunity through the animal-to-human transfer of cowpox matter, which was a socially contentious yet politically mandatory intervention in eighteenth and nineteenth century England. The reasons underlying resistance included the anxiety that transferring cowpox matter to humans could result in contamination with zoonotic diseases. The 1853 Compulsory Vaccination Act (applying to infants) instituted in England came to be viewed as 'political tyranny' by the working class, giving rise to a fierce anti-vaccination movement which resisted the institutionalised sanctioning of physical and spiritual contamination through 'blood pollution' (Durbach 2000). Anti-vaccination material at this time reproduced these concerns by featuring vaccinated humans growing cow heads or bovine features.
46. I use the term 'adverse reaction' to describe the (potentially severe) encounter between a body and an extraneous substance but also the multiple issues which can provoke an immune response. Whilst parents may identify a vaccine as the cause of disruption to their child's health (by way of adverse reaction), it is important to note that a reported adverse event does not necessarily implicate a vaccine as the cause (see Oxford Vaccine Group 2013). Bodily reactions might, for instance, result from a component of the vaccine itself, an issue in the supply, storage, and cold chain, or an underlying medical condition in the recipient or 'target' (Public Health England 2013b). Parents might

- view a vaccine as the cause of an adverse reaction, but they might not be able to identify which component (if any) in the vaccination process triggered a reaction. Some of the above-mentioned causes of an adverse reaction can be more readily accepted over others by parents, which can result in all vaccines (and the biomedical technique of inducing immunity) rejected as being a ‘toxic’ intervention.
47. What is perceived as monstrous is defined and represented by its embodiment, and presents an insult to the socio-cultural construction of ‘ideal bodylines – that is the being of the self in the body ... where everything is in its expected place’ (cf. Shildrick 2002: 1).
 48. Routine childhood immunisations which are produced with *human* derived cell-lines include rubella (forming part of the MMR vaccine). Those which are produced with *animal* derived cell-lines include the polio component of the ‘six-in-one’ vaccine (see Appendix 1), see Oxford Vaccine Project (2018).
 49. Cell-lines are a ‘technology of living substance’ where the boundaries of the body are disintegrated at the cellular-level and reduced to fibres, constituting a microscopic degree of materialisation and commodification of the human body for biomedical and pharmaceutical profit (see Landecker 2007; Lock 2007; Lock and Nguyen 2010).
 50. The continued use of manipulated cell-lines deriving from aborted foetuses is particularly problematic for Catholic religious authorities. Such vaccinations were viewed as ‘tainted’ by the Vatican’s Pontifical Academy for Life, which decreed that there was a ‘grave responsibility to use alternative vaccines’ if possible but that ‘vaccines with moral problems pertaining to them may also be used on a temporary basis’ (see Pontificia Academia Pro Vita 2005).
 51. Doctors have a contractual agreement to record any adverse reaction to an immunisation (or any other pharmaceutical) within a patient’s medical record. It is advised that all suspected adverse reactions occurring in children should be reported to GP, or through the ‘Yellow Card Scheme’, which is specifically designed for voluntary reporting of adverse reactions (Medicines and Healthcare Products Regulatory Authority 2016).
 52. Averse and adverse reactions to the pertussis immunisation described in these mothers’ accounts resonate with previous studies into how Haredi mothers navigate immunisation services in London, where this particular jab was ‘selectively declined’ (Loewenthal and Bradley 1996).
 53. The cultural construction and communication of vaccine safety is not a concern specific to the Haredim of Manchester, and parents in the broader population of England have demanded that expertise and evidence be based on lived experience of adverse reactions rather than epidemiological or population-level statistics alone (Casiday 2008: 130).

