Immunities at the margins: Negotiating health and bodily care among Haredi Jews in the UK.

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Abstract

Using an integrated archival and ethnographic approach, this study investigates how the growing Haredi Jewish minority and the UK government negotiate their positions in the context of healthcare services in Manchester as one of the few sites where they directly engage. Low-level uptake of certain maternal and infant health interventions has led to claims that Haredi Jews are 'hard to reach' or a 'non-compliant community.' This thesis critically engages the above outlook by exploring how responses to healthcare services should be framed.

Rather than evading the NHS altogether, as the 'hard to reach' label implies, Haredi Jews in Manchester selectively negotiate healthcare services in order to avoid a cosmological conflict with the *halachic* custodianship of Jewish bodies. Maternal and infant care is situated as a particularly sensitive area of minority-state relations in which competing constructions of bodily protection are at play. Whilst maternal and infant care has historically formed part of the state's strategy to govern the population, it is increasingly being seized as a point of intervention by Haredi rabbis, doulas, and parents when attempting to reproduce the Haredi social body.

Following Roberto Esposito's (2015 [2002]) theoretical elaboration of '*immunitas'* the present work depicts the margins as giving rise to antonymic conceptions of 'immunity' as a means of protecting collective life. Interventions that the state regard as protecting the health of the nation can, in turn, be viewed as a threat to the life of the Jewish social body. Immunity at the margins can be characterised by an antonymic fault of both the Haredim and the state to understand each other's expectations of health and bodily care. The margins of the state illustrate how responses to healthcare interventions can be entangled within a struggle of integration, insulation, and assimilation for minority groups in ways that are contiguous over time.

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Statement of copyright

This is a tale of a small street in the Longton district of Doomington, in the North Country. Its name is Magnolia Street […] We make a long journey, all the way from the ghettoes of Russia, the walled towns of Judea, the black camel-hair tents of the wilderness beyond Jordan, for the dwellings of the Jewish pavement have something of the quality of all of those.

Louis Golding, Magnolia Street (1932).

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Dedication

For my grandmother, Esther Kasstan, who passed away during the final year of writing this PhD.

‘Grandchildren are the crowns of their elders’ ([*Tanakh*] Proverbs 17: 6).

Translation note

Hebrew and Yiddish words are transliterated (and to a lesser extent translated) throughout this thesis unless I am referring to a direct quotation. There are nuanced differences in the pronunciation of Hebrew between Jews of Ashkenazi and Sephardi origin. Transliterated Hebrew words appear in the Ashkenazi pronunciation when referring to direct quotations from participants because it was the dominant linguistic variety of Jewish Manchester, often amongst Sephardim as well. I use the Sephardi pronunciation of Hebrew words in general discussions and when drawing on ethnographic studies of Haredi Jews, particularly in Israel (where the Sephardi pronunciation is dominant). For clarity, transliterations appear with both Ashkenazi and Sephardi pronunciations in footnotes in the first instance. The glossary lists both styles of transliteration for frequently used Hebrew words (as well as Yiddish references).

Chapter One

Introduction

In this thesis I analyse how the Haredi Jews of Manchester navigate maternal and infant care and respond to biomedical interventions, particularly those that are seen to contest the governance of Jewish bodies as dictated by the Judaic cosmology or, more specifically, the interpretations propagated by rabbinical and 'lay' authorities. Jews are as much a 'people of the body' as of the book, and a focus on maternal and infant care illustrates the way in which the body is incorporated into the Judaic cosmology and, in turn, how the latter takes command of the body to 'organ-ize' it (cf. Eilberg-Schwartz 1992: 8) and reproduce the group. My focus lies in the conducts of a minority[1] group that are intended to preserve social life against threats which have the potential to destabilise established and embodied boundaries that are constructed by the group in relation to the external world.

The title of this work (*immunities at the margins*) constitutes a theoretical reflection on the historical and contemporary experience of Haredi Jews in the UK and their attempts to negotiate health and bodily care as constructed in the Judaic and biomedical cosmologies. I apply theoretical perspectives on 'immunity' and 'immunitary reactions' to the multiple ways in which a Jewish minority continuously attempts to manage encounters with the external world by focusing on the body as a socio-political terrain of intervention. In doing this, my thesis advances a broader body of work which explores how immunity has been conceptualised as a creative and crucial system that negotiates socially-constructed boundaries of the self and difference (see Esposito 2015 [2002]; Haraway 1991; Martin 1990, 1994; Napier 2016).

The paradigm of immunity is deployed to illustrate and frame the biomedical as well as socio-political aspirations of the Haredi settlement and the state in ways

[1] See pp. 8–9 where I critique the term 'minority' and discuss it in relation to Jews in England.

that are constant over time. It provides a schema to critique: a) how émigré[2] Jews were perceived as 'alien' bodies and the target of assimilation and prophylaxis during the nineteenth and twentieth centuries, b) the way in which the Haredi lifeworld is now preserved by strategies of self-insulation and self-protection from the external world, which I discuss in the context of implications for healthcare delivery strategies, as well as c) the current perceptions of childhood immunisations in Haredi families — who are otherwise represented as having a low uptake of immunisations in public health discourse. Roberto Esposito's (2015 [2002]) paradigm of '*immunitas'* is mobilised as a major body of theoretical inspiration to critically engage with the social construction of immunities that form the mainstay of this thesis.[3]

Research context and aims

Haredi Jews are a rapidly growing minority with some of the highest birth rates in England, but their health and bodily care needs remain poorly understood by Public Health England — the body that is mandated to 'protect and improve the nation's health.'[4] Public Health England holds a dominant position in constructing and circulating 'authoritative knowledge'[5] — and thus formulating associated citizenly ideals — pertaining to health and bodily care. International public health discourse

[2] An émigré is 'a person who has left their own country in order to settle in another, typically for political reasons.' It is my opinion that the term émigré is more appropriate than 'immigrant' or 'refugee' to describe the broader context of Jewish relocation to the UK and Manchester during this historical period of persecution and socioeconomic marginalisation in Europe (see Chapter Three).

[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 the opposing uses of the term, as made explicit in the title (and the concluding chapter) of this thesis. References to Esposito's (2015 [2002]) paradigm of immunity ('*immunitas')* are clearly made in text.

[4] 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' (see Public Health England n.d. A).

[5] The term 'authoritative knowledge' is borrowed from Brigitte Jordan (1997). In this thesis I use the term 'public health authority' (or authorities) interchangeably with Pubic Health England and international counterparts by virtue of their mandate to formulate authoritative knowledge, guidelines, and schedules pertaining to maternal and child health interventions.

frames Haredi Jews as being 'non-compliant' or 'resistant' to its services,[6] yet, 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. Opposing constructions of 'immunity' and bodily protection emerge as a key issue in the relation between the Haredi minority and the state.

From the perspective of the state, immunising the population against untoward threats is engineered through biomedical surveillance and interventions that necessitate bodily compliance, as is the case for areas of maternal and infant care, and especially immunisations, which is 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 — especially those relating to maternal and child health, where the biological and cultural perpetuation of the collective is seen to be at stake. The Haredi minority can therefore be understood as claiming *immunity* from the obligation bestowed to the broader population (cf. Esposito 2012 [2002]; 2010 [1998]; 2008 [2004]), 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. To quote one of my research participants, 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 to this research

[6] 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); Stein-Zamir et al. (2008); World Health Organization: Regional Office for Europe (2013, 2016).

project, I illustrate how health and bodily care form an enduring area of contestation between an ethno-religious group and the state through three overarching research questions outlined below.

My first research question addresses the entanglement of culture, faith, and health, where I critically engage with the construction of an 'ultra-Orthodox Jewish community' in public health discourse and reflect on the nuanced socio-religious differences that this term tends to obscure. 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 minority group — which is both highly diverse and fragmented — 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 [1983]).

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 'dissimilation'[7] and self-protection that Haredi Jews pursue. Rather than outright evasion of state services — as the hard to reach label implies — I argue that the Haredi religious and 'lay' authorities in Jewish Manchester prefer to negotiate and mediate the delivery of healthcare services to the settlement. 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.

Clarifying the ways in which the Haredi Jews of Manchester negotiate health and bodily care forms the second research question. I begin by analysing the culture of maternal and infant care in Jewish Manchester that has 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

[7] James 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.'

caesarean sections a challenge to the custodianship of Jewish bodies which can disrupt biological and cultural perpetuation, warranting appropriate responses from experienced Haredi doulas and maternity carers. I frame 'intervention' as a double-edged term which not only manifests through the biomedical culture or 'discipline' of obstetrics but also the direct involvement of Jewish birth supporters in local maternity wards. The cultures of reproductive care in Jewish Manchester then offer a concrete example of how mainstream NHS services are enacted upon by Jews in Manchester and made '*kosher*.'[8]

Finally I discuss the complex issues and concerns that underlie responses to childhood immunisations, which remain one of the most effective (but also controversial) public health interventions that Haredi parents in the UK must navigate. Despite representations that Haredi Jews are 'non-compliant' with immunisation regimes, I argue that there is no monolithic attitude toward this apparatus of the biomedical (and political) authority. A focus on maternal and infant care demonstrates that the responses to, or 'low uptake' of, immunisation regimes in this minority group are not appropriately framed if presented as an issue of 'compliance.' Rather than attributing low uptake of immunisations to 'cultural factors' or religious 'beliefs,' Haredi parents in Manchester negotiate immunisations primarily because of safety concerns. The reasons that underlie low uptake of immunisations among Haredi families accord strongly with those observed in the 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 immunisation safety.

My thesis forms part of a broader anthropological concern with the historically contiguous relation between marginality and health. It 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 reproduction and reproductive health, where the biological and cultural

[8] Acceptable or permissible according to the codex of dietary laws (*kashrut*).

perpetuation of a minority can be threatened. A Jewish settlement sitting at the 'hard to reach' margins of the state serves as a microcosm in which core issues in the anthropology of health are explored.

Conceptualising bodies and 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. Instrumental to this argument is Michel Foucault's (2006 [1977]) paradigm of 'governmentality,' as well as a broader body of work that examines how marginality produces particular intentions and responses on the part of minority groups vis-à-vis their relation to the state — but also how these responses should be most appropriately conceptualised (such as Das and Poole 2004; Lock and Farquhar 2007; Ong 1990; Scott 1985, 2009; Tsing 1993). The paradigm of immunitary protection and reactions spearheaded by Esposito (2015 [2002]) enriches the co-construction of my ethnographic research and theoretical reflections on marginality and minority-state relations in the context of health and bodily care.

The individual body, the social body, and the body politic have been defined as three categories of analysis, the interaction between which 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.' In this thesis 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.

Nancy Scheper-Hughes and Margaret 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. Rather than propagating the term 'community' (see a critique in Chapter Three), 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. Conceptual references to the 'three bodies' offer a terrain in which immunity (and *immunity*) — as the 'general paradigm of modernity' (cf. Esposito 2015 [2002]: 50) — is 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.'[9] I interpret this label as warranting an intervention of the body politic on the part of the public health authority, 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. Not only does the public health authority 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 not only constructs but also *imagines* Haredi Jews as forming a monolithic 'ultra-Orthodox Jewish community' (cf. Anderson 2006 [1983]), 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.' Studies have articulated how these social groups, such as 'homeless persons' in urban areas of France, can view the health authority with mistrust and thus require the careful outreach of heath services in order to enable social inclusion through the institution of medicine (see Sarradon-Eck, Farnarier, and Hymans 2014). Ethnographic research more broadly has been mobilised as a vehicle to demonstrate how biomedicine is a self-proclaimed centre that sits in relation to those at the margins of society. 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

[9] See Judith Okely, who argues that the category of 'Traveller' is, contrary to public discourse, not synonymous with being 'a drop out from sedentary society' (1983: 18).

relation to a majority, dominant, and national population. The state can be mapped by both territorial and cultural boundaries, where 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.[10]

The relation between a majority and minority populations is typically one of disparities in power, where 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' (see Eriksen 2015 [1995]: 357). However, it is important to note that minority and state relations do not exist in a vacuum but are, as Saba 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).

By including archival records and oral histories, I narrate the 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. In the latter case, we might say this is an internal minority status (among Jews in England) that can be contrasted against high birth rates and a growing Haredi population.

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), as well as for émigré Jews 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 immigrant minorities, with specific reference to the Jews, as dependent on their capacity to assimilate, and thus *intermarry* (see Chapter Three). However, the Biblical injunction against intermarriage in the Judaic cosmology prevents assimilation into the national (non-Jewish) majority, which demonstrates how Jews

[10] See Yakobson (2013: 356–357) who discusses the English dominance of British historical consciousness. The reference to 'imagine' is taken from Benedict Anderson (2006 [1983]).

— as a minority group in England — have historically had to negotiate opposing responsibilities to the Judaic cosmology and body of the nation.[11]

Rather than a minority status being a monolithic category, it should then 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 approximately ten per cent of 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' status (cf. Tsing 1993: 17) — but also the ways in which this status becomes a lived reality at the margins of the state.

The broader anthropological discourse pinpoints the margin as 'both a lived reality and a site of intervention' (Nijhawan 2005; see also Das and Poole 2004), but 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. Margins are simultaneously within and beyond the reach of the state, they can be imagined as occupying a space that is unruly and perhaps even organic, where the state is desperately re-establishing and re-imprinting its order through various techniques of power (Das and Poole 2004). Enforcing order and asserting authority at the physical and conceptual margins of the state, essentially the attempt of overcoming the margin, is an enduring expression of sovereignty (see Asad 2004). Whilst the margins have, on the one hand, been critiqued as a 'site of intervention' on the part of the state, they are, on the other hand, equally a site of 'dissimilation' and self-protection for some minority groups (see Scott 2009).

Domination, whether colonial or sovereign, does not always achieve its intended command of the social body, and has been challenged, subverted, and resisted. Bodies that Margaret Lock and Judith Farquhar regard as 'hybrid' are those that are crafted through overlapping currents of power, and 'proliferate under

[11] 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.'

colonial regimes in ways that surprise and frustrate the imperial impulse' (2007: 307). An anthropological focus on the body offers a foundation to understand how the enduring contention between a minority and the biomedical or public health authority is enacted:

> 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)

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 at the margins 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.[12] 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 (see 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 (see 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 reproduction and reproductive health then point to the theoretical crux of this thesis, where the preservation of collective life rests on the construction of what I call 'antonymic immunities' between the Haredi minority and the state.

[12] As Aihwa Ong (1990) has discussed in the context of Malaysia's Muslim population, who form a national majority.

The social construction of immunities

Public health is a body of government that rests on the 'moral assumption that response to the perceived suffering of others is a worthy action' (Hahn and Inhorn 2009: 4), which arguably results in the state formulating ideals of citizenship that are expected to be expressed or performed through the body or bodily compliance.[13] Reproduction is emblematic of this, where standards of "good" maternal and infant care are articulated according to socio-politically constructed norms (see Ginsburg and Rapp 1991). The need to reproduce ideals of a "good" (read: compliant) mother or parent is particularly important in order to reproduce the idealised population as a whole, often as an economic resource or "manpower" (see Davin 1978; Hyatt 1999; Jolly 1998; Oakley 1984).

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; see also Sargent 1989). However, as anthropological scholarship upholds, being a target of biomedical intervention does not equate with being a passive recipient (see, for example, Jolly 1998; Root and Browner 2001; Parker, Allen, and Hastings 2008), illustrating how the bodies of women and children can emerge as a terrain that is caught between competing worldviews.

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' (see Ballard 2004: 110). Moreover, it is arguably the case that use of the term 'compliance' reflects the paternalistic way in which the biomedical authority commands obedience from people and deference to its authoritative knowledge. 'Concordance' has instead been suggested as an alternative term that realigns patient-practitioner relations to resemble an agreement over treatment regimes (Ballard 2004). However, I hold the view that the limitations of concordance (as an

[13] See Judith Farquhar and Margaret 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.'

agreement) are seen in certain maternal or child health interventions (such as immunisations or ante-natal screening), which construct an expectation of parents to follow rigid or 'routine' schedules. Parents who choose to negotiate acceptance of immunisations by delaying uptake are nonetheless regarded as 'non-compliant' in leading studies in England (such as 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. The paternalistic expectation to comply therefore continues to circulate in public health discourse, probably because observing clinical instructions forms a central part of treatment outcomes and the overall success of disease control from the perspective of the biomedical authority.[14]

I interpret non-compliance as a failure to fulfil an obligation to the biomedical or public health authority, and thus a self-exclusion, exemption, disincorporation, or '*immunitas*' from a debt to the common or body of the nation (cf. Esposito 2008 [2004], 2010 [1998], 2015 [2002]). 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 [2004]: 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.