54. The authors suggest that improving knowledge of the Yellow Card Scheme may be one potential solution. This government intervention collates incidences of adverse reactions (though it may be affected by under-reporting).
55. The last recorded outbreak of rubella in the UK occurred in 2013, with twelve confirmed cases (NHS 2015b). Fewer than twenty congenitally acquired cases of rubella have been reported in the UK since 1997. Most incidences of congenital rubella occur in mothers who contract the infection abroad (see Royal College of Paediatrics and Child Health 2015).
56. The NHS does not recommend giving the MMR immunisation during pregnancy. The stage at which a mother contracts rubella can have different implications for the foetus. Risk of CRS is exceptionally high (90 per cent) during the first ten weeks of pregnancy and presents a strong likelihood of adversely affecting foetal development. The risk of CRS (causing visual or hearing impairment) drops to ten to twenty per cent during the eleven to sixteen week stage, with a low chance of deafness remaining until the twenty-week stage (see NHS 2015).
57. Although 'word of mouth' has been regarded as a 'potent source of rumours about vaccination dangers' for Haredi Jews, it has also proposed as a means to circulate an influential counter-narrative of immunisation safety (Henderson, Millett and Thorogood 2008). Rumour is often associated with the circulation of vaccine dangers yet the power relations that substantiate and underline hearsay are not always fully considered (see Feldman-Savelsberg, Ndonko and Schmidt-Ehry 2000).
58. Hebrew (*shailoh* was the vernacular in Jewish Manchester); a question put forward to a rabbinical authority that usually entails a *halachic* ruling, but can also be to solicit guidance.
59. Previous studies have remarked how public health officials colluded with rabbinical authorities in order to increase uptake of immunisations amongst Haredi minorities in Israel. In one instance, public health nurses and doctors were disguised in order to gain access to Haredi institutions, whereas another group refused to comply with rabbinical rulings to immunise children with the MMR or co-operate with state attempts to control outbreaks of measles (Stein-Zamir et al. 2007).
60. The fact that Haredi individuals do not always follow religious rulings or the dictates of authorities therefore demonstrates how 'emblematic labels and stereotypes of collective identity do not always provide reliable instruments of diagnosis of how people experience their own social identity' (Jacobson-Widding 1983: 23), or how they chose to care for their own bodies.
61. 'Contagious communities' is borrowed from Bivins (2015), who discusses the term in relation to the NHS and migrant groups in Britain.

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Archival Material

Archives & Local History, Manchester (GB127)

M182/3/1–4: Manchester Jewish Board of Guardians for the Relief of the Jewish Poor

CONCLUSION

ANTONYMIC IMMUNITIES

Taking Jewish Manchester as a stepping stone I have critically engaged with the construction of a Haredi population that sits evasively at the ‘hard to reach’ margins of the state. There, Haredi Jews are portrayed as responding to preventive health interventions with poor ‘compliance’ or indeed outright resistance to state authority in some cases. In challenging the view that Haredi Jews are ‘non-compliant’ with areas of NHS provision, *Making Bodies Kosher* presents an image of how responses to maternity care and infant health interventions should instead be understood. What has emerged over the course of this book is a situation where ‘antonymic immunities’ are exercised between the Haredim and the state, marked by a failure of each to reach the other’s expectations and responsibilities concerning health and bodily protection (Chapters Two, Three and Four). An antonym denotes a state of opposition and applied to the case at hand it illustrates how a body is fully understood when placed in relation to another, rather than being viewed in isolation. Antonymic immunities articulate how contests over a Jewish body – which is itself the margin between the Haredim and the state – rest on opposing conceptualisations of protecting collective life. The antonymic pursuits of ‘immunity’ undertaken by the Haredim and the state respectively are only fully understood when placed side-by-side.

Preserving Collective Life

The historical and contemporary trajectories of this book articulate how health and bodily care reflect an enduring pressure on the Jews of Manchester to assimilate, integrate or insulate. Émigré Jews during the nineteenth and early twentieth centuries were cast as a threat to the body of the nation, undermining it from within, and were targeted as a foreign antigen in need of cultural prophylaxis or ‘anglicisation’ (Introduction and Chapter One). In many ways this historical narrative is contiguous with the present experience of Haredi Jews who sit in the gaze of the public health authority as a ‘community’ that must be reached in order to secure the protection of all. In each of these cases, a contest arises in attempting to preserve the life of the social body and that of the nation. My focus on maternity and infant care captures how anxieties around bodily protection intensify in health borderlands, particularly when interventions are seen to disrupt social reproduction or the processes through which bodies are made kosher.

Haredi Jews constitute a rapidly growing yet composite minority who are amalgamated and categorised as an ‘ultra-Orthodox Jewish community’ in public health discourse. Public health authorities typically attribute the low uptake of available health services to ‘cultural factors’ or religious ‘beliefs’ (see Parker and Harper 2005). The construction and targeting of ‘hard to reach’ groups for intervention is symptomatic of a discourse of blame, but is actually unhelpful and counter-productive to understanding their health needs (Chapter Two).

Pious Jews in Manchester do not fully trust state healthcare services to care for Jewish bodies in line with their cosmology and expectations to preserve life and bodily integrity, in ways that parallel the experiences of émigré Jews in the Jewish Quarter. The former Manchester Victoria Memorial Jewish Hospital and the current role of Haredi paramedic brigades, *askonim*, and maternity carers reveals how the relation between a Jewish minority and the state is more complicated than is otherwise presented.

Whereas forms of self-insulation have previously been framed as dissimulation (Scott 2009), the Haredi context is best described as a pursuit of *immunity* in ways that are antonymic to the biomedical construction of the term. Immunitary reactions to what are perceived as virulent changes in the outside world over recent decades take the form of a protective and fortified settlement, or

'zone of cultural refusal',¹ that manifests in the development of culturally-specific and professional health and bodily care services. The intention is to reduce the need for Haredi Jews to encounter the state and the broader population as much as possible, thus fortifying group autonomy.

The 'hard to reach' label is a superficial reference to the Haredi aspiration for self-protection that is intended to preserve individual and collective life. The preference for self-protection exemplifies how Haredi Jews station themselves at the margins of society just as much as they are marginalised by the mainstream – they cast themselves aside whilst they are simultaneously positioned as outcasts. Pursuits of autonomy and self-protection enable religious authorities to negotiate areas of healthcare that have the potential to disrupt social reproduction, yet this intervention also has the potential to come at the expense of individuals. The stringency with which self-protection is pursued as an immunitary strategy (Chapter Two) can come to present a danger to the Haredi social body from within, in what can be read as autoimmune reactions (cf. Esposito 2015).

Protecting the Social Body

Rabbinical authorities and doulas directly intervene in the state provision and delivery of health and bodily care often because of the mistrust with which the NHS is viewed in terms of its ability to meet, or understand, Haredi needs. The Haredi cultures of health that I encountered in Manchester are best described as a preference for managing and mediating its relation to the biomedical authority, rather than evading it altogether. Negotiation thereby becomes a conscious and necessary strategy for Haredi authorities to police the body, which can be conceived as a vulnerable and porous margin with the external world – thus compromising the social *immunity* of the group. Health and bodily care are therefore vital areas of intervention and protection because they represent (and will probably continue to be) two of the remaining points in which the British state and Haredi authorities engage with each other (see Chapters Two, Three and Four).

The culture in which NHS maternity and child health interventions are constructed can contravene interpretations of *halachic* law propagated by local ('lay') Haredi Jews or religious authorities. The concern with preserving (collective) life forms the heart of the Haredi preoccupations and the 'non-compliance' that they field to rebut biomedical interventions that are perceived to be unnecessary.

Studies have articulated how the loss of control over childbirth in marginalised minorities is reflected in the loss of political and collective autonomy (for example Kaufert and O'Neil 1990 on 'the co-optation and control' of Inuit birth by the Canadian state). However, the interventions made by *frum* doulas in Manchester arguably offer an increased sense of protection and *immunity* against incursions into the Haredi social body.