Minority groups are then portrayed as shelving the expectation to act as responsible citizens — and in the context of obstetric and child health interventions — possibly compromise the integrity or immunity of the body of the nation. Immunisations 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 immunity' can become compromised, thus warranting public health interventions.[15] Low responses to immunisation

[14] See also Ian Harper (2010), who discusses how 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.

[15] In Chapter Six I critique the term 'herd immunity' and instead advocate the use of 'social immunity' in public health discourse.

campaigns are one of the overwhelming reasons why Haredi Jews seem to be portrayed as beyond the reach of Public Health England. Studies in Israel have, for instance, complained how its health system is 'plagued' by issues of poor 'compliance' amongst particular Haredi sub-groups, in which 'culture' is seen to perform a leading role (see Chapter Six). In attempting to reach — or perhaps 'save'[16] — Haredi Jews, the public health authority emphasises 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 MMR[17] controversy in the UK).

The conceptualisation of ethnic and religious minority groups as 'hard to reach' can be placed into a broader discourse of public health, which all too often situates '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, the biomedical and public health authority 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). Dismissing opposition to treatment regimes as 'cultural factors' then overshadows, and perhaps absolves, the role of the biomedical authority in providing healthcare services that meet local expectations (see Fassin 2001).

Claims that Haredi Jews are non-compliant with preventive healthcare services are rarely explored from an anthropological perspective and do not fully consider how health conducts are framed within a religious worldview 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

[16] See Lila Abu-Lughod (2002), who critiques the emphasis placed on the socio-religious construction of gender in Afghanistan that warrants intervention rather than the historical or political production of context.

[17] The triple antigen immunisation against measles, mumps, and rubella, see Chapter Six for a more detailed discussion.

governance, and politics, the ethnographic study of which elucidates how perceptions of health services are constructed and responded to in their given contexts.

Public health interventions form a salient strategy of what Michel Foucault (2006) termed 'governmentality,' the crux of which is the capacity and tactics used to 'discipline' and co-opt subjects into being 'governable' — at both the level of the individual and the population — by exercising power over life. The control of bodies by the state is achieved through techniques and technologies of surveillance that are enmeshed in areas of everyday life and entrusted to manage subjects, 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 described as 'biopolitics,' with interventions often paved by the production of statistics or epidemiology:

> 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)

I use Foucault's theoretical approach as a general course of analysis regarding public health strategies and the way in which they target minority groups 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 [2002]) to critically engage with health interventions as a strategy to preserve collective life.

Esposito (2015 [2002]) 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 emerges as an attempt to preserve life and protect from danger, but the rigorous pursuit of which can have the consequence of negating life itself in the form of an autoimmune response — or the self-implosion of the body (Esposito 2015 [2002]). The mainstay of Esposito's thesis 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 [2002]: 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 [2002]: 112).

The individual body (cf. Scheper-Hughes and Lock 1987) is positioned as the level in which the immunitary strategy of politics is enacted, tasking itself with preserving life and delaying death to the furthest point possible, and is increasingly mediated by technology. For this reason, Esposito regards the immunitary paradigm as the cornerstone of modern socio-political systems, and this notion is applied in my thesis to analyse how public health interventions mark an entanglement and alignment between the individual and social bodies and that of the nation. I argue that the power of 'immunity' as a mechanism to preserve life 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, I take social immunisation to be 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 [2004]; 2015 [2002]), and in the context of this thesis, I take it to describe 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 are intensified (Douglas 2002 [1966]; see also Scheper-Hughes and Lock 1987). Self-insulation and self-protection are strategies to defend the Haredi cosmology against contagion from the external world, and manifests in 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 [2002]) puts it, the barriers 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 population with considerable internal socio-religious diversity. 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 birth 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 (see Staetsky and Boyd 2015). Jews of the dominant, integrated, and Anglicised culture will then 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 England during the nineteenth and twentieth centuries (introduced shortly and discussed at length in Chapter Three).

The broader Jewish body in England is apprehensive of the anticipated changes caused by a generation of 'black hats and Jewish babies,'[18] 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 Haredi aversions 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) Jews, the Haredim can be viewed as 'ultra-Orthodox' or 'extremist' Jews who uphold a backwards way of life — one that is reminiscent of the *shtetls*[19] in Eastern and Central Europe (from where many émigré Jews came to England during the nineteenth and early twentieth centuries). Haredi Jews have been the target of unwanted limelight as of recent, particularly with secular

[18] Taken from Geoffrey Alderman ([The Jewish Chronicle] 2012).
[19] Small town with a large Ashkenazi Jewish population, historically in Eastern and Central Europe.

education and differences in the social-construction of gender being high on the political agenda, which signifies how marginality does 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. 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 (see Watzman 1994: XI).

In the Haredi worldview 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 rabbinical law known as *halachah* (see Figures 1 and 2), but also the customs *(minhagim*) 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 Torah and means 'those who tremble at God's word' (Isaiah 66:5). Although the meaning of Haredi is revived from the Hebrew Bible, 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 to what was considered 'Orthodox' (see 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 institutions. Haredi Jews can be told apart by the aforementioned preference to be self-insulating, but also in terms of socio-religious organisation. It is generally the case that Haredi Jews in England do not follow the religious authority

of Ephraim Mirvis, the current 'Chief Rabbi,'[20] and instead have their own respective *Bet Din*[21] or rabbinical elite (as was the case in Manchester).

Ashkenazi[22] Haredim do not form a monolithic body but comprise two major wings, which formed out of an historical and cosmological opposition in Eastern Europe between the Litvak[23] and Hassidic[24] Jews around the time of the mid-eighteenth century. Historically speaking, Litvak Jews were regarded as '*mitnagdim*' (also *misnagdim*), meaning 'opponents' (or 'the opposition') of *Hassidut* (Hassidic philosophies) and its approach to mysticism. Hassidic groups continue to revolve around the authority of a *rebbe* and his particular teachings, philosophies, and interpretations of the Judaic cosmology.[25] Jews of a 'Litvish' origin now constitute a dominant culture in the Haredi world — particularly in Israel — and elite educational institutions (*yeshivot*)[26] reproduce this socio-religious hegemony (see Hakak 2012). It is not uncommon for other Haredi groups (including those of Sephardi and Mizrahi origin)[27] to assimilate into these structures of Ashkenazi and, more specifically, Litvish cultural dominance.

Haredi men are nowadays identifiable by wearing 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 amongst the marginalised Haredi minority of Sephardi and Mizrahi origin. Conforming to (Litvish) Haredi standards of

[20] Mirvis holds the position of 'Chief Rabbi of the United Hebrew Congregations of the Commonwealth,' but this is a religious authority only of the Anglo-Orthodox consortium called 'The United Synagogue' (and allied institutions).
[21] Court of Jewish law, also *Beis Din*.
[22] Ashkenazi is generally a reference to 'ethnic' background for Jews of Eastern and Central European origin.
[23] 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 Litvaks and Hassidish Jews constitute major branches of the Ashkenazi Haredim, there are also other sub-groups such as the *Yekke* (German origin).
[24] 'Hassidish' was the vernacular term in Jewish Manchester, and is used throughout this thesis.
[25] Hassidic groups (or 'dynasties' as they are often referred to) are typically named after the towns in Central and Eastern Europe from which they originate, as is the case for Belz, Ger, and Vishnitz.
[26] *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.
[27] 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. Mizrahi Jews trace their origin to the Middle East, such as Iraq and Iran.

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). Hassidic men are identifiable by variations in garb, long *peyot,*[28] and an emphasis on the Yiddish rather than English language (especially amongst males).

I take issue with previous studies that describe the Haredim as constituting a form of 'Jewish fundamentalism' or Jewish 'fundamentalist enclaves,' which are terms often used in the context of Israel (such as Aran, Stadler, and Ben-Ari 2008; Stadler 2009; and Hakak 2012).[29] In my view 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 conflation (rather than comparison). To a similar extent the representation of Haredi Jews as being 'nonliberal' (such as Fader 2009)[30] is arguably an etic construction and bounds a group as one defined category when the emic reading of conducts may indicate otherwise.

The terms 'fundamentalism' (and also 'extremism') form part of the socially constructed pursuits of religious authenticity that are typically discussed at length in the context of Islam. The term 'nonliberal,' for instance, has also been used to describe the position of Muslim women in what Saba Mahmood (2005) regards as a 'politics of piety' in Egypt. Similar to the issue with the 'ultra-Orthodox' and 'hard to reach' branding that is imposed on Haredi Jews, it is my concern that the 'nonliberal' label is misleading and not conducive to understanding the complexities at play for socio-religious minority *movements* — who might exist in a fluid relation with the external world. It is in danger of casting religious groups such as the Haredim against

[28] Side-locks that men are religiously mandated to maintain. Whereas Litvish Jews usually have discreet *peyot* (also *peyos*) that are tucked behind the ears, Hassidish Jews generally have long and dangling *peyot* but short hair.

[29] 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 (see also Chapters Three and Six). The specific context in which Haredi Jews are portrayed as 'extremist' in Israel might not be transferrable to the UK context.

[30] Ayala Fader (2009: 221) acknowledges 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).

an imagined and polarised construction of a moderate and liberal 'norm.'[31] Haredi Jews in Manchester are positioned as part of a global and growing 'ultra-Orthodox' movement, but, as I discuss in this thesis, attention to reproductive conducts illuminates how relatively 'unorthodox' and previously unheard of changes are taking place (Chapter Five).

Figure 1: *Shacharit* (morning prayers), Jewish Manchester.
Photo credit: Wellcome Images. Photograph by Thomas Farnetti, September 2015.

[31] The term 'liberal' has been critiqued in anthropological discourse, and Talal Asad views it as comprised of values that are 'more contradictory and ambiguous than is sometimes acknowledged' (2011: 36).

Figure 2: Observance, Jewish Manchester.
Photo credit: Wellcome Images. Photograph by Thomas Farnetti, September 2015.

A Jewish and Haredi settlement in Manchester

The United Kingdom has the second largest Jewish population in Europe (after France), currently numbering approximately 271, 250.[32] 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[33] is home to the UK's second largest Jewish and Haredi settlement after London, and sits in a region of historical and contemporary significance.

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

[32] See Daniel Statesky and Jonathan 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 in the UK.
[33] 'Manchester' is also 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.

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 birth 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 (see Manchester University News 2007).

My research was 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 that I visited weekly was, for instance, positioned in the heart of the Haredi and Hassidish quarter. Many neighbourhoods were not exclusively Jewish but also interspersed with Mancunian,[34] South Asian, and East European locals. A mosque, Polish grocery stores, non-*kosher* restaurants, and comprehensive schools are all nestled amidst 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 [1966]).

Frederik 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 [2002]). However, the separation of internal and external along a 'boundary,' as Barth (1969) argued, does not reflect the propensity for exchange between Jewish Manchester and the broader non-Jewish world, which I discuss in the context of the Haredi culture of health.

Instead, the notion of a 'frontier area' encompassing overlapping and fluid cultures and cultural encounters can more accurately describe the experience of

[34] Somebody 'born and bred' in Manchester, but the term was generally not used by Jews in Manchester to describe themselves.

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 over the space where they engage with each other. In the words of Thomas Wilson and Hastings 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 Roberto 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 [2002]: 2).

The thirty-six months (2013–2016) of planning, conducting field-work, and writing this research coincided with several tragic and threatening events that were widely perceived as violent provocations not only in the relevant places in which they occurred, but also for all of *Klal Yisrael,*[35] as the responses of Jews in Manchester suggested.[36] Jewish Manchester itself was not immune from hate crimes. Two local Jewish cemeteries were targeted over the course of my fieldwork, with vandals desecrating, damaging, and tagging swastikas on headstones, which heightened perceptions of vulnerability (see BBC News 2014; Halliday 2016).

In particular, the international events of July and August 2014 caused levels of hate crimes against Jews in England to peak (see Community Security Trust 2014), and provoked particular tensions for the Jewish constituency in Manchester. Following the kidnapping and murder of three Israeli teenagers in the occupied West

[35] The entire people of Israel. Note this does not refer specifically to those living in the State of Israel but the entirety of the Jewish people.

[36] 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; the fatal shooting of a Jewish security guard outside the Great Synagogue of Krystalgade, Copenhagen, in February 2015, as well as a string of anti-Jewish attacks that occurred across Europe during this period.

Bank in June 2014, and subsequently the retaliation that led to the Israel–Gaza conflict of July 2014, worldwide demonstrations had ensued. To my consternation, news sources aired protests and counter-protests that had been consuming Manchester's city centre. It seemed the conflict had been repositioned from the Middle East to an Israeli-owned 'Kedem' store, which consequently dragged the nature and demographic of the field-site under media scrutiny. Images of polarized 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 field-site was 're-presented.' Jewish institutions as well as local and national media coverage portrayed a 'community' under assault, but this is an image I critically engage with in Chapter Three.

Responses in Jewish Manchester to the 2014 Israel–Gaza conflict and the aforementioned attacks committed over the 2013–2016 period varied between prayers of redemption or of mourning, or organised pro-Jewish (and pro-Israel) demonstrations (Figure 3). They indicated how the field-site did not sit in isolation from, but in relation to, events in the broader Jewish and non-Jewish worlds. At the time of writing this introduction in May 2016, a *kosher* diner in Manchester was set ablaze, which provoked some speculation that the arson was an act of anti-Semitism and no doubt fuelled many apprehensions that Jewish Manchester would be the next target of a 'terror attack.' The preference of the Manchester settlement to be self-protective (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 anticipation of a targeted attack.

Figure 3: 'We say no to anti-Semitism' demonstration staged in Manchester.[37]
Photo credit: Ben Kasstan, October 2015.

Jewish immigration to England[38]

During the nineteenth and early twentieth centuries, especially the years 1880–1914, the United Kingdom became a significant destination for Jewish immigration from Eastern and Central Europe. These years saw an exodus of up to three million Jews from the European continent, of which 150,000–250,000 (with variation in estimates) settled in the UK (Dee 2012a; Tananbaum 2004, 2015). Up to 30,000 of these émigré Jews arrived in the already existing Jewish settlement in Manchester by 1914 (and came to form the majority of the Jewish population) a time marked by growing resistance to 'alien immigration' in the local area and country as a whole

[37] The demonstration was organised by 'The North West Friends of Israel,' indicating how the event was linked to pro-Israel advocacy groups.

[38] In this thesis 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 Three).

(National Archives n.d A).[39] With only a few exceptions (notably the work of Bill Williams 1978, 2011), historical studies of Jewish immigration tend to focus on London's East End as a microcosm of British Jewry and often ignore the development and trajectory of constituencies in the 'provinces' such as Manchester.

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 points 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 (see Rubinstein, Jolles, and Rubinstein 2011; Williams 1985). Industrialism and commerce were dawning in Manchester at this time, and scaremongering cast 'Jews and other foreigners' as conspiring to procure secrets on behalf of competitors overseas (see Williams 2011).

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).[40] 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 émigré men and women laboured in trades such as tailoring and 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,[41] 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 being increasingly

[39] 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. A). 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 (home to the Jewish and immigrant quarter), were born abroad (see Vaughan and Penn 2006).

[40] Immigration to Manchester reoccurred in the 1930s due to the rise of Nazism in Germany and the '*anschluss'* (annexation of Austria), (see Williams 2011).

[41] 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.

considered as a 'burden' to the settled (and composite) minority of German, Dutch, and French origin (see Alderman 1992; Endelman 2002; Williams 1989). The pace of immigration picked up by 1869, 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 (discussed in Chapter Three).

Moves to Anglicise and assimilate 'foreign Jews' in England were typically spurred by their more established and integrated co-religionists who had, by the period of increased immigration, only relatively recently achieved socio-political privileges as a minority group in the UK. The period of intensified 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 2012a: 328). Sport came to be emphasised in Jewish ambitions to Anglicise children. It was seen as an essential intervention to improve the social body of 'foreign' Jews — shaping and correcting its 'stunted physique' and 'physical degeneration' to more closely resemble (and perhaps even surpass) the elevated status of the 'host' population (see Dee 2012a, 2012b, 2012c).

Jewish Manchester was no exception to having a pro-Anglicisation agenda for 'foreign' Jews, which, as will be discussed in Chapter Four, was achieved through Jewish health and wellbeing bands. The Anglicised Jewish class, 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 diminished, as well as 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 (see Cesarani 1992).

Nazism caused the last wave of 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 exclusionary (see Kushner 1989).[42] Jewish immigration during Nazism has been well discussed by Bill 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 evidently presented in public discourse, with a history of assimilatory pressures (engineered by both the established Jewish class as well as the broader English society) and implicit and explicit expressions of anti-Jewish hostility. 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 (see The Economist 2015; Staetsky and Boyd 2015). It is arguably the case that the growth of the Haredi population can be viewed as a counter-

[42] Resistance to Jewish immigration was a political demand of the British Union of Fascists at the time, and can be situated in a broader historical narrative of anti-Semitism in the UK (see also Chapter Five 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).

balance to this historical experience of assimilative pressures, with self-insulation and self-protection now serving as a survival strategy. Chapters Three to Six elaborate on this 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.