Haredi populations, both in the UK and internationally, are growing exponentially by virtue of larger family sizes. However, there is little debate about how to appropriately meet the maternity care needs of Haredi Jewish families. While hospitals are generally viewed as the safest place for Jewish women to labour, some religious authorities perceive Haredi mothers as being at undue risk as a result of changes in the political and economic organisation of healthcare – especially pertaining to midwifery practice. Pious doulas offer a primarily caring role in childbirth whereas the prerogative of NHS midwives is seen to be one of safeguarding labouring women.

Some Haredi doulas can intervene in clinical encounters to ensure that as few caesarean sections as possible are performed because this obstetric surgery is feared to reduce the number of births a woman can have, and thus presents a threat to the perpetuation of the group (Chapter Three). These Haredi maternity carers can be understood as an 'immunitary reaction' to manage the intrusion of mainstream interventions in a borderland, and enable these external forms of health and bodily care to comply with the Judaic cosmology.

Birth spacing technologies (BSTs) are a routine area of primary care that can contravene the Haredi and Biblical aspiration to 'be fruitful and multiply' and perpetuate the social body. Individuals can experience barriers to accessing BSTs when consulting particular *frum* healthcare professionals, who are reported to collude with rabbinical authorities on the matter of access (Chapter Two). In other cases rabbinical authorities and *frum* maternity carers counsel Haredi couples to approach these services with caution and sensitivity (Chapter Three). Rather than an outright ban on (female) BSTs, as is the case for men, the increasing access to 'the pill' might instead indicate a relative degree of flexibility among women who, in public (health) discourse, are otherwise viewed as being an 'ultra-Orthodox community'. Public health discourse, as Fassin (2001) has argued, amplifies the tendency of culture to constitute differences and thereby overshadows possible similarities.

The prominent role that religious authorities and doulas perform in Manchester illustrates how maternity and infant care is a carefully

navigated area, rather than being a site of outright ‘non-compliance’ or resistance, and thus offers a backdrop against which to critically engage with local responses to childhood vaccinations. Childhood vaccinations are a lauded public health technique to arrest the transmission of infectious diseases, but they are as much a socio-political intervention as they are biomedical. What is often regarded as an issue of poor ‘compliance’ often does not allow for the anxieties that persist after past failings to restore public confidence in controversial vaccination campaigns – such as the MMR.

Vaccinations then form part of a broader culture of biomedical hegemony that is viewed with varying degrees of mistrust. Opposition to vaccinations among Haredi parents are often rooted in safety anxieties that have been informed by experiences of ‘adverse reactions’ or a fear of bodily contamination and damage, which resonates with a broader and historical issue of public concern (and resistance) in England (Chapter Four). Most *frum* parents I met regard vaccinations as an important area of child health, but individual vaccines are nonetheless accepted selectively. The intervention of *frum* doulas in state maternity services, as well as the vaccination anxieties held by families in Jewish Manchester, should therefore be understood in the context of Haredi Jews being a minority group in the UK.

State healthcare is the site where an individual’s body can be entangled between the Judaic and biomedical cosmologies, having the potential for grave consequences for the Haredi social body as a whole. Thus sophisticated and impressive ‘immunitary responses’ emerge as strategies of protection on the part of *frum* women and religious authorities. They direct their gaze towards healthcare, and more specifically, the body, because it constitutes the boundary between what is positioned as internal and external to the group – or social constructions of ‘purity’ and ‘danger’ (cf. Douglas 2002; Esposito 2015).

Immunising the Body of the Nation

The Haredi quest for *immunity* and protection, from what it positions as belonging to the outside world, is often antonymic to that which is put forward by the biomedical and public health authorities. Public health is a political intervention, under the semblance of ‘welfare’, that targets the body of the nation in order to preserve collective life (cf. Esposito 2015: 137). Biomedicine and public health form a culture in which the body of the nation is reproduced, and construct ideals of citizenly obligations that it expects to be performed through bodily compliance.