Outline of the thesis

Chapter Two outlines the research methods used to approach a context in which a population are portrayed as culturally closed or 'hard to reach,' and how, in turn, locals would respond when I (an 'outsider') tested the *immunity* of the Manchester settlement. I reflect on the issue of positionality when conducting anthropology at home, as research participants disputed my Jewish identity and instead imposed on me the status of 'non-Jew' or '*goy',*[43] which presented both obstacles and opportunities in the field. Chapter Two goes on to discuss the limitations in engaging with archival documents from an anthropological perspective, and ends by considering the ethical implications that the research raised.

Chapters Three and Four form two strands of my objective to critically engage with 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 Three 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. Chapter Three goes on to argue how internal fragmentation is often caused by a multiplicity of worldviews whose interaction can be perceived as dangerous or contaminating. After detailing how aspirations of self-protection manifest in the Haredi lifeworld, I conclude the chapter by analysing the concept of positioning and citizenship for the Haredim of Manchester.

[43] Literally 'nation(s),' the term '*goy'* (singular masculine) or '*goyim'* (plural) is generally used pejoratively to describe a non-Jew and their conducts (*goyish*).

In Chapter Four I discuss the implications for healthcare delivery strategies that emerge from the aforementioned 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 [2002]). 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 Four 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 individual needs in order to protect the social body as a whole. The issue of 'antonymic immunities' is contextualised as the theoretical crux of my thesis in this chapter by contrasting the 'hard to reach' label that is imposed on Haredi Jews with the emic constructions of health and bodily care.

Chapters Five and Six explore how maternal 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 Five integrates archival and ethnographic research to illustrate how reproduction and reproductive care are positioned in the gaze of both the biomedical and Judaic cosmologies, and more specifically as areas of continuous intervention. The chapter first explores the relation of émigré Jews to local maternity services, and how they attempted to navigate a healthcare service that was viewed with mistrust, danger, and prejudice. Ethnographic research illustrates how pious doulas (and to a lesser extent midwives) nowadays attempt to birth the Jewish social body within the mainstream biomedical culture, and moderate the dominance of biomedically-oriented maternity 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. The way in which these doulas support women through reproduction and reproductive health, as conceived by the biomedical and Judaic cosmologies, advances past conceptualisations of labour support.

Chapter Six cross-examines 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 immunisation regimes. The chapter challenges the reductionist representation that the 'ultra-Orthodox Jewish community' has an issue with 'compliance' by narrating the complex ways in which local Haredi mothers navigate this sensitive arena of child health. Critiquing the representation of Haredi Jews as being opposed to immunisations because of 'religious beliefs' or 'cultural factors' forms the mainstay of this chapter. Haredi responses to this particular biomedical technology are embedded in historical anxieties about immunisation safety in England, and are also informed by parental 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 landmark studies previously conducted in the UK. The concerns observed in Jewish Manchester are not dissimilar to immunisation 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 [2002]).

The mutual-constitution of ethnography and theory presented in this thesis are tied together in the concluding chapter using the trope of 'antonymic immunities,' which discusses the opposing constructions of immunity and protection that exist for the Haredim of Manchester and the state. A view from the margins exposes how antonymic strategies to preserve the collective lives of the social body and that of the nation are sanctioned.

Chapter Two

Doing fieldwork

My ethnography of a socio-religious group regarded as being 'culturally-closed' or 'hard to reach' required a sensitive approach to the research issues at hand. Groups and spaces that are considered 'forbidden fields' may in actual fact be considered 'forbidden to some researchers but not to others' (Stadler 2007: 200). I am going to illustrate through my own experience how access and obstacles to conducting research in forbidden fields can be an issue of the researcher's cultural or religious proximity to the field — or may be related to the approach or method used to 'reach' out to social groups at the margins of the state.[44] Discussing my own experience of Jewish ethnography as a 'Jew-ish' ethnographer in this chapter forms part of the broader aim of this thesis to critically engage with the construct of a 'community' and how it is employed in health discourse.

Just over twelve months of immersive fieldwork were conducted between May 2014 and June 2015, and comprised of participant-observation, semi-structured informal interviews, informal discussions, analysis of Orthodox and Haredi publications, and archival research. Forty-three semi-structured interviews were conducted altogether, often with individuals who held overlapping roles within the field-site — such as Jewish mothers who were also doulas or midwives. All interviews were conducted in English (often with Yiddish and Biblical Hebrew references), transcribed personally, and then analysed thematically.

Participant-observation was the leading method employed in this study to collect qualitative material. It enabled me to produce 'experiential knowledge' by immersing myself in the day-to-day life of Jewish Manchester whilst returning to my home later in the evenings or the next day (in the case of *Shabbat* or religious holidays) in order to process what I had encountered or what had been shared with me (cf. Bernard 2011). Setting aside an initial exploratory phase of participant-observation (or 'hanging out') in order to nurture rapport with Jewish locals enabled

[44] Part of this chapter includes an abridged version of Kasstan (2016), included here with permission from the publisher.

me to begin formulating the questions I would ask during semi-structured interviews. My key research participants and I generated data which could be grouped into three major categories of research: contextual interviews to understand the nature of the field-site and Haredi Judaism; mapping of a network consisting of nine qualified midwives, doulas, and infant feeding supporters (referred to as 'maternity carers' in this thesis) who performed multiple roles around maternal and infant health; parental perceptions of child health services and information.

However, participant-observation presented some challenges and limitations. Sitting in *kosher* cafes was initially exciting as one could encounter an endless stream of residents during the busy lunch periods, but this thrill soon wore off when I realised that these facilities were 'open' spaces of engagement. Instead, the so-called 'closed' spaces (such as homes and *shuls*),[45] which generally framed interactions that may be considered problematic (such as interviewing women), were made possible by progressively developing the 'right' social networks and personal introductions. A creative and patient approach to the research agenda was therefore necessary; it required moving to the heart of Manchester's Orthodox and Haredi district — the *shtetl*.[46] The house I shared with other Jewish students had a *kosher* kitchen, which enabled me to serve refreshments (often in plastic disposables) for visitors.

By having a *mezuzah*[47] fixed to the front door of my shared house, I received weekly information and circulars that enabled me to keep track of events in the local area as well as the latest special offers at *kosher* shops. The North Manchester Circular — known locally as the *Heimisher*[48] — was particularly important, as it was a trusted source of advertisement and means of circulating information to 3,400 Jewish homes. Delivered alongside the *Heimisher* was a quarterly periodical (*Zei*

[45] Yiddish, synagogue. Used vernacularly and in replacement of synagogue, often in the local Sephardi circles.
[46] My residence was located in an area with numerous Haredi neighbourhoods and was regarded as being 'in the *cholent* pot' (a reference to a traditional Ashkenazi meal served on Shabbat afternoon) by my non-Haredi friends and research participants.
[47] An encased parchment containing a verse from the Torah (the first five books of the Hebrew Bible), which Jews are commanded to fix to their doorposts and gates.
[48] This term does not translate well into English, but stems from the word *heim* (Yiddish, home). It signifies a point of commonality in worldview and religious practice between Orthodox and Haredi Jews.

Gezunt) produced by a local Haredi organisation (and funded by the local health authority), which tailored health promotional messages to the Jewish constituency. Collecting these periodicals was a strategic way of seeing how mainstream health messages were culturally translated for Haredi families (discussed in Chapters Four and Six).

A pragmatic point of access into the Haredi settlement was associating and providing voluntary assistance to an organisation that markets itself as a representative body of the 'Orthodox Jewish community' in relation to public services. The association allowed me to be given a *hechsher,*[49] reassuring some Haredi and Hassidish research participants that I had been vetted and approved by a respected Jewish social authority. Over the course of the fieldwork I conducted participant-observation with a local Jewish wing of a council-funded and volunteer-led agency that distributed health information to local neighbourhoods (Chapter Four), in addition to attending some of their monthly meetings. I also befriended two men from Haredi families with whom I spent vast amounts of time discussing my PhD research. They provided much support in interpreting and applying religious texts to issues of health and wellbeing through informal discussions, tuition, and the method of *chavrutah* (Figure 4).[50]

The working week for Orthodox and Haredi Jews runs from Sunday through to Friday afternoon. It then grinds to a halt in preparation for *Shabbat,* which is a twenty-five hour period of rest that runs from minutes before sunset on a Friday until an hour after sunset on Saturday. *Shabbat* is observed according to particular laws and prohibitions, such as not writing or switching on and off of electronic devices. *Shabbatot* (pl.) were the weekly occasions I would be invited for meals and to stay with families that I had become close to. It involved participation in their rituals and associated *minhagim* (customs), which would differ from household to household. Rather than a researcher, I was invited as a guest — eventually as a friend — and I was unable to make notes during these ethnographically rich periods,

[49] A *hechsher* designates that a food is *kosher* approved, and is a stamp or certificate to reassure consumers that a product has been subjected to rabbinical supervision and is 'safe' to be consumed.
[50] Discussion and debate of religious texts between male pairs or small groups in institutions of religious learning (generally a *yeshivah* for unmarried men or *kollel* for married men).

relying instead on memory recall once *Shabbat* or *yamim tovim*[51] had ended. Conducting research and interviews around religious festivals was challenging because families would often be travelling out of Manchester or receiving visitors. Moreover, Jewish women would be busy preparing for days (or weeks in the case of *Pessah*) in advance of religious holidays, which made these challenging periods of research.

Figure 4: *Chavrutah* with a Haredi local.
Photo credit: Wellcome Images. Photograph by Thomas Farnetti, September 2015.

Being 'neither fish nor fowl'

There are opposing socio-religious constructions and definitions of who is a Jew across Jewish denominational divides in the UK. Orthodox and Haredi Judaism determine a Jew as being born from a Jewish mother or through a conversion performed under a 'reputable' *Bet Din*,[52] whereas the British Liberal and Reform movements uphold an 'equilineal' position (where a child is considered Jewish through either parent). In being a 'patrilineal Jew' and active in the movement for

[51] Religious holidays with laws prohibiting particular activities, such as writing or using a computer.
[52] 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.

Liberal Judaism, I presented an anomaly for research participants as I was not positioned by them as Jewish but could mobilise an understanding of the law, customs and Hebrew language. For the Haredim in Manchester it was my mother's identity that came to dominate my own, despite the fluidity of my multi-ethnic and multi-national family background.

Liminality is often constructed as being 'dangerous, inauspicious, or polluting' (Turner 2002: 368), and it frequently seemed as if I embodied the threats which Orthodox, and particularly Haredi, Judaism seeks to protect and immunise itself from — integration, assimilation, and most grievous of all, intermarriage. I then 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 Orthodox and Haredi Jews regard themselves as the authoritative, authentic, and legitimate practitioners of Judaism (see Chapters One and Three).

I initially reflected on the experience of Jewish anthropologists who conducted ethnographic research within Jewish contexts for support on how to navigate issues in social interaction, and also the ways in which they personally identified with their chosen field-sites (such as Myerhoff 1978; Dein 2004; Winston 2005; Stadler 2009, 2013). However, I found this material did not fully relate to my position as someone with a contested Jewish status. On the other hand, reflections by William Mitchell (1988) of being a '*goy* in the ghetto' also did not reflect my liminal position within the field-site as I was not a complete outsider to the socio-religious context under study.

As Orthodox and Haredi Judaism places specific obligations and responsibilities on co-religionists but not those positioned as non-Jews, I found that some research participants used particular methods to reinforce their positioning of me. One such example was *Shabbat* (Sabbath) observance and being used as a '*Shabbos goy*,'[53] or being referred to as a *Sheigetz*[54] — a derogatory Yiddish word for

[53] Goy(im), sing/pl. Using somebody positioned as a non-Jew (by definition of *halachah*) to perform tasks that a Jewish person is prohibited from doing on *Shabbat*.

a non-Jewish male meaning 'impure' or 'abominable.' The status imposed on me proved to be an obstacle when engaging with some potential research participants, especially when authoritative figures would advise families to exclude or disinvite me from meals during *Shabbat* or *chagim* (holidays or festivals). These invitations were often the most opportune events at which to meet Jewish locals and engage in conversation about the research, which meant that the status of '*goy'* could be a difficult one to manoeuvre with.

It is likely that some locals agreed to meet me because they assumed I was *(halachically)* Jewish. Whereas some Haredim accused me of being deceitful when I would later discuss my family background, I instead argue that the issue rests in different conceptions of what constitutes Jewish belonging and identity. The status of being 'neither fish nor fowl' — as one of my research participants described me — was therefore an accurate reflection of my 'betwixt and between' position(ing). My own positioning — and how I was positioned in the field-site — became a continuous process of negotiating and navigation that was constantly in a state of flux. Conducting Jewish ethnography as a Jewish ethnographer soon became conducting Jewish ethnography as a 'Jew-ish' ethnographer, and was an experience that tested my own identity and perhaps those of my research participants too. The schism between how I positioned myself and how I was positioned in the field therefore epitomised the view that 'even for those of us who study our ethnic group, the distance between the anthropologist and the "natives" remains' (Tsuda 2015: 15). Ethnicity should therefore be understood as a socially constructed category in which the (conflicting) boundaries of inclusion and exclusion give rise to a contested terrain of belonging.

Dress and the politics of positioning

Dressing in the field can leave anthropologists caught between a "rock and a hard place," creating a contest between 'identification and differentiation' when attempting to negotiate socio-political and sartorial boundaries (see Mookherjee 2001). Although dress can offer a degree of identification with research participants,

[54] Derived from the Hebrew word '*sheketz.*'

Nurit Stadler (2009) has explained how her research with Haredi male *yeshivah* students in Israel raised a conflict between dressing modestly (*tzniut*) without (re)presenting herself fraudulently as a Haredi woman. Dress was a particularly challenging point of consideration for me considering my liminal position of being 'neither fish nor fowl,' and I was conscious not to deceive research participants into thinking I was Jewish by Orthodox definition or practice. However, I was equally aware that the sense of division between Haredi Jews and '*goyim*' could be so fierce that I needed to demonstrate my personal degree of 'insider' relation through dress.

In moving to the area that many participants referred to as the '*shtetl,'* I needed to negotiate my self-presentation with the material culture and sartorial standards of life within an Orthodox and Haredi Jewish population. I first imagined that the issue of dress would involve conforming to the principle of *tzniut*, but this actually resulted in a much larger process of navigating intra-group boundaries and their associated customs or expectations. I immediately ruled out wearing *tzit tzit*[55] because this is not common in the Progressive wing of Judaism and doing so would have felt uncomfortable, though I chose to wear a *kippah*[56] as this was not unusual for me prior to commencing the fieldwork.

Wearing a *kippah* was itself a political issue, as the style and form can be seen as a powerful expression of religious positioning. Haredi Jews will typically wear a black velvet *kippah* (with nuanced variations in style) and some Orthodox or modern Orthodox Jews might wear a black suede alternative. I instead wore coloured-cotton or crochet style, which is common in the Progressive Jewish movement (see Figure 5). However, unbeknown to me at the beginning of the fieldwork, this style is termed a *kippah srugah* in Orthodoxy and is synonymous with 'religious-Zionism'[57] (*Dati Leumi*) in Israel, which may have had implications for how and where I was positioned in the field. I wore smart-casual clothes such as trousers

[55] Garment with tassels, which *halachically*-observant men wear under a shirt, with the tassels either tucked in or sometimes hanging loose.
[56] Head covering worn by men, *kippah* (sing.), *kippot* (pl.). Often referred to as a *kappel* in the vernacular.
[57] Religious-Zionism (also National-Religious) is the attempted reconciliation of Orthodox Judaism and Zionism, whereas some Haredi sub-groups oppose Zionism and view the establishment of Israel as contravening a Divine prophecy in the Judaic theology.

and shirt (without a tie)[58] during interviews but I was careful not to wear black trousers and white shirts, which are customary modes of dress for many Orthodox and certainly Haredi Jews. In my view this was an attempt to be professional and mindful of *tznit* without appearing as a complete 'insider.' Being identifiably Jewish but also visibly different (or non-Haredi) through dress enabled me to move in spaces that would otherwise not have been possible, and the *kippot* I wore came to reflect the broader position of being 'neither fish nor fowl.'

Figure 5: *Kippot* and the politics of positioning.
Photo credit: Wellcome Images. Photograph by Thomas Farnetti, September 2015.

Anthropology across homes

Anthropology at home encourages an individual to consider how fieldwork will be approached and what research methods will be employed, but also to confront the meaning of 'home' and how it is conceptualised. The ways in which 'home' as a field-site (and the field-site as a home) is envisioned and experienced consequently

[58] Haredi Jewish men in Manchester would not wear a tie, though some Orthodox and modern Orthodox men would.

shapes the relationships that are built with research participants, which is so crucial to anthropological work.

It has been noted that the motivations for pursuing anthropological work at home might be because 'many of the people we study are those with whom we most closely identify; people of our ethnic group or subculture, people with our same social class, history, and traditions' (Messerschmidt 1981: 8). Researchers who conduct anthropological work at home may choose a field-site in which to sojourn based on a nostalgic, internalised, or even imagined bond to the social or physical topography. These impulses for research have certainly been the case in Jewish ethnography, as expressed by Jonathan Boyarin, 'I will hazard a guess that Jewish anthropologists — perhaps anthropologists in general — are motivated by a sense of loss' (1988: 73), which resonated strongly with me. Defining 'home' has been a constant challenge as I grew up away from the UK and lived in Mauritius, Djibouti, Benin, and Botswana, and also because my family narrative crosses countries, continents, and religious traditions. Home was then a physical absence, augmented by a spiritual distance from an expression of Judaism that I imagined as more 'traditional.'

It seemed clear to me at first that I was undertaking anthropological work at home as I was choosing to move from one Jewish context to another, and also from one city in the UK to another. Durham University has been my 'home' as a student over the last seven years, where I received all of my methodological and theoretical training — right from undergraduate to PhD level. In May 2014 it was time to pack up years of preparatory notes and relocate for ethnographic fieldwork in Jewish Manchester, my chosen 'home' for the next twelve months. However, conducting anthropological work at home caused the boundaries between 'work' and 'non-work' to become destabilised in a number of ways, not least as I had (re)connected with distant relatives (one of whom I had initially lived with) or looked after the children of *frum*[59] friends over the course of the research. More specifically, it felt as if I was conducting anthropology *across* homes rather than at home, especially as the 'boundaries' between oneself and the field, oneself and the research

[59] The term '*frum*' is the Yiddish for 'pious,' and was widely used as a vernacular term to describe a religiously observant Jew (or who appeared to be observant).

participants, as well as one's quotidian or ritual facets of life, were constantly being re-drawn.

Moving from a Progressive to an Orthodox and Haredi construction of Judaism, for instance, entailed abiding by their standards and stringencies of religious observance, especially in relation to *kashrut*, gender, and dress, which I would not previously have kept to the same degree. I also took a 'leap of faith' and stopped attending Liberal Jewish religious services during the twelve-month period in order to understand the context in which the research was grounded. Attending Orthodox and Haredi synagogues soon illuminated the extent of the socio-religious diversity that existed in a so-called 'community' (See Chapter Three).

My formative ventures in Jewish ethnography felt like I was undertaking 'anthropological work in the spiritual as well as the physical sense of the word "home"' (Kasstan 2015: 353). I perceived the fieldwork as being another sort of home by proxy or extension of my Jewish heritage, and I (naively) expected a smooth process of immersion and integration into the field. I imagined this partly because of past fieldwork experiences, my involvement with the Jewish world in a personal capacity, my exposure to the teachings of Orthodox Judaism through my paternal Jewish relatives, but also because of a key passage inscribed in the Torah:

> When a stranger resides with you in your land, you shall not wrong him. The stranger who resides with you shall be to you as one of your citizens, you shall love him as yourself, for you were strangers in the land of Egypt. ([Tanakh] Leviticus 19:33–34)

The above edict on strangers, I was later told by a Haredi research participant, can be interpreted as only applying to bona fide Jews. And this was part of a harder lesson I received when working with Haredi Jews — my own Jewish identity would present both obstacles and opportunities for the research. Regardless of the social or geographical proximity of the researcher to the area under study, ethnographic fieldwork 'requires us to […] embark on the uncomfortable process of learning about persons and power from scratch and often through mistakes and manifest ignorance' (Simpson 2006: 126). Anthropological work at home is not exempt from this process of navigating the field-site and its internal dynamics of power and potential. In fact, it arguably adds further layers of complexity, as the researcher's

subjectivity undergoes a transitional role in becoming an ethnographer at home, negotiating dualities in identities and status, and (re)aligning relationships along the way. It is this complex process of negotiation and navigation that makes fieldwork an 'initiatory rite' of social anthropology, where 'unless one proves oneself in the field, one has not earned the right to call oneself an anthropologist' (Jackson 2012: 4).

Implications of (re)presentation

Many locals were concerned with the way in which Jewish Manchester would be represented in my research, and I was urged to consider the implications of my study. As a 'representational discipline,' the implications of anthropological work present acute ethical issues given that 'ethnographic representation has […] immediate resonance in those places where we conduct fieldwork and often participate as regular members' (Vargas-Cetina 2013: 6). Ayala Fader (a non-observant Jew working with Hassidic women and girls) remarked on the challenge of representation within 'the politics of contemporary ethnography where the "informants" are literate, politically active, and engaged in their own representation' (2009: 17). How participants are represented is a particularly sensitive issue in Jewish ethnography, where criticisms could be misappropriated and used to propagate existing ideas and tools of anti-Semitism.

Kimberley Arkin has also found 'Jewish representation' to be a challenging area of negotiation and contestation, claiming that, 'as part of the dominant class, French Jews have the resources to produce their own representation of Jews' (2014: 9). Jews in the UK also have national and regional established bodies that are involved in the re-presentation of the Jewish minority's public image. These include the Board of Deputies of British Jews and The Jewish Representative Council of Greater Manchester and Region; outward looking groups who monitor anti-Semitism such as the Community Security Trust (CST) and *Shomrim*; organisations such as *Pikuach* who were set up as a response to OfSTED[60] inspections of religious schools and curriculum; and also online, radio, and radio outlets.

[60] Office for Standards in Education, Children's Services, and Skills.

Although the Haredim may rely or cooperate with services from the broader Jewish population, it is also worth noting that Haredi groups have their own specific and representative bodies. The settlement in Manchester was not politically impotent, and there is indeed access to professional skillsets such as law and legal representation within (or within reach of) the Haredi social body through these organisations or the wider Jewish (non-Haredi) population. How representations of Haredi Jews in my research could conflict with the way in which they articulate their own representations was an issue that I became mindful of, with the difference being that ethnography 'does not speak *for* others, but *about* them' (Comaroff and Comaroff 1992: 9 [emphasis in original]).

The implications of representation — and also representing difference within a group (cf. Buckler 2007) — are therefore a concern for the social group under study, but also their relation to broader society. Research participants warned me on many occasions that I had a responsibility to ensure that the thesis or related publications were not 'twisted' and used against 'the community.' Some locals also asserted that my 'outsider' status meant that I would be unable to reach particularly insulated parts of the settlement, signalling that my study might not be representative of all Haredi Jews in Jewish Manchester. In both of these instances, it seemed to me that many locals were concerned with how the Haredi constituency in Manchester would be represented by my study in the public domain. The perceived threat of external media and political attention was of paramount concern for potential gatekeepers who govern strategic spaces of research interest. In fact, I lost the opportunity to engage with the only local children and family centre apparently due to fears that the outcome of the thesis could be appropriated and used to fuel a Daily Mail[61] style exposé of Jewish Manchester.

The potential for particulars of the research to be used against the Haredi minority was a constant consideration of mine, especially when discussing the intervention of religious authorities in decisions surrounding contraception or techniques of birth spacing (see Chapters Three and Four). I decided to include some

[61] The Daily Mail is a right-wing tabloid newspaper with the second widest readership in the UK, and is also renowned for its scare-mongering and sensationalist headlines (particularly regarding migrant and minority groups).

sensitive material in the thesis following the example of Rhoda Ann Kanaaneh, who was concerned that areas of her work could potentially perpetuate 'Orientalist biases' but nonetheless 'resisted the urge to censor, because this would constitute a type of recapitulation' (2002: 21). In a similar regard it was 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.

It should be stated clearly that the quotations, observations, and field-notes inscribed in the thesis form my analysis of how *frum* Jews in Manchester *interpret* Judaism and how this relates to their social constructions of the body and health. I was frequently told in the field, 'don't judge Judaism by the Jews' and my intention is to avoid fuelling anti-Jewish tropes or what Chimamanda Ngozi Adichie (2009) describes as 'danger of a single story,' which she says, is to 'show a people as one thing — as only one thing — over and over again, and that is what they become.' Instead my research provides a thorough deconstruction into the complex ways that Orthodox and Haredi Jews conduct themselves and their strategies of pursuing health and health services. It is intended as means of providing a more holistic account of health practices and perhaps even a counter-narrative to previous accusations that Haredi minorities are 'non-compliant' with certain health services.

Although it is not my intention to determine what is normative of Haredi Judaism or all Haredi Jews, the way in which I, as a researcher, represent the field and my research participants is a different concern. I therefore uphold the view that 'empathy with informants does not necessarily imply, however, an anthropologist's uncritical sympathy for the former's causes, values, and motivations' (Ovesen and Trankell 2010: 3).

Gender relations

Many participants considered the area of family health and wellbeing to fall under the women's domain, unless it (potentially) presented a *halachic* issue that would require consultation with a religious authority (see Chapters Four, Five, and Six). In the majority of cases, such an authority would be a male, or if a personal issue, then

the rabbi's wife (*rebbetzin* or *rabbinate*). Orthodox and Haredi women were my principal research participants, especially those who held positions of responsibility (such as doulas and infant feeding supporters). They would often connect me with their colleagues and friends, which helped me to gain a deeper insight into the culture of maternity care that is offered to Jewish women in Manchester.

The intra-group diversity of Manchester was the greatest methodological challenge that I had to navigate, particularly when trying to understand the *hashkafah* (worldview) or position of research participants vis-à-vis the wider Jewish population. I would usually ask participants how they would self-define, for instance, as being 'Orthodox,' 'Haredi,' or 'Hassidish,' rather than imposing a category upon them. Moreover, Jewish Manchester was home to overlapping sub-groups who sit 'cheek by jowl' rather than being neatly fitted into 'Haredi' or 'Hassidish' boxes (see Chapter Three). I then had to continuously negotiate what situations with *frum* women would be acceptable and what would not, especially as Orthodox and Haredi Judaism uphold the strict segregation of genders, and that specific doctrines are mobilised to minimise those interactions or degrees of engagement.

On many occasions, for instance, I invited research participants for breakfast or a late lunch in the local *kosher*[62] cafes in gratitude for their time. However, it was a constant challenge to comprehend which research participants this would be (un)acceptable to regarding the stringencies they applied to interactions with the opposite gender. Moreover, meeting in public cafes also ran the risk of conversations being overheard, or worse, misconstrued as inappropriate.

One law that I had to abide by was being *shomer negiah* (guarding one's touch), where men and women (unless they are close relatives) are prohibited from touching. More pertinent is *yichud* (seclusion), which is a law that forbade an exclusive encounter in a private setting between a female research participant and myself. As Orthodox and Haredi Jewish women often have hectic work and family schedules, they frequently arranged interviews to be conducted at their homes. In

[62] The *kosher* cafes in Jewish Manchester are under the supervision of two different *Bet Din* who might apply — or are considered to apply — different stringencies to *kashrut*, so what might be considered *kosher* for one participant could be considered not *kosher* for another. One participant told me that the *Bet Din* who was considered to be more stringent would not grant approval for *kosher* cafes under its supervision to provide Internet access, whereas the other *Bet Din* apparently did.

order to avert the issue of *yichud* there would typically be somebody else in the house to act as a *shomer* (guard), or otherwise the front door would be left open to make the encounter inclusive of others and leave open the possibility of people joining the meeting. To interview or even meet informally with an unmarried woman, particularly those attending Seminaries,[63] however, would be unacceptable in the Orthodox and Haredi worldview. In fact, on one occasion I met with a recently divorced woman in a *kosher* café when an acquaintance of hers stopped to ask if we were on a *shidduch.*[64] On reflection, I view this as an example of how the Orthodox and Haredi social body enforces standards of moral order by challenging conducts which are perceived to be inappropriate.

Enquiring about intimate areas of women's lived experience (and to a lesser extent infant care) was something that I was conscious, and at times, nervous about. The maternity carers I met with 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 Haredi 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 engaged in full time learning at Durham — perhaps similar to their own boys who might be studying at prestigious *yeshivot* (or in *kollelim* if they were married) away from home*,* such as Israel or Gateshead. Whilst it was a local norm for Haredi men of my age to be married with children, it is likely that this expectation was not put upon me as an 'outsider' who was not Haredi (and also positioned as a 'non-Jew').

[63] Young Haredi women in England attend seminary ('sem') as a preparatory stage before marriage, usually around the age of sixteen or seventeen for one to two years.
[64] Informal and formal system of brokering relationships, where single men and women are 'introduced' with the intention of marriage.

Archival research

Inspired by examples of combining an historical and ethnographic approach to dualisms in Cambodian medical cultures (Ovesen and Trankell 2010), I was keen to engage with relevant historical material relating to health in the formative years of Jewish Manchester. From January to March 2015 I made frequent visits to the Manchester Archives & Local History centre where I viewed countless records from Jewish welfare organisations, and to the Manchester Jewish Museum where I listened to hours of oral histories.[65]

The majority of archival documents explored were annual reports and records from various health and Jewish social support services at the time, and the dates under study varied according to the material that was available or up until watershed periods such as the establishment of the NHS in 1948. The reports included those belonging to the former Manchester Victoria Memorial Jewish Hospital between the years 1904–1948 and the Board of Guardians for the Relief of the Jewish Poor of Manchester, 1867–1937.

In examining archival 'documents themselves as the equivalent of field notes' (Ovesen and Trankell 2010: 3), I have attempted to integrate these borrowed 'field notes' into the thesis with a similar level of regard and integrity. The ethnographic material and research questions can then be entrenched in a deep social history of health conducts amongst a composite 'community.' However, archival documents should not be immune from critical-engagement. The available documents relating to the former Jewish quarter are overwhelmingly written from the perspective of the Anglo-Jewish elite and clearly narrate its assimilatory agenda, with little trace left in the archive collection to illuminate the first-hand experience of the 'foreign' Jews (see also Williams 1979).

The oral histories housed in the Manchester Jewish Museum recounted a lived experience of a world that has not quite gone by, but remains the cornerstone of a socio-religious structure which has become more developed and elaborate over

[65] The oral histories that are available in the MJM were recorded during the 1970s and 1980s, and offer an insight into Jewish life (as well as life for non-Jews) in Manchester during the nineteenth and early twentieth centuries.

time — one that continues to sustain and support subsequent Jewish generations in Manchester. They also offered an invaluable narration of the émigré experience when archival records mainly offered the perspective of the Jewish elite. The reams of historical documents that were available illuminated a complexly woven and layered narrative of social, political, economic, religious, and migratory lived experiences that otherwise tend to be unified or categorised under one 'Jewish' label (cf. Cohen and Stein 2014). In placing archival documents and oral histories alongside my own ethnographic field-notes, I aimed to juxtapose 'historically situated'[66] contexts and illustrate how health emerges as a recurring area of intervention.

Ethical considerations

I abided by the ethical guidelines outlined by the Association of Social Anthropologists (2011) when conducting this research in order to minimise the impact of my presence as a researcher as well as the future implications of this study. Ethical approval to commence this research was obtained from the Department of Anthropology, Durham University.

The names of all research participants have been replaced with pseudonyms in order to protect their identities. All pseudonyms used in this ethnography are common Hebrew first names as well as Anglicised-Jewish, Ashkenazi or Sephardi surnames (such as Rose, Birenbaum, or Attias). These names are randomly assigned and do not reflect the identities of people in Jewish Manchester, any relation between the names used in this thesis and families who live in Jewish Manchester is coincidental. No connections should be made between the pseudonyms I have selected and any people sharing those names in Manchester.

Using oral histories and archival material presented an ethical quandary of whether to ascribe the same standards of anonymity as ethnographic diary notes or interview material. I decided, in most cases, not to treat the material anonymously as it is essentially 'open access' by virtue of being openly accessible to the public.

[66] See Comaroff and Comaroff (1992: 9) who describe ethnography as 'historically situated mode of understanding historically situated contexts.'

Moreover, many of the documentary and oral records that I consulted could be easily recognisable by living generations, as prominent members of the Manchester Jewish narrative had left them in legacy. Pseudonyms were used in cases where oral or historical records related to established families who continue to reside in the Jewish Manchester.

In order to obtain informed consent from participants, I produced information sheets explaining the research project and its aims (in English). Accompanying the information sheets were consent forms which participants were invited to sign, recording that they understood the research project and their rights as participants — such as anonymity, but also to not answer certain questions or terminate the interviews without reason. These documents included my contact details in case they had any subsequent questions about the research or their contributions to it.