Reproduction is not only a biological experience of a woman's life but also the basis of nationalism and its perpetuation, and is thus an eminently political domain concerning collective life (cf. Ginsburg and Rapp 1991; Kanaaneh 2002). For this reason, "the politics of reproduction" cannot and should not be extracted from the examination of politics in general' (Ginsburg and Rapp 1991: 331). Obstetric and maternity care is paramount to not only reproducing the body of the nation but also the *way* in which it is reproduced, and is thus a significant target of medicalisation and intervention (cf. Oakley 1984). Areas of biomedicine are intended to maintain a degree of biological immunity from untoward threats posed by populations as well as contagions – which consequently result in obstetric interventions (such as antenatal screening) and vaccinations schedules, as explained in Chapters Three and Four. From this perspective, vaccination coverage is presented as necessary for the protection of all, with 'non-compliance' posing a threat to the health and defence of the body of the nation.

Making Bodies Kosher explores the encounters between these antonymic immunities and protections, particularly in the context of maternity care and child health. The Haredi Jews of Manchester are an example of how particular and subversive responses from minority groups are provoked by biomedical interventions that are perceived to contest the cosmological governance of Jewish bodies. Being 'hard to reach' is therefore not an attempt to evade the state altogether. Instead the Haredi minority arguably attempts to evade a 'subject status' (cf. Scott 2009). Their quest for self-protection and *immunity* from the obligations bestowed on the social body make them 'graded citizens' (cf. Esposito 2015; McCargo 2011), causing socio-politically constructed expectations of bodily citizenship to be negotiated. Yet margins are a demarcation of both territories and bodies (Das and Poole 2004), and the maternity and infant care is emblematic of bodies forming a contested terrain of intervention and consequent 'immunitary reactions'.

Biomedicine is exemplary of state attempts to not only control subjects into being governable but to preserve the lifeblood of the body of the nation, which necessitates an exercise of techniques and technologies of power at both the level of the individual and the population (cf. Foucault 2006; Esposito 2015). I have analysed the strategies used by a religious minority group to intervene in the state's use of the biomedical and public health authorities to incorporate the Jewish social body into that of the nation.

Last Words: *Sof davar*

The pressure for Jewish émigrés to integrate and assimilate in Manchester during the nineteenth and early twentieth centuries resembles the struggles I have observed during the years 2013–2019. The implications of maternity care and infant health for social reproduction can result in contestations over the body, the guardianship of which is sought by competing authorities in ways that persist over time. The struggles investigated in this book are not confined to the by-gone ‘*Yiddisher Hospital*’ that was conceived by émigré Jews who settled in Manchester. They continue to be at play in the current interventions imparted by rabbinical authorities and organised Haredi services, which all attempt to fulfil the *halachic* imperative of preserving life (*pikuach nefesh*) – the life of an individual, but also the social body.

Just a short walk from where the *Yiddisher Hospital* used to sit is a *Hatzolah* brigade providing free emergency care to cyclists by the roadside, as was the case for me when I moved to Jewish Manchester in 2014 (Chapter Two). The *frum* doulas can be found nearby birthing the Jewish social body in the twenty-first century, just like the ‘unregistered’ émigré midwives and the *Hameyaldot Ha’ivriot* before them. These Haredi maternity carers are all busy performing ‘God’s holy work’ amidst NHS hospitals situated at the frontier area of a Jewish settlement and the state – where the politics of parturition and bodily protection are performed.

Note

1. Term borrowed from Scott (2009: 20).

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APPENDIX

NHS Recommended Childhood Vaccination Schedule

As of September 2018 the NHS childhood vaccination schedule,¹ specifically from newborn to preschool-aged children, consists of:

- Diphtheria, tetanus, whooping cough, polio, Haemophilus influenza type b, and hepatitis B (DTaP/IPV/Hib also termed a primary² immunisation courses): multiple-antigen vaccine administered at 8, 12 and 16 weeks of age.
- Pneumococcal (PCV): vaccine administered at 8 weeks, 16 weeks and 12 months of age.
- Meningitis B: vaccine administered at 8 weeks, 16 weeks and 12 months of age.
- Rotavirus: vaccine administered at 8 and 12 weeks of age.
- Haemophilus influenza type b and meningitis C: administered as a combined-antigen vaccine at 12 months of age.
- Measles, mumps and rubella: administered as a triple-antigen vaccine at 12 months of age, and again when the child is 3 years and 4 months old.
- Diphtheria, tetanus, whooping cough and polio (DTaP/IPV or colloquially termed the 'pre-school booster'): administered as a multiple-antigen vaccine at 3 years and 4 months old.

Notes

1. National Health Service. 2016. 'Childhood vaccination timeline', 16 July. Retrieved 9 September 2018 from: <https://www.nhs.uk/conditions/vaccinations/childhood-vaccines-timeline/>
2. National Health Service. 2016. 'NHS Immunisation statistics, England — 2015-16'. Retrieved 9 September 2018 from <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-immunisation-statistics/nhs-immunisation-statistics-england-2015-16>.

GLOSSARY

List of Frequently Used Hebrew and Yiddish Terms

Notes:

1. Singular followed by the plural (when relevant). Example: Ashkenazi, Ashkenazim.
2. When relevant (S) denotes the vernacular Sephardi and (A) Ashkenazi pronunciations. Example: Kashrut (S), Kashrus (A).

Aron HaKodesh Torah ark (in synagogue)

Arukah Healing

Ashkenazi Jews of Eastern and Central European Jewish origin.
Ashkenazim (pl.)

Askan (S), *askon* (A) Lay helper or 'doer' who often assume the role of a culture-broker in medical contexts. *Askanim*, *askonim* (pl.)

Bet Din (S), *Beis Din* (A) House of Law, Jewish court of law

Brit milah (S), *Bris milah* (A) Circumcision of male Jewish infants on the eighth day

Chabad Lubavitch Hassidish group

Chesed Kindness, usually an act of kindness.

Chumrah Stringency, usually in how religious law is practiced.
Chumrot (pl.)

Frum Pious (Yiddish)

Gehah To distance illness

Gemara Rabbinic discussions that comprise part of the *Talmud*

Goy 'Nation,' used to (often pejoratively) describe a non-Jew, according to *halachic* definition. *Goyim* (pl.)

Halachah (S), *halochoh* (A) Codex of rabbinical law. *Halachot*, *halochos* (pl.)

Halachic, *halachically* (adj.)

Haredi Literally God fearing. Protect religious practices and values by limiting engagement with external non-Haredi world, including

forms of education, knowledge and employment. Haredi Jews in the UK generally do not follow the religious authority of the Chief Rabbi. *Haredim* (pl.)

Hashem The name, synonym for God

Hashkafah (S), *hashkofoh* (A) Worldview or outlook. *Hashkafot* (S), *hashkofos* (A) (pl.). *Hashkafic*, *hashkofic* (adj.).

Hassidish Branch of Ashkenazi Haredim, consisting of diverse groups or dynasties that usually follow the philosophy and authority of a *rebbe* and are named after towns of origin in Central and Eastern Europe. *Hassidim* (pl.)

Hatzalah (S), *hatzolah* (A) Rescue or save, Haredi rapid response service

Hechsher A stamp or certificate of approval that denotes a product has been subjected to rabbinical supervision under the auspices of a particular *Bet Din* and is kosher. *Hechsherim* (pl.)