As the majority of my research participants were women with hectic work and family routines, it was often more convenient for me to verbalise the research aims (and also conduct the semi-structured interviews) whilst they were preparing the meals for *Shabbat*. It was often difficult to obtain written consent from research participants when conducting interviews, and this was typically replaced with verbal consent that was, when permitted, recorded with the use of a Dictaphone. Moreover, not all willing participants gave consent for the interviews to be recorded, and others also requested that I did not take notes during interviews. Whilst this presented limitations as I attempted to recall rich and lengthy interviews in nearby *kosher* cafés, on the other hand I appreciated the sensitivity in which Haredi Jews preferred to discuss their way of life.

I soon encountered prominent locals who worked in health and bodily care (either in 'professional' or 'lay' capacities) outside of their working roles within the settlement when attending synagogue services or *Shabbat* meals. The network of maternity carers was exemplary of this. The boundaries between interviewing Jewish locals about health and interviewing healthcare professionals therefore became blurred, and I subsequently consulted the Chair of Ethics at the Department of Anthropology (Durham University) on this matter.

I was concerned that this study would contribute to the heightened vulnerability and vigilance felt within the Jewish social body at the present time (see Chapter One) by drawing attention to areas of the local topography. A resolve was to disguise references to the local area, but to state Manchester as the field-site because it is so recognisable as the second largest Jewish population in the UK after London. The sensitivity felt by Jews at the time of research meant that I was careful to reassure participants that obtaining informed consent was a continuous negotiation rather than event.

In this chapter I have outlined the process of research and the issues I encountered over the course of the fieldwork. My personal experience of having to navigate the intra-group diversity in Manchester is followed up in Chapter Three, where I critique representations of a homogenous Jewish 'community' — a term that obscures internal processes of marginalisation that occur along ethnic, socioeconomic, and religious lines.

Chapter Three

Reoccurring social dynamics and dissonance

The main aim of this chapter is to explore the social dynamics and fragmentations among the Jews of Manchester that reoccur over time, and then to illustrate 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 is central to the broader objective of my thesis, as it has a consequent impact on meeting the health and wellbeing needs — as well as expectations — of this diverse minority group.

Archival records illustrate how economic, socio-religious, and ethnic multiplicity in the historical Jewish Quarter manifested in a gradation of internal marginalities that is continuous with the present day construction of Jewish Manchester. I first narrate the implications of consecutive flows of immigration, and the consequent attempts to assimilate and incorporate émigré Jews into the established Jewish social body, and also 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 (*hashkafot*), the coming together of which can be viewed as dangerous to local moral orders. The representation of a homogenous 'ultra-Orthodox Jewish community' can then be challenged as being an imagined and amalgamated category.

The chapter goes on to explore how a growing Haredi settlement attempts to meet its own socioeconomic and material needs, which 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 Haredi lifeworlds have become increasingly self-protective — enabling encounters with the non-Jewish and non-Haredi worlds to be carefully negotiated, and socially constructed contagions to be avoided. The Haredi worldview can then be understood as being both historically-contingent and also continuously responding to perceived threats: 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 with the state.

The Jewish 'community'

As part of my archival research I visited the Manchester Jewish Museum, which now occupies a deconsecrated Sephardi synagogue in the area that was formerly the Jewish Quarter. A volunteer guide, Sara, 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. The Jewish settlement sat in the shadows of the city and formed a significant part of the slums of Red Bank and Strangeways, the latter of which was overlooked by the prominent and panoptical prison.[67] The main reason for moving to the slums was 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 indeed escaping pogroms and strife on the European continent, Sara informed me how many came 'not in need, but in preference, because tradings were good […] and Manchester was *the* area to be in the world, rivalling London' (original emphasis).

She paused to take a bite out of the bagels I prepared in advance of our interview one afternoon in December 2014 and gently reminded me of my privilege, 'you have been to university in Durham, you travel, to do that a hundred years ago was very, very, unusual.' With such close proximity to Victoria station, immigration meant the slums of Redbank and Strangeways became 'absolutely saturated with Jews and Jewish culture.'

The area was not exclusively Jewish, and the émigré settlement sat 'cheek by jowl' with the wider immigrant and 'indigenous' population that were just as financially marginalised — often leading to tense and hostile relations. The aspirations 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

[67] According to Monty 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.

Hightown. These areas, according to Sara, were home to 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 the rich and illustrious Jewish past that is explored in this chapter (and broader thesis) remains since the Jewish population began to gradually move into the leafier and more affluent districts to the north of the city. Traces of Hebrew inscriptions can 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 the area (see Figures 6 and 7).

Figure 6: Formerly the New Synagogue (consecrated 1889), now a South Asian business.
Photo credit: Ben Kasstan, September 2015.

Figure 7: A montage of the former Jewish Quarter.
A street named after the 'Torah' (Hebrew Bible), above. 'J. Cohen,' a previously Jewish-owned warehouse, below. Photo credit: Ben Kasstan, June 2015.

For Jews in England during the middle of the twentieth century and the immediate decades after, 'the big thing was to integrate, assimilate, and if you want to be Jewish [then] go to Israel' (Sara). The surge of the Haredim has since presented a historical counter-balance with this trajectory, as Jewish Manchester has changed in size, diversity, and intensity over recent generations. One of my interlocutors was Diane, who descends from a rabbinical lineage, and she told me that Jewish Manchester used to be smaller and tightly woven, resembling 'an area in Jerusalem called *bayit v'gan*[68] — it was just a garden in between the neighbours. Manchester was a little bit like that, everybody knew everybody.' Many locals were quick to

[68] Hebrew, literally 'house and garden.'

assert that the "community" had grown exponentially, and is now formed of a greater proportion of young families than it was in the past.

Changing dynamics in Manchester are most clearly associated with notably higher birth 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). Other influences include inward migration from London and international Jewish settlements, as well as those who form the 'nouveau *frum*'[69] (by becoming *halachically* observant[70] or becoming Jewish through *giyur*).[71] The anecdotal evidence and changes described by my research participants, as well as available data (see Valins 2003), would suggest that the growing prominence of the Haredim in Jewish Manchester reflects wider changes that are currently underway in the Jewish populations of the United States and Israel.

Oral histories indicate how shifting ideas of religious authenticity and internal fragmentation in Manchester were already developing by the mid to late twentieth century, which, according to Mrs Levy, was 'too awful for words' in what she described as an age of 'religious mania.'[72] The rise in numbers and plurality of Hassidish groups in the settlement is one example of these socio-religious changes in the Jewish social body over time, as my research participants told me. Whereas 'there were very, very, few Hassidim in Manchester years ago when my mother was a little girl,' now, 'even people who were not brought up Hassidish have taken on their ways and their garb for some reason' (Diane). Remarks such as these indicate how Haredi Judaism is a socio-religious *movement* that is responding to broader social processes, rather than being a static construction of religious 'extremism' or 'fundamentalism' (see Chapter One). Mrs Gellner, my neighbour at the time, made this clear by discussing how the settlement has become:

[69] Introduced during an interview with an Anglo-Orthodox woman, to describe Jews who have become more *halachically* observant than they were raised.
[70] *Baal teshuvah* (literally master of repentance).
[71] *Giyur* is taken from the root *l'ger*, meaning 'to sojourn.' Although *giyur* is often translated into English as 'conversion,' I prefer to avoid this conceptual reference. Judaism is not a proselyting religion but *giyurim* (pl.) are tolerated in Orthodox and Haredi Judaism.
[72] See MJM J162. Mrs Levy was born in 1893 and interviewed in 1977 (making her eighty-four at the time of recording), which would suggest that internal divisions were already occurring by the later decades of the twentieth century.

> More Haredi than it was twenty to thirty years ago and that's a *protection*. But I think we've probably gone more right[73] 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)

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 Mrs Gellner's claim that changes in the standard of religious observance is an antonymic shift in response to the increasing (and dangerous) strides that the non-Haredi world and national culture has taken towards the "left." Thus Haredi Judaism should be understood as sitting relationally (and as a continuous response) to broader political and socio-religious changes in the outside world.

The flux in which *frum* Jews have become more Haredi and protective against the external world over time may then differ from what is described as 'denominational switching' from one conceptualisation of Judaism to another.[74] As Orr (a Sephardi elder) 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 Orr, the Haredi expression of Judaism in Manchester and the vernacular construction of religious authenticity is then perceived to surpass the "extreme" of what public discourse otherwise regards as 'religious fundamentalism.'

The Jewish settlement in Manchester that Mrs Gellner described can be understood as a protective refuge and form of 'dissimilation,' 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 domination, integrity, and

[73] 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.'

[74] 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.

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.

James 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 a 'subject status' rather than a relationship with the state altogether, an argument which I use here to frame the experience of Haredi Jews in England.[75] 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 Four) can be grounded in a broader anthropological discourse of minority identity and positioning in relation to the state.

The historical quest for autonomy in Jewish Manchester (and increasing strides towards self-protection) 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).

As introduced in Chapter One, 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

[75] 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.

(such as the Sephardim, as I go on to discuss). Moreover, 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 resembles the immensely diverse, but similarly amalgamated, 'Malay world' (cf. Benjamin 2002). As Geoffrey Benjamin (2002: 8) has argued, we 'need to problematize the notion of community [...] to stop talking of the community as a unitary subject and to analyse axes of contestation within it.'

The term 'community' is often used to describe the Jewish social body, and is generally regarded in a positive light and is imagined as being a place of comfort and safety. A 'community' is, as Zygmunt Bauman describes, bound up in the imagination and 'is nowadays another name for paradise lost — but one 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. Conceptual references to 'community' have been problematised in the broader academic discourse of intra-group relations because of its 'mythic value,' which can — and does — give rise to a 'misplaced belief in "community" and the "participation" that goes with it' (Cannon et al. 2014: 93). Perhaps for this reason, Benedict Anderson has remarked that 'communities are to be distinguished, not by their falsity/genuineness, but by the style in which they are *imagined* (2006 [1983]: 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 thesis, 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.

Assimilation and integration

Immigration to Manchester had been increasing steadily around the time of the mid-nineteenth century through to the early twentieth century, much to the concern of the already established Jewish settlement. 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.' For others growing up in that time, the Jewish minority felt like an explicit target of prejudice and hostility. Louis Rich was one local who, in his oral history, recalled anti-Jewish hostility during the first half of the twentieth century as being apparently rife, 'and they used to treat these immigrants — these Jewish immigrants — like *we* treat the Pakistanis now and the Hindus, with contempt, disdain.'[76] 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, if not pathological, in medical discourse, and thus 'unworthy of being completely integrated into the social fabric of the modern state' (Gilman 1992: 223). Hostility towards the growing 'alien' Jewish minority in England tended to articulate the implications of immigration for the body of the nation. Prevailing stereotypes of Jews being weaker, sicklier, or biologically racialised were routinely mobilised in anti-'alien' discourse during the period of Jewish immigration to Britain (see Tananbaum 2015). Moreover, these representations featured prominently in twentieth century concerns of 'national eugenics' and the consequences of immigration.

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 hygiene 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 or subject status:

[76] MJM J273 (emphasis added). I italicise 'we' here as points to a broader and enduring prejudice held by the Jewish minority towards Muslims in the area, an issue that I return to later in this chapter.

> 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)

However claims that Jews were inferior compared with the 'native standard of fitness' were challenged 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).[77] 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 (see Chapter Five).

A regime of assimilation and Anglicisation was imposed by the established Jewish elite in the major English settlements and targeted the 'foreign' customs of the émigré Jews. The intention was to forge a syncretic Jewish and British identity, whilst being cautious of 'marrying out'[78] 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.

[77] William Moses Feldman was a leading Jewish physician of Russian origin (See Rubinstein, Jolles, and Rubinstein 2011: 271).
[78] This is a common expression among Jews in England for marrying a non-Jewish partner.

Jewish Manchester was no exception to having a pro-Anglicisation agenda for 'foreign' 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. Interventions were therefore seen as necessary to maintain the standing of the elite Jewish class, which 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). Jewish institutions that could liaise with the statutory authorities also developed out of the inability of the Poor Law Amendment Act (1834)[79] to meet the needs of this ethno-religious minority group, but also the aforementioned fact that the elite were reluctant to have poor Jews resorting to tax-funded welfare resources (see Heggie 2015; Jones 2001 [1977]; Williams 1985). The establishment of the Jewish Board of Guardians for the Relief of the Jewish Poor[80] in 1867 (henceforth 'the Board') was exemplary of this. It 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.[81]

The Board not only gave rise to an authoritative and representational communal body to provide welfare services, 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 were aimed at maintaining a positive public image of the Jewish minority. Moreover, the Board's assimilatory strategy also traversed the broader

[79] 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 were suspicious that the poor could then 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 arguably punitive environment of a 'workhouse,' where basic accommodation was available in exchange for manual labour (National Archives n.d. B). 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 (see Davey Smith, Dorling, and Shaw 2001).

[80] Replicated the Board that was instituted in London, which was itself created in response to amendments made to the 1834 Poor Law.

[81] 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 social welfare organisations that were ran internally.

settlement, such as Jewish schools, to enforce blanket immunisation policies (Chapter Six).

It is important to note that Manchester at this time was an industrial powerhouse but also home to some of country's most overcrowded, squalid, and insanitary living conditions. 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 (MoSI 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 (see Chapter Four).

By 1873–1875, up to ninety-five per cent of Jews requesting financial relief from the settled Jewish constituency and its welfare infrastructure were 'Foreigners,' with the remaining five per cent being the 'Native Jewish Population.'[82] Using the term 'native' to describe 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 area,[83] yet attempted to *present* Jewish immigration positively by claiming it 'has not injuriously, but on the contrary, has beneficially affected Manchester.'[84] 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 the reproducing the body of the nation.

Responses to assimilatory pressures

Jewish observance during the nineteenth and twentieth centuries was not a period of greater authenticity and uniformity; denominational, ideological, or social

[82] See Manchester Jewish Board of Guardians for the Relief of the Jewish poor (M182/3/1: 1873–1874, 1874–1875).
[83] M182/3/1:1869–1870.
[84] M182/3/3: 1890–1891.

differences were a feature of life for Jews in the North West as elsewhere. Manchester has historically had great diversity and plurality in its Jewish topography, including a Reform synagogue following its highly controversial split from local Orthodoxy in 1856 (as well as the Zionist movement which emerged at the end of the nineteenth century). Attempts to assimilate the 'foreign' and Haredi Jews were not always met submissively because of these opposing constructions of Judaism and religious observance.

Many of the émigrés during the nineteenth and early twentieth centuries were indeed strictly observant (see 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 *shtiebels*[85] rather than join what they viewed as the 'English *shul*' (synagogue) — which was primarily used by the Anglicised and integrated Jewish class.[86] The smaller and exclusive *chevrot*[87] 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 (see Williams 2011: 218–219; also Wise 2007; Dobkin 1994). In developing their own relief and welfare programmes, such as the Russian-Jewish Benevolent Society,[88] pious émigré Jewish groups consciously sought 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' (cf. Scott 2009) from both the state and the wider Jewish social body. Moreover, the historical pursuit of 'dissimilation' is continuous with the Haredi context of present day Manchester, which I discuss later in this chapter, and exemplifies the recurrence of internal fragmentation and the preference for some Jews to maintain degrees of autonomy

[85] Small room used for prayer. These were usually comprised of ethnic sub-groups, such as Polish or Russian Jews.
[86] 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).
[87] Society, *chevra* (sing.), *chevrot* (pl.).
[88] The name of the 'Russian-Jewish Benevolent Society,' established in 1905, would imply this fund was established by émigré Jews.

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 has many 'types,' 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 then 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 (see Chapter Four).

Times of economic depression were recurring and 'brought the horrors of unemployment to thousands of working class homes,'[89] 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'[90] through its relief. 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' in 1875 regarded the majority of foreign people living on alms as 'idle and worthless.'[91] 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).[92] 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 established Jewish industries, instead '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 [emphasis added]). Whilst taking employment within the Jewish Quarter (and for Jewish employers) enabled cultural distance with non-Jews to be maintained, accommodating religious requirements was not always the case as many Jewish

[89] M151/4/12: 1895
[90] M182/3/1: 1871–1872
[91] M294/2 (emphasis added). 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 decide who was 'deserving' of financial and material help, synagogues would tend not to refuse 'the kind of temporary financial assistance which the society "avoided as much as possible"' (Williams 1985: 157).
[92] 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.'