Heim, *heimish* This term does not translate well into English, but stems from the Yiddish word 'home'. It signifies a point of commonality in worldview and religious practice between Orthodox and Haredi Jews

Heimisher Circular that was freely distributed in Jewish Manchester (Yiddish derivative)

Ivrit Modern Hebrew

Kashrut (S), *kashrus* (A) Laws governing food and system of production and consumption that are acceptable or approved

Kosher Satisfying the requirements of *Kashrut*. Used generally as a term to describe something as acceptable or approved

Kollel Often likened to being a 'post-graduate' learning institute, a Haredi man attends *kollel* after *yeshiva* and marriage. *Kollelim* (pl.)

Labriut Hebrew expression 'to health'

Litvish Ashkenazi Jews originating from the historical region of Lithuania who follow non-Hassidish customs (*minhagim*). Jews of a Litvish origin constitute a dominant culture in the Haredi world

Meshuganah Yiddish, crazy

Minhag Custom in which religious law is practiced. *Minhagim* (pl.)

Mizrachi Eastern, Jews of Middle Eastern origin. *Mizrahim* (pl.)

Neturei Karta Haredi sub-group who oppose Zionism and the State of Israel

Pessah (S), *Pesach* (A) Passover, Jewish festival

Pikuach nefesh Dictate of *halachic* law, 'to save a life'

Posek Decider of *halachic* law in cases without a precedent or when previous rulings remain inconclusive. *Poskim* (pl.)

- Rabbi* Denotes a male religious authority/ties in Haredi Judaism.
- Rabbonim* (pl.)
- Rabbanite* (S), *Rebbetzin* (A) Wife of a rabbi
- Satmar* Hassidish group
- Sephardi* Jews originally of Spanish and Portuguese origin.
- Sephardim* (pl.)
- Shabbat* (S), *Shabbos* (A) Sabbath, twenty-five hour period of rest from Friday evening to Saturday evening. *Shabbatot* (pl.)
- Shalom bayit* (S), *Shalom bayis* (A) Peace in the home
- Sheigetz* non-Jewish male (*Shikska*: non-Jewish female). Highly derogatory Yiddish term originating from the Hebrew word 'sheketz' (meaning 'impure' or 'abominable' non-Jewish male)
- Shidduch* System of introducing males and females for courtship and brokering marriage (Yiddish). *Shidduchim* (pl.)
- Shtark* Strict or pious in religious observance (Yiddish)
- Shtetl* Yiddish term for a small town with a large Ashkenazi Jewish population, typically in Eastern or Central Europe
- Shomer* To guard
- Shomrim* Haredi security and neighbourhood watch group
- Shul* Yiddish term for synagogue
- Torah* (S), *Toyrah* (A) First five books of the Hebrew Bible
- Tzedakah* (S), *tzedokoh* (A) Social justice, but commonly interpreted as 'charity' in English
- Tzniut* (S), *tznius* (A) Modesty, in dress and comportment
- Yeshivah* Male religious educational institutions. Haredi men generally attend *yeshiva* until they marry, and then attend *kollel*.
- Yeshivot* (pl.)
- Zei Gezunt* Yiddish expression for 'be well'

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362.1 M64: Manchester Victoria Memorial Jewish Hospital

C15/1/1–5: United Sister's Maternity Society

(Later changed to 'The Jewish Maternity and Rest Home' in 1925; 'Jewish Rest Home and Maternity Society' in 1926; 'Jewish Holiday Home for Mothers & Babies and Convalescent Children' in 1929).

G25/3/6/1–8: Manchester Medical Mission and Dispensary (Red Bank Working Men's Christian Institute).

M151/4/2: Manchester Jewish Soup Kitchen

M182/3/1–4: Manchester Jewish Board of Guardians for the Relief of the Jewish Poor

M182/5/2: Manchester Jewish Ladies Visiting Association

M294/2: Society for the Relief of Really Deserving Distressed Foreigners

M443: Manchester Hebrew Visitation Board for Religious Ministration in the Manchester Regional Hospital Area.

M790/2/6: Anniversary Booklet for Manchester Jewish Visiting Services, 1984.v

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