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 restricted to the local and seasonal trades of waterproofing and garment making, men could be in a situation where one is 'very busy all winter, and idle, or what was rather pitifully called "you played all summer."'[93] 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.'[94] The most vulnerable would then lean on the services and resources of the Jewish establishment and the Board in the formative years of the twentieth century.[95] The cyclical nature of 'boom and bust' in the local trading continued to profoundly affect health right through to the twentieth century, as, for instance, reported levels of illness and disease almost doubled between 1903–1904 and 1904–1905.[96] In contrast, non-communicable diseases such as diabetes was noted, at the same time, to be more prevalent 'among the better classes' of Jews who lived in the more affluent districts.[97]

Despite the realities of destitution, the slums generally offered a sense of camaraderie for the immigrant Jews and were, in some cases, a preferable place to live compared with the suburbs[98] — perhaps because of the majority Jewish population and the potential security this could have offered. Many émigrés from Tsarist Russia could attest to 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 anti-Jewish attacks by Christians,[99] so a preference for living in a densely populated Jewish area is not surprising.

In her oral history, Dina McCormack 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

[93] MJM J143.
[94] MJM J279.
[95] See, for example, M182/3/4: 1904–1905; M151/4/2: Manchester Jewish Soup Kitchen.
[96] See M182/3/4: 1904–1905.
[97] M182/3/4: 1905–1906.
[98] See MJM J279.
[99] MJM J279; G25/3/6/8: 1909.

any food and hundreds lived like me.'[100] In the shadows of the Strangeways prison sat a Jewish soup kitchen 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' (see Figures 8 and 9).[101] 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 who lived close-by or attended the same schools.

The stigma attached to using a Jewish soup kitchen, and 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.'[102] As an elder, Dina recalled 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. As she said, '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?'[103] 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 Strangeways and Red Bank were generally disregarded as 'a horrible, dirty, miserable place'[104] by the 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).[105]

[100] MJM J279. Dina was born in 1909, and interviewed in 1980.
[101] M151/4/2.
[102] MJM J279.
[103] MJM J279.
[104] See MJM J162.
[105] Emphasis in original. Steffan Ecks and William Sax (2006: 208) argue that that marginality is a construction of society and social hierarchy, and a practice that 'people do to each other.'

Figure 8: 'A view outside the Manchester Jewish Soup Kitchen,' Philanthropic Hall.
Credit: M151/4/2. Undated.

Figure 9: Street view.
To the left is the former Philanthropic Hall (housing the Jewish Soup Kitchen) on Southall Street, inaugurated in the Hebrew year 5666 (1906). To the right is Strangeways Prison (HM Prison Manchester). Photo credit: Ben Kasstan, June 2016.

When I visited the Manchester Jewish Museum, a guide 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' (Sara). However, *Shabbat* (or *Shabbos*) was, for many Jews employed in trades, a working day by virtue of the necessity to earn a living. Working on *Shabbat* was often a difficult and morally-challenging decision that testifies to the pressure of integration at the time, and some oral histories in the archives reported how Jewish employers would finish for *Shabbat* whilst expecting their employees to continue working (see also Williams 1979). However, some individuals acted as 'defenders of the faith' by policing and reprimanding those who did not uphold religious obligations such as *Shabbat* observance by working.[106] Rather than being positioned as apostates, the conditions and pressures facing families in the slums meant that *Shabbat* observance took less precedence.

Dina McCormack, for instance, would recall her mother say 'God understands I'm poor, and when I'm rich, I'll keep *Shabbos* like the rich do, but when I go to work all week, I've got to do my cooking on *Shabbos* morning.'[107] The inability to observe *Shabbat* was 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. Working on *Shabbat* was, as Bill Williams has argued, 'a painful concession to the necessity of survival in England' (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. One participant described there being 'fifty shades of grey here,' which indicated how the Haredi settlement today has much more diversity than the uniform black and white garments that are worn 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

[106] See MJM J279; MJM J229; Golding 1932. In some instances the Jewish establishment had negotiated for Jews to be exempt from working on Saturdays providing that they attended synagogue.
[107] MJM J279.

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).[108] The 'ultra-Orthodox Jewish community' should then be understood as an imagined and etic category that obscures internal dynamics and fragmentations.

When meeting Haredi locals over the course of my fieldwork, they would usually describe Jewish Manchester as a 'friendly community' — and the fabric of society appeared rich and tightly woven (for those positioned as being on the 'inside'). 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 *mishloach manot*,[109] 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.

However, *Purim* occurs just once a year, and the ethnographic research and interviews unravelled 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 as[110] — 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

[108] Whilst Oliver 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.

[109] Gifts of food that are given to friends and family on *Purim.*

[110] 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.'

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 *hashkafot* (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 (Orr).[111]

Mrs Gellner, who married into an established Manchester family, described the basic standard of being an Orthodox Jew as observing the laws of *Shabbat* and *Kashrut*. 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 Orr, 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 other Haredi strongholds in London.

Outside the social body: The Sephardim

In her oral history, Dina 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 a clear ethno-religious gradient amongst its diverse population. She said, 'there was the German Jews that looked down on everybody — and the Austrian Jews — they looked down on the Russian Jews and the Romanians Jews and the Polish Jews.'[112] Louis Rich also recalled in his oral history how Jewish Manchester was divided into 'clans,' but that

[111] Orr'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 Chapter One.
[112] MJM J279.

there was also a common 'Other' and point of difference, as he said, 'then there were the outsiders: the Sephardic Jews.'[113]

The Sephardim had generally settled in Manchester around 1845 to engage in trade (before the period of mass Ashkenazi immigration), arriving from what are now Syria, Iraq, and Turkey. 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 (see Rollins 2016).[114] Sephardi Jews did live in proximity to the slums and factories, but many were cotton merchants rather than being the 'foreign poor.' By virtue of their relatively privileged marginality,[115] one could argue that Sephardi Jews were just as 'alien' to the Eastern European émigrés as the local non-Jewish population. Mrs Black claimed (in her oral history) 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.[116]

Animosity between Sephardi and Ashkenazi Jews manifested in resistance to inter-marriage and separate synagogues were maintained. 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 the affluent area of South Manchester (see 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 their Ashkenazi brethren.

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[113] MJM J273.
[114] Central to the festival of *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.'
[115] I borrow and adapt the concept of privileged marginality from James Faubion (1993: 191), who describes 'distinguished women, distinguished "homosexuals," distinguished "provincials" who belong to the Greek intelligentsia' as 'privileged marginal.'
[116] MJM J153.

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 synagogues that were either Iberian or Moroccan in *nusachaot*,[117] or, as was more commonly the case amongst Haredi circles, families assimilated into the dominant Ashkenazi and Litvish population. In a discussion with Orr, he 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 a Haredi worldview. For Sephardi Jews to be accepted amongst the *frum* circles, Orr 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, apparently '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). Orthodox and Haredi 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*[118] were perceived to be more *kosher* and authoritative than others.

Whereas *Kedassiah* (one of the most stringent authorities) was viewed as an acceptable *hechsher* amongst some Hassidish circles, 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 some (Ashkenazi) Haredi mothers. *Kosher* was then something of a relative term

[117] Hebrew, styles of prayer (pl.). Sephardi synagogues tend to be divided by "ethnic" background, such as Iberian, Moroccan, Yemenite etc.
[118] 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.

as families aligned to different sub-groups or worldviews might not eat or "break bread" together — thus fortifying intra-group boundaries and divisions.

A protective 'world within a world'

Although described as 'provincial' by individuals who had relocated from other constituencies, Jewish Manchester has a range of Haredi-led institutions, enterprises, and services that are designed to support and sustain its growing settlement. The local infrastructure in Jewish Manchester reinforces its reputation as an affordable and alternative centre of Jewish life compared with London, which apparently makes it an 'easier' place to live. In 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. As Rabbi Kaplan told me:

> You have to realise that the Jewish community is a self-sustaining community, here nearly, and in London even more, but somebody wouldn't have to go out and buy something from a non-Jewish shop in his whole life. That means he has a local Jewish dry cleaner, a local Jewish bakery, a local Jewish grocer. That all provides local business. There are clothes shops, what local Jewish people want to wear.

The internal services that help to create a 'self-sustaining' settlement also has the result of *protecting* Haredi Jews from the need to encounter the outside world in areas of quotidian life. The Haredi strategy of self-sufficiency was made clear during an interview with Sara, a volunteer-guide at the Manchester Jewish Museum:

> BK: How would you describe the Orthodox and Haredi population?
>
> Sara: I would call it self-sufficient, 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)

It can then be inferred that the allegedly self-insulating stance of the Haredi cosmology and fortification of the settlement is a conscious strategy of resilience, but is also an aspiration that has not been fully achieved. Social conducts that the non-Haredi world incorrectly interpret as being offensive are, I was told, in fact

defensiveness on the part of the Haredim. As a key Hassidish figure who is an integral part of the Haredi institutional landscape made clear, 'I'm hoping what I've said to you is that I'm talking about communities trying to cope but on the other hand, it's a community that is vulnerable.' It might then be inferred that the social body is attempting to cope, but self-protection from external pressures can consequently leave it vulnerable to internal pressures (see Chapter Four).

The extent to which Jewish Manchester is self-containing and protective, Mrs Rubin 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 self-sufficient nature of the settlement means that Haredi Jews can make a choice and negotiate the extent to which they engage with the 'outside.' The doctrine and stringent practice of dogma that defines the Haredi cosmology (which was regularly criticised in the mainstream news during the field-work) is considered 'oppressive, but the care is immense' (Mrs Rubin). Intra-group care is described as forming part of the religious obligation of *tzedakah* and is an enormous advantage to the Haredi lifeworld, which also increases the autonomy of the settlement.

Mrs Rubin 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,' in ways that echo the systems of mutual support in the nineteenth and early twentieth centuries. Internal strategies to alleviate socioeconomic stress then create a position where the Haredi minority might be called 'privileged marginals' (cf. Faubion 1993: 191) when viewed in relation to the area's socioeconomically deprived and minority groups 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 the state. These took the form of remarkable

intra-group services as well as *gemachim*,[119] which are dedicated forms of *chesed* (kindness), and were made available to any Jewish person in the settlement — thus cutting across Orthodox and Haredi divisions. The services perform a unique role in catering to the needs of the religious constituency for whom outside agencies that are viewed as non-Jewish or not *frum* would be considered as culturally inappropriate. These include therapists, a swimming pool, special educational needs facilities, a family and children's centre, a financial advisor, a service to absorb new arrivals, and hospital visitation groups. 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 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* to support vulnerable and deprived Jewish locals. According to one Hassidish authority, 'the amount of good, of care, that is built into our community lifestyle is actually a tremendous assistance to the health service.'[120] Moreover, studies conducted in the London Borough of Hackney have shown that *gemachim* for infant and children provisions are particularly significant, reflecting the staggering number of Jewish families receiving government child benefits in the area (see Abramson, Graham, and Boyd 2011). Intra-group and government welfare provisions are then 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. Cited as anecdotal, or evidence by 'deduction,' there is allegedly a strategy where 'what is declared is certainly not income that is actually earned in one year' (Mrs Rubin). Mrs Rubin based her judgment on the reasoning

[119] Hebrew; an abbreviation of *gemilut chassadim*, acts of kindness.
[120] See also Chapter Five, where I discuss how a Haredi culture of maternity care attempts to meet the limitations of NHS maternity services rather than replace them altogether.

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, the higher cost of *kosher* food, and religious events. 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.' Moreover, the informal economy described by Mrs Rubin apparently allows for flexibility when attempting to meet the expectations and stringencies of a Haredi lifestyle, such as parents offering services to supplement, or in place of, private school and *cheder*[121] fees.

Similar to Jewish constituencies in London (see Gonen 2006), an authoritative and dedicated body have been instituted in Jewish Manchester to support Haredi locals to navigate the British welfare system. Some non-Haredi research participants were quick to portray the 'frummies'[122] as fraudulently abusing the benefit system, but government support was conversely described as being an imperative medium in which Haredi women could fulfil the *halachic* demands that fall within their domestic domain. As one Hassidish *rebbetzin* claimed, welfare benefits were an essential 'need [for women] to be able to serve *HaShem*[123] by running their homes.'

Indicators of poverty that are applied to the non-Jewish population are therefore not suitable for 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 Rubin 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.'

[121] Hebrew; room. School and method of teaching *kodesh* (religion), Yiddish, and Biblical Hebrew.
[122] 'Frummies' (also frummers) is a pejorative play on the word '*frum*' (pious), and was used by less observant Jews to describe their Orthodox and Haredi co-religionists.
[123] Hebrew, the name. Used by pious Jews in place of 'God' or more formal references such as 'Adonai.'

'Hashkafic contamination'

Protection from socially constructed contagions was not only pursued against the external world, but also within the settlement. When I joined Hadassah (a Haredi mother) and her children for dinner one evening she recounted an incident that occurred in the secondary school that her twelve-year old son attends, which serves the Haredi population (but retains a state-aided status). She expressed her horror that a pupil had tagged a classroom locker with 'Rabbi Black wanked here,' as onanism constitutes a grave *aveirah* (transgression or sin) in the Judaic cosmology. Hadassah viewed her son's exposure to this language and sinful act as a consequence of the secondary school bringing together children from two very different state-aided 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, Hadassah 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 Hadassah and many other Orthodox and Haredi 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 *hashkafot*[124] or worldviews into contact, which could consequently threaten standards of religious observance (or interpretations of religious authenticity).

Hadassah 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.' Here, the issue of '*hashkofic* contamination' — as one participant regarded it — is much greater because modern Orthodox Jews still define themselves as religiously observant, yet they may have a wildly different

[124] Worldviews or outlooks (also *hashkofos*), pl. *Hashkofah* (also *hashkafah*), sing.

hashkafah and apply different stringencies to *halachah* than their *frum* or Haredi counterparts, so the boundaries effectively become more blurred. 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 [2004]).

Dror was one participant who had transitioned his children from a 'black'[125] expression of Judaism and attendance at a private Haredi school to a state-aided Jewish school that was more modern Orthodox and Zionist in its outlook. 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 *hashkofah* 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 it being an issue confined to the 'extremities' of Jewish Orthodoxy. 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 *hashkafot*:

> 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*[126] 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.' Protection extended to avoiding the use of a local organisation that claims to be 'cross-

[125] 'Black' was commonly used in the field-site as being Haredi, religiously right-wing, or '*shtark*' (strict).
[126] 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* takes a publically 'anti-Zionist' position.

community,' also serving the local non-Jewish population, and has an agenda to bridge informal Jewish and Zionist education with sports and social activities. 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 space (such as 'different homes' or the physical 'outside world'), but more related to the worldviews that underpin different interpretations of the Judaic cosmology and the unwelcome or unanticipated 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 and 'God-fearing' mothers. 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 [1966]: 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 [2002]).

Mrs Burshtein's quotation alludes to the possibility that childhood physical activity provisions in the 'community' also bring unwanted and uncontrollable exposure to both other Jewish modalities and customs, and potentially also 'body cultures.' For *yeshivah* students, the Haredi body is an artefact in which any slight change in appearance or conduct of the Haredi body is scrutinised as being indicative of religious transgressions, which would present serious consequences for the moral order (see Hakak 2009). There is then an institutional resistance to exercise, which is

portrayed as a 'gentile custom' (see Hakak 2009), which positions the body as a margin that must be fortified.[127]

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 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 there was no normative experience of inter-group relations during the nineteenth and early twentieth centuries. Louise Dawson lived in a predominantly Jewish neighbourhood as a child, and in her oral history recalled how her mother would not receive Jewish children in the house and instead they would often play together in the street.[128] The same could be said in reverse, as Jewish neighbours would remark to Dina McCormack's mother, 'fancy letting a Christian into the house.'[129] Some oral histories indeed positioned anti-Semitism as being largely confined to childhood, but despite the fact that Jewish and non-Jewish neighbours were, to an extent, cordial they actually 'mixed very little.'[130] It is my interpretation that the Jewish slums shared 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.[131]

One notable testimony to Jewish and non-Jewish relations during the 'crowded' years of the early twentieth century is the literary masterpiece 'Magnolia Street,' written by Louis Golding (1932) and inspired by his formative years in Jewish

[127] It is important to note that Hakak (2009) describes this in the context of Israel where the Haredi men are cast against a large secular Jewish population and a social expectation to join the Israeli Defense Forces, an institution which cultivates a specific corporeal ideal of the 'chosen body' (see also Weiss 2002).
[128] MJM J76. Louise was born in 1892.
[129] MJM J279.
[130] MJM J74.
[131] MJM J160.

Manchester. Set between the two world wars, it charts the lifeworld of Manchester's past Jewish Quarter by narrating the encounters between the Jewish and non-Jewish sides of Magnolia Street and the relationships that flowed or festered between the odd and even numbers of the road. As Golding wrote, 'there was something symbolic about that crossing of the road' (1932: 47), with the cobbles concealing and confessing the complexities of inter-group relations, from the anti-Semitic taunts to the clandestine and illicit love affairs.

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 Four). Archival evidence also exposes how the Jewish settlement supported non-Jews in broader areas of life, such as the aforementioned Jewish soup kitchen[132] but also maternal and infant care services (see Chapter Five). 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 Five).[133]

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 attest how the settlement cannot be completely self-contained and cut-off from the external world. Although previous studies describe Haredi Jews in Israel as preferring to 'voluntarily live in sort of ghettos' (cf. Aran, Stadler, and Ben-Ari 2008: 32), the historical-baggage associated with this term and the (forced) isolation it implies can conceal the complex way in which non-Jews (and non-Jewish cosmologies) nonetheless overlap with and cut into Jewish Manchester.

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[132] 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' (or non-Jewish) neighbours were handed to 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.

[133] The current preference to provide maternity care only to Jewish women, as I discuss in Chapter Five, is arguably part of a broader strategy of self-insulation 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.

The local non-Jewish population are often regarded under the collective term '*goyim,*' but are diverse and formed of "indigenous" Mancunians,[134] Polish and East European economic migrants, as well as Muslims of South Asian and Middle-Eastern origin. Whereas women from the Mancunian and especially East European neighbourhoods typically service the needs of middle class or *balabotish*[135] Orthodox and Haredi families in the form of domestic work,[136] the Muslim population are viewed with suspicion and avoided.

Anti-Semitism is often discussed as being on the rise in the UK, and residents of Jewish Manchester had complained that 'you do feel it is more acceptable to be anti-Semitic 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, which occurred consistently during the field-research, as mentioned in Chapter One. The rise in anti-Semitism experienced over the summer of 2014 (following the Israel–Gaza strife) as well as the more general fear of being 'outnumbered' by Muslims, was particularly threatening for Susan, who came from London when she married a man from a Manchester family. On one occasion we met for coffee in an area that was once previously in the heart of the former Jewish Quarter, but is now largely populated by Muslim and South Asian migrant families. She walked towards me and announced, 'it's like Gaza City in here,' before sitting down to our interview.

Susan made this reference to the Muslim social body that surrounded us rather than the physical structure of the café or the environment, which is a well-known brand in the UK. 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 settlement (in what was the former Jewish Quarter) — evokes Susan's comparison with Gaza.[137] The prominent shopping area in question, with a large Tesco supermarket, was just a stone's throw away from Jewish neighbourhoods, but I was

[134] Demonym of (and colloquial reference to) somebody originating from Manchester.
[135] Yiddish (also *balabatish*), middle-class, respectable, good-standing.
[136] Referred to in the Yiddish-derivative of *goytah* amongst Hassidish circles.
[137] Gaza has been described in anthropological studies as a 'collective prison under the embargo imposed by [Israel]' (Kosmatopoulos 2010: 29), and is thus physically, politically, and ethno-religiously contained.

told that a lot of Orthodox and Haredi people 'would not visit full stop, even to Tesco' despite its array of *kosher* goods.

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).[138] Susan likened the café as 'Gaza City' by pointing out the Muslim clientele 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]). Frederik 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 émigré and Haredi Jewish settlements to establish varying degrees of self-sufficiency, 'dissimilation' and, increasingly, protection. However, this does not mean that the Jews of Manchester constitute a homogenous 'community' — an *imagined*[139] category that bears little relation to the lived realities of internal marginality experienced by some émigré and Haredi Jews. 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.

[138] Erikson'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.
[139] Cf. Anderson (2006 [1983]).

The aspiration for self-sufficiency and self-protection from the external world illustrates how minority groups can negotiate citizenship or 'subject status'[140] as well challenge the ways in which they are incorporated within the body of the nation. Duncan McCargo (2011) has argued how gradations or 'graduated' positionalities in relation to the state occurs 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. 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 state) 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 extent to which they integrate (or do not) into UK society (cf. Staetsky and Boyd 2015). Services that are instituted by the broader Jewish (and pro-Zionist) population in Manchester can bring exposure to 'stuff' that is viewed as dangerous and threatening to authoritative interpretations of the Judaic cosmology. The mainstream and integrated Jews in England might position themselves as being further along the scale of graduated citizenship than their Haredi co-religionists.

Haredi Judaism should therefore be understood as sitting 'relationally and positionally'[141] to the outside world, and continuously responding to political and socio-religious shifts in the state and national culture. Maintaining a graded relation

[140] Cf. Scott (2009).

[141] 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.'

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 'dissimilation,' graded protection, and *immunity* in the Haredi context serves as the point of departure for Chapter Four, where I critique the 'hard to reach' label that appears routinely 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'[142] 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 subsequent chapter addresses the broader aim and theoretical crux of this thesis, which is to understand how responses to healthcare and the public health authority can be most appropriately framed.

[142] See Tsing 1993: 18, who describes marginality as both a 'source of both constraint and creativity.'

Chapter Four

Disentangling culture, faith, and health

The juxtaposition of archival and ethnographic material in this chapter articulates the continuous and complex entanglement of culture, faith, and health over time — which is inadequately described by the representation of an 'ultra-Orthodox Jewish community' being 'hard to reach' in current public health discourse. An overarching aim of this chapter is to contrast the representation of Haredi Jews as a 'hard to reach' minority (which implies a preference to evade mainstream healthcare services) with the local perceptions of health and bodily care in Jewish Manchester. Health surveillance emerges as a recurring technique of assimilating and 'saving' émigré, and now Haredi, Jews in Manchester, but these attempts often fail to understand how health and bodily care is situated in the Judaic cosmology.

The development of a Jewish medical culture in Manchester was entrenched in a broader struggle of insulation and integration for émigrés during the nineteenth and early twentieth centuries, as introduced in the previous chapter. Ethnographic material is then mobilised to offer a comparative account of how a Haredi culture of health performs a critical role in negotiating how the social body is exposed to — and incorporated within — mainstream biomedical services. Using the examples of rapid response services and primary care, I position 'culturally specific care' within a broader preference for self-protection and autonomy, the achievement of which presents specific benefits for the group and their struggle to maintain *immunity* over the social body.

Health and healthcare is presented as a contested area of bodily governance between the minority and state because it was previously, and remains, one of the few points in which Haredi and non-Jewish people engage with *each other*. The discussion 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 biomedicine is often synonymous with underserved minority populations who are the intended beneficiaries (read: targets) of public health and biomedical 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. The latter population are similar to the Haredim in that they form a composite collective, and have a historical preference of dissimilation in order to preserve their lifeworld (not least because of persecution from state authorities), but this does not necessarily equate with wanting to be excluded from mainstream healthcare services (see Perez 1995: 116).

The 'Gypsy' minority in England, like in the Haredi Jewish context, have experienced rampant marginalisation in public discourse and explicit racialisation over time (see Buckler 2007; Okely 1983, 2014; Perez 1995), and current mistrust against the outside world and authorities (including public health) can only be understood against this backdrop.[143] 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 Six), but ignores 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 an attempt to 'create and to defend their own identities and "purified communities"' (Valins 2003: 160). Being within 'reach' of the biomedical authority

[143] Forthcoming research is countering the claim that Gypsies and Travellers are 'hard to reach,' instead suggesting how uptake of health services might be contextualised within a historically persistent narrative of marginalisation and assimilative strategies (see Forster et al. 2015).

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 theoretical critique of evading a 'subject status' (cf. Scott 2009) 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 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 for the Haredi settlement's sustenance, such as welfare benefits and healthcare, and thus necessitate a graduated relationship as citizens (see Chapter Three). Whereas my participants described the Haredi settlement in Manchester as being 'self-sufficient' and 'self-sustaining,' I interpret this as self-protection because 'dissimilation' is vital for the *immunity* (and continuity) of the Haredi lifeworld.

The representation of being 'hard to reach' provoked conflicting responses from my research participants in Manchester. Whilst the status reflected the self-protective nature of Haredi Judaism for one local, another Haredi mother felt unease about being categorised as 'hard to reach' and exclaimed 'it makes us sound like hippies or something' (Mrs Birenbaum). Her reaction was clearly one of surprise, and perhaps Mrs Birenbaum took exception to the Haredim being amalgamated with other historically marginalised or 'counter-culture' groups — when each should be understood in their own historical, political, and cosmological context. Moreover, 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 emic 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 (see Fassin 2004; Parker and Harper 2005), and I argue how

— despite being positioned as hard to reach — Haredi populations can have complex and coexisting strategies of practicing health. Public health, Didier 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]). However, the Haredi context illustrates how biomedicine, as a culture, is acted upon in order 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 understand the expectations of the other.

The mutual fault to grasp how health and bodily care is constructed in the biomedical and Judaic cosmologies questions how responses to (or 'non-compliance' with) healthcare services should be conceptualised. Rather than being interpreted as resistance per se, 'refusal' can instead illustrate how responses arise out of social and political relations, and 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; see also Sobo 2016). Carole McGranahan (2016: 320) has argued that 'refusal marks the point of a limit having been reached,' and thus, in the Haredi context, refusal takes the form of a protective *reaction* that occurs at the margin where the threat of contagion is located (cf. Esposito 2015 [2002]).

Culturally *specific* care[144] 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 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

[144] 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).

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 has enjoyed a prominent place in public health discourse as of late, and tailoring areas of healthcare to meet the needs of minority groups has been viewed as a potential solution to underutilisation or low coverage of biomedical services (see Shaw 2005). Culturally specific care in the Haredi context illustrates how health conducts are not considered in isolation but rather as part of a cosmology or worldview, but also how minority groups can attempt to reinforce their preference for autonomy and self-protection through the management of healthcare services.

The relation of culture and faith to healthcare services recently became the focus of two editions of The Lancet,[145] as cosmological conflicts between religious and scientific traditions remain — despite radical progress in biomedical practice over recent years (see Beyrer 2015). The 2014 Commission on 'culture and health' was the first of these two Lancet editions, and claimed that 'the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide' (Napier et al. 2014: 1610). One proposed resolution is the issue of 'cultural competency,' argued to be a fundamental part of developing a 'more responsive (and responsible) clinical culture' (Napier et al. 2014: 1614). Upholding 'cultural competency' as a tenet of clinical practice can be interpreted as the biomedical authority attempting to reconcile its dominance onto the cosmologies that govern the bodies of patients. Moreover, the growing emphasis of 'cultural-competency' in public health and biomedical discourse should then be viewed as furthering past debates concerning the place of medical anthropology *in* clinical medicine and framing how healthcare should be appropriately delivered in order to be most 'effective' (cf. Hemmings 2005; Shand 2005).

[145] 'Culture and health' (Napier et al. 2014); 'Faith-based health-care' (see Summerskill and Horton 2015).

Faith and religious traditions provide individuals and social groups with a worldview and order within which heath conducts may be grounded, but considerations of faith have, so far, been poorly integrated within public health strategies and protocols (see Karam et al. 2015). The 2015 faith and health series of articles was authored by a consortium of public health consultants, physicians as well as social scientists, but they arguably did not deconstruct the power imbalances involved in what was described as the 'faith based delivery of science-based care' (such as Summerskill and Horton 2015). One example was the explicit call by Andrew Tomkins and colleagues for religious and spiritual leaders to:

> Review their interpretation of sacred texts carefully in view of contemporary biomedicine, especially when differing viewpoints are held within the same religion. Analysis of the interaction between culture, politics, and faith is particularly important so that faith leaders and faith faculties can become more aware of how their faith-based viewpoints might become *manipulated*. (2015: 7 [emphasis added])

The above expectation for faith leaders to distort or 'doctor' religious teachings for the benefit of biomedicine requires critical engagement as it positions people as problems rather than 'agents of health' in their own right (cf. Biehl and Petryna 2013: 11). The prevailing rhetoric used by public health is arguably not conducive to improving trust and confidence between state institutions and minority groups, who should ultimately be 'partners in health'[146] in order for preventive health campaigns to be viewed as more acceptable. In positioning scientific knowledge as unequivocal and absolute it is, in turn, the religious mandates that must prove flexible and attentive to the needs of biomedicine. The (in)compatibility of religious and biomedical authorities therefore rests on the former's pliability rather than the latter's ability to adapt and tailor its 'reach' to all bodies within its jurisdiction. The entanglement of cosmology and health in the case of Jewish Manchester is illustrated by the demand for culturally specific care among émigré Jews and now Haredim, and demonstrates the ways in which biomedical hegemony can be negotiated at the conceptual margins of the state.

[146] Term borrowed from the organisation co-founded by physician and anthropologist Paul Farmer.

The Haredi context demonstrates that the preference for culturally specific (or negotiated) 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 meet their heightened expectations of healthcare services and supplement 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 body rescue and recovery services that are discussed in this chapter, exemplify attempts to bridge 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.

Historical medical cultures

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

Only a remnant of the MVMJH remains since it was enveloped into the newly established National Health Service in 1948 and later disbanded in the 1980s. 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 was, however, an object of dissent and staunch opposition between the aforementioned Anglicised elite and émigré (along with the upwardly mobile and aspiring middle class) Jews in Manchester (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. The historical issues encountered by émigré Jews are entrenched in a broader anthropological study of assimilating difference as an attempt by the state to protect the body of the nation and the way in which it is reproduced.

Conversion and assimilation as a Christian medical 'mission'

Free medical services and pharmaceuticals were seized by evangelical Christian groups as a strategic opportunity to convert Jews — who were regarded as 'the foreigner in our midst'[147] — into the Christian religion, and demonstrates the broader context in which émigré Jews were viewed as a target for assimilation. Previous studies have demonstrated how Christian medical missionaries in London's East End targeted Jews needing 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 (see Chapter Three) meant that the Jewish slums were in reach of Christian medical missionaries, who took great pride in the fact that

[147] G25/3/6/6: 1906, 'the foreigner in our midst may be a Russian, German, or even Turkish Jew.'

'not a week goes without some conversions.'[148] 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.'[149] Rather than missionary medicine being a model of medical pluralism, 'double healing' was the provision of medical diagnoses and treatment for the body, alongside conversion to Christianity in order to 'heal' the soul. Whereas anthropological discourse positions missionary medicine as being a feature of the colonial world in which the saving of souls and curing of bodies were inextricably linked (Lock and Nguyen 2010: 162), missions also formed part of a broader strategy of 'internal colonialism'[150] to assimilate difference. Christian missionary medicine in Manchester can then be viewed as an attempt to overcome the bodies (and souls) that constituted the margins of the state.

However, it has been previously claimed that 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 the émigré and 'foreign Jewish poor,' as the mission had a large pool of Yiddish literature at their disposal for the attempted conversion of local Jews.[151]

The perceptions of the émigré Jews held by evangelical Christians can also be gleaned from the annual reports. These records indicate a sense of protest against the reluctance of Jews to convert to Christianity, despite (apparently) not having a thorough understanding of Judaic texts and teachings, as 'most of whom know what a New Testament [Christian Bible] is by unfavourable contrast with their cherished

[148] 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.
[149] See G25/3/6/2: 1902
[150] 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.
[151] G25/3/6/2: 1902, tracts in Yiddish were provided (possibly gratuitously) by 'The Religious Tract Society.'

but *unread* Old Testament [Hebrew Bible]' (emphasis added).[152] The acquaintance with Christianity on the part of émigré Jews might, however, be attributed to the fact that a large proportion of them were fleeing violent pogroms and anti-Jewish persecution sparked by Christians at the time.[153] By 1909 the Christian medical missionary in Manchester had boasted an almost record number of 12,000 attendances, approximately four thousand of which were Jews, therefore demonstrating how a sizeable number of the Jewish settlement (then estimated to number some 28,000) had been 'reached' through their mission.[154] Thus medicine was mobilised by evangelical Christians as a vehicle to "de-marginalise"[155] Jews, physically and spiritually, and demonstrates how healthcare performed a historical technique of assimilating émigré Jews into the dominant religion of the national culture.

The Manchester Victoria Memorial Jewish Hospital

In the eyes of the Anglicised Jews, a dedicated hospital was 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. The Jewish Board of Guardians had instead led attempts to push for a *kosher* kitchen at the Manchester Royal Infirmary as a counter-proposal to a 'Jewish hospital ghetto' (Heggie 2005; Williams 1989).[156] In her oral history, Marjorie Smith remarked how the Anglicised class feared that a hospital specifically serving the needs of the Jewish minority would provoke anti-Semitism, whereas her father 'of course, being one of the foreign religious ones, thought it would be a good thing.'[157] Hostility to the Jewish hospital on the part of the Anglicised elite has led to suggestions that 'they

[152] MMC/8/13: 1903.
[153] G25/3/6/6: 1906. The report notes how 'in spite of the brutalities inflicted on them [Jews] by nominal Christians elsewhere, some of them are learning that Jesus Christ loves them.'
[154] See G25/3/6/8: 1909.
[155] The idea that medicine can be used to demarginalise groups is taken from Ecks and Sax (2005).
[156] See 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' (M443) on 10 May 1921 noting that there were objections to providing 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.
[157] MJM J229

were too worried about being seen to encourage integration and appeasing anti-Semitic 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*[158] Hospital' in the émigré vernacular (cf. Golding 1932), the MVMJH was situated in the (then) Jewish Quarter and funded by significant grants but also a subscription system of one penny per week for its Jewish custodians. Whilst 'the hospital is, of course, built primarily for Jews' (The Lancet 1904: 1382) it initially pledged to serve the local non-Jewish population depending on capacity.[159] 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, began to treat 'all humanity irrespective of denomination on an equality when applying for assistance in their time of sickness and suffering.'[160]

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' (Figure 10).[161] Beginning with just ten beds (six for men and the remainder for women), the hospital soon prided itself

[158] Yiddish, Jewish.
[159] I include this reference to a Lancet article as it demonstrates how the Jewish hospital, in 'provincial England,' had received attention in a mainstream and leading medical journal.
[160] 362.1 M64: 1905.
[161] 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' (362.1 M64: 1907–1908]), though one could speculate that there might have been an economic incentive for having a female medical officer 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 (MJM J192), see Figure 11. 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' (362.1 M64: 1926–1927). By 1926, the hospital held aspirations of being a recognised training centre for nursing, supposedly with the specific intention of widening access to prospective Jewish nurses who, in the absence of a culturally-appropriate training institution, would allegedly be unable to enter the profession (362.1 M64: 1926–1927).

on ‘quickly gaining the confidence of the medical profession and the public,’ with admissions continuing to rise significantly year on year.[162]

Mainstream health and medical facilities were known to present issues of accessibility for ‘foreign’ Jews due to ‘religious scruples’ and language barriers as far back as 1868.[163] The Jewish hospital was therefore 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.’[164] Providing a familiar or culturally specific service involved a space where religious dictates could be integrated into the care, with *kosher* food served during periods of hospital admission as well as ‘the consolation of [patients] seeing Jewish faces around them.’[165]

Figure 10: Women’s ward, Manchester Victoria Memorial Jewish Hospital (n.d.).
Photo credit: Manchester Jewish Museum.

[162] 362.1 M64: 1908–1909.
[163] M182/3/1: 1868–1869.
[164] MJM 1984.684: Jewish Gazette, 2 July 1931.
[165] 362.1 M64: 1904.

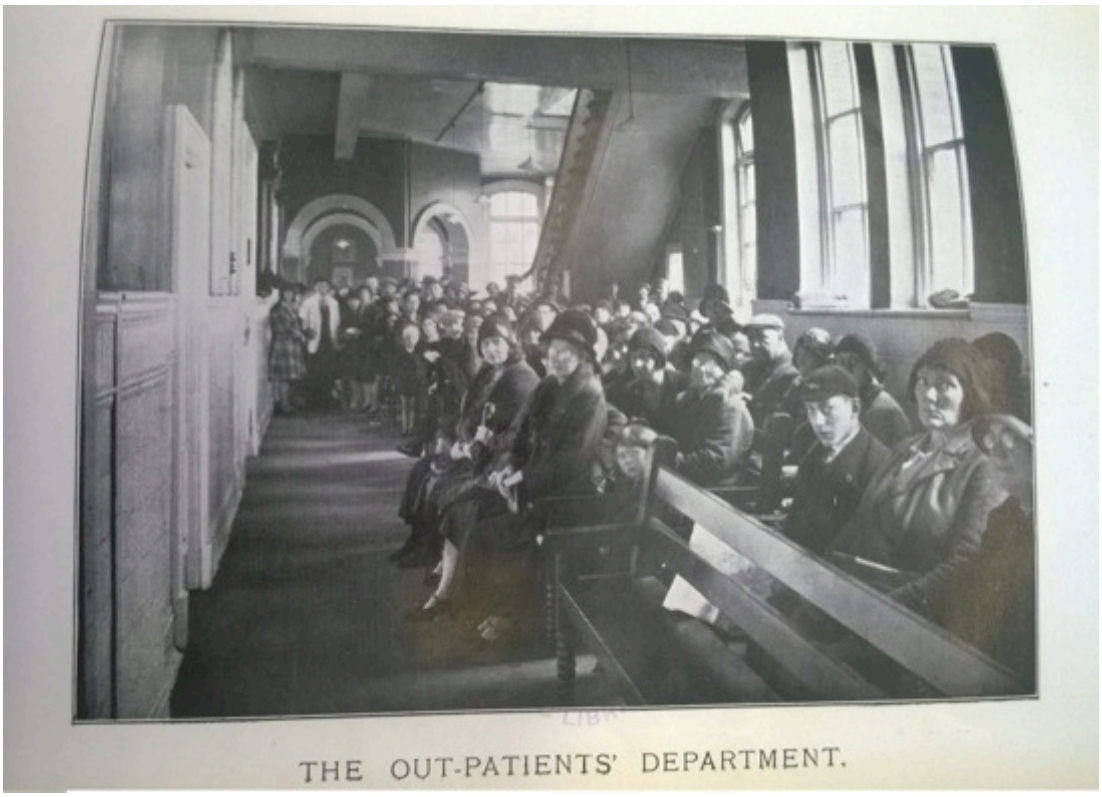

Figure 11: Waiting for an outpatient appointment, 1930.
Photo credit: Manchester Archives & Local History (362.1 M64).

Underlying the establishment of the MVMJH was then the preference for culturally specific care amongst the Jewish constituency, especially among the émigrés. Patients could receive medical and surgical provisions (at no cost) that were immersed in an environment of care conducive to the dictates of Orthodox Jewish dogma 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, grappling with the intra-group diversity of the immigrant patients would have been a challenging encounter for the Anglicised Jewish medical professionals but also non-Jewish staff. A significant number of Jewish patients at the turn of the twentieth century were, for instance, 'unable to speak more than a few words of English, nearly all speak some dialect of Yiddish, a few French, and Arabic. The bulk of the patients have been Russian, Roumanian, Austrian, or German.'[166] Rather than solving the issue of culturally specific care, the '*Yiddisher* Hospital' can also be interpreted as a contested margin between the biomedical and

[166] 362.1 M64: 1907–1908.

Judaic cosmologies, provoking conflicts and negotiations between the two (as I discuss later in this chapter).

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.[167] Having a sharp imbalance between Jewish and non-Jewish patients and staff resulted in several instances of public criticism due to perceived feelings 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.*[168] The mandate of the MVMJH to serve non-Jewish patients was challenged by a Jewish subscriber, which, in turn, prompted Nathan Laski[169] (the hospital's Chairman at the time) to publically announce that:

> 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 out 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.[170]

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 elite long after its establishment. Whereas the former sought an institution that could offer culturally specific care, and thus maintain markers of ethno-cultural difference, such as the Yiddish language, the Anglicised Jews arguably saw the hospital as a tactic to maintain their position within society by caring for 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 a fundamental part of the 'host' society — therefore

[167] MJM 1984.684: Manchester Guardian, 1 February 1932.
[168] A quorum of ten Jewish men needed for specific prayer rituals. See MJM 1984.684 (Jewish Gazette, 2 July 1931).
[169] 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.).
[170] MJM 1984.684: undated.

realising the aspirations of the Anglicised Jews. Moreover, 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 permission being sought, and granted, to name the King Edward VII Ward as well as the Princess Elizabeth Ward for children.[171] Donations to the hospital were also bestowed by wealthy non-Jewish individuals and Manchester-based organisations during the twentieth century,[172] which is further suggestive of how cordial relations between the Jewish minority and the surrounding majority may have been constructed through the medium of a Jewish medical culture.

When the '*Yiddisher* Hospital' closed in the 1980s, what Leah Martin described as having been 'the jewel in the crown of the Jewish community' had become 'nothing but a sad memory.'[173] 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 bring them within reach of the state can, for instance, have the result of pushing them further away (as I 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 (see also Chapter Five), which points to a historical departure from the purpose of the MVMJH as a vehicle for fostering inter-group relations.

Public health surveillance as an 'art of government'

The racialisation of émigré Jews in England and the interventions levied upon their 'alien' bodies during the nineteenth and early twentieth centuries can be placed in 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 [2002]: 8). State attempts to assimilate difference follow a

[171] MJM 1984.684 (Jewish Free Gazette, 13 November 1931).
[172] MJM 1984.684.
[173] MJM J192. Leah began working as a nurse at the MVMJH in 1930.

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. Public health has performed a historically persistent and leading role in this immunitary strategy, demonstrating how the body of the nation is cultivated in a powerful realm of inclusion and exclusion — which constantly redefines 'the threshold in life that distinguishes and separates what is inside from what is outside' (Agamben 1998: 137).[174] 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 [2002]). 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.

Endowing the biomedical establishment with the power and authority to determine the bounds of exclusivity is something of a historical legacy. As John and Jean 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). Moreover, the consolidation of medicine and politics can, in a more extreme and recent example, be illustrated through the Nazi 'euthanasia' programme, where physicians became state executioners for a 'life unworthy of being lived' (Agamben 1998: 137).

The aforementioned historical representations of émigré Jews as a threat to the body of the nation is reflected in contemporary debates of immigration in Europe, where the medical establishment is entrusted to preside over the legal

[174] Commanding the foreign body through medical and public health surveillance has been a recurring immunitary strategy, as exemplified by the case of Israel (for historical discussions, see Bernstein 1981; Davidovitch and Shvarts 2004; Seidelman 2012). The relatively recent assimilation of the Ethiopian social body has been feared and viewed as polluting to the body of the nation cultivated by the Israeli state. Ethiopian blood donations were a gift and lifeblood to the state in a time of terror, but Israel's medical authority had, for a time, routinely and secretly destroyed them due to concerns of infectious disease. It has instead been argued that the highly controversial 'blood affair' was less to do with the risk of hepatitis and HIV transmission, but more the contested relation of the Beta Israel to the Israeli-Jewish body of the nation, prompting violent demonstrations (Seeman 2010: 163). From 'the chosen people,' Zionism chiselled 'the chosen body' and so moulded the parameters of inclusion and exclusion, giving rise to 'the disembodiment of "the Other within us" (cf. Weiss 2002: 16). What is carved out of the social body are those which do not conform to the ideal bodies 'chosen' by the state but also its religious establishment, as demonstrated by the discriminatory experience of Ethiopian immigration to Israel and its Orthodox monopoly on the definition of being Jewish and Judaism.

situation of asylum seekers — the current regard of 'aliens' (cf. Ticktin 2008, 2011; Fassin and d'Halluin 2005). 'Foreign' bodies that sit at the margins of society are then subjected to the stealth subjugation of governmentality, where, presented as an independent entity, the biomedical establishment comes to perform a fundamental role in the management of the state. Falling either within the bounds of inclusion or exclusion, 'foreign' or 'alien' bodies are likely to find themselves subjected to a quasi-form of medical jurisdiction and in an 'ambiguous terrain in which the physician and the sovereign seem to exchange roles' (Agamben 1998: 143).

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 a filthy and insalubrious area, reflecting the poverty and neglected sanitary conditions of the time. Poverty in the area was apparently graded, with there being a 'very unfavourable comparison' between the 'poor' of Jewish and 'other denominations,' meaning, most likely, the neighbouring Christian population.[175] 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 authority.

Infant morbidity and mortality was a feature of life in the Jewish slums, and fourteen incidences between 1871–1872 were attributed to parental 'ignorance of, or inattention to, the first principles of hygiene, viz. [that is to say], cleanliness and ventilation.'[176] 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.'[177] In a classic example

[175] 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.'
[176] M182/3/1: 1871–1872.
[177] M182/3/1: 1871–1872.

of attributing blame to the poor rather than counteracting the trappings of poverty, it was the 'ignorance' of the parents that was 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.[178] Despite the adversity of life in the slums, the Board often praised the efforts of mothers to respond to infant health crises and cited the attentiveness and 'affectionate solicitude' of mothers as contributing to the avoidance of a high infant 'death rate.'[179]

Lack of access to clean drinking water and sanitation usually underlie the cause of morbidity and mortality arising from diarrhoea, cholera, and dysentery to name a few examples (see Stein 2009). The confluence of poor sanitary conditions, street pollution, and poor nutrition were 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.[180]

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.[181] Although, strict immunisation policies were enforced for outbreaks of smallpox (Chapter Six), the same preventive strategies could not, in the nineteenth century, be deployed against frequently occurring and overlapping epidemics of measles, scarlet fever, chickenpox or whooping-cough, which often preyed on the slums by virtue of their close confines. Whilst disinfecting and deodorising 'infected

[178] See M182/ 3/1: 1869–1870; M182/3/2:1877–1878; M182/3/4: 1905–1906; M182/3/5: 1908–1909.
[179] M182/3/1: 1874–1875; M182/3/3: 1905–1906.
[180] See M182/2/: 1877–1878; M182/3/: 1881–1882; M182/3/4: 1902–1903)
[181] MJM J273.

habitations' was a typical resolve to prevent infectious outbreaks, the Board noted that 'much is yet required in this direction as a means of prevention.'[182]

Although the slums were an expression of socioeconomic disenfranchisement for the urban non-Jewish and Jewish poor (Chapter Three), they were also an embodiment of relational and positional marginalisation that was explicitly anti-Semitic. Prevailing judgements at the turn of the twentieth century were of 'the uncleanliness of the 'Jewish poor' and of the overcrowding and supposed insanitary conditions of their houses.'[183] 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.'[184] The Medical Officer's statement, evidenced by the use of 'now', implies that these 'popular notions' grew out of stereotypical roots and a lived reality from the formative years of Jewish immigration.

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. 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). Jewish, as well as Italian, émigrés were socially 'reviled' to the extent that they were placed in quarantine under the guise of public health (Markel 1997), which is indicative of how the broader relation between government and public health led to protocols that were laced with anti-Semitism.

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

[182] M182/3/1: 1872–1873.
[183] M182/3/4: 1902–1903.
[184] M182/3/4: 1902–1903 (emphasis added).

mandated to 'spread hygienic knowledge among the poor' from as early as the 1860s.[185] At this time it became a strategy of public health to recruit women as local Health Visitors and for them to survey the homes of those from a similar class and background (see Manderson 1998: 38). Compliance with mainstream public health dictates were 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.'[186]

Jewish Health Visitors were initially 'leisured people' from the Anglicising or Anglicised 'class' that had come to act as a mediator between the mainstream health authority and a minority group. These leisured women were also usually married or related to the men who led the Board, often making the work of these two organisations complementary and probably mutually-reinforcing (see 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 (see 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 advancing the aims of the Board, the MJLVA sought to implement 'a high standard of hygiene among the poor.' Lists of residences that required visitation and surveillance were received directly from the Medical Officer of Health for Manchester,[187] 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 (see Liedtke 1998: 178). By 1896 the women were making 11,500[188] annual visits and struggling to manage the volume of work and visitations amongst the Jewish poor, prompting them to seek financial supplementation from the Municipality for a third colleague in 1899. The work of Jewish Health Visitors was considered so successful

[185] M182/5/2: 1903; see also Davin 1978.
[186] M182/5/2: 1903.
[187] 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 the state at the time.
[188] See Heggie (2005).

that the Jewish Board of Guardians in London had 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).[189]

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 the occupiers of houses which require cleaning to satisfy the requirements of the Health Department of the Corporation of Manchester.'[190] Effective surveillance of the Jewish poor was made possible through the Health Visitors and their ability to target and monitor the symptoms that had manifested at the dispossessed margins of Manchester — its slums located just a stone's throw away from the city.

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 maternal and infant health was becoming an area of political concern (Chapter Five). 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.'[191]

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.*'[192] Whilst the slum areas did have deficits in health (as the archival records made clear), it is likely that the *appearance* of the slums (densely populated by an identifiable minority) also warranted intervention and surveillance from the Jewish elite and public health authority — even if this did not always manifest in a more pronounced mortality or morbidity rate.

As health reports began to improve for the Jewish poor, the Board's Medical Officer suggested that positive health reports were a result of socio-religious

[189] M182/5/2: 1897; also M182/5/2: 1903.
[190] 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.
[191] M182/5/2: 1903.
[192] M182/5/2: 1901 (emphasis added).

conducts governing diet and the body. The strict adherence to *kashrut* was one example, apparently because 'no old or diseased meat is eaten, all vegetables and cereals are carefully washed and sorted. Perhaps, also, their partiality to a fish diet is a cause.'[193] Abstinence from alcohol was considered to be more pertinent as a continuously cited example of good health in the Jewish poor which contrasted with the neighbouring non-Jewish population, 'no Licensing Act is needed here — the closing of public houses would become automatic.'[194]

Margaret Langdon was one notable Health Visitor in 1910 to come from the 'Jewish "leisured classes,"'[195] and discussed the slums in her oral history. Health Visitors would apparently express their revulsion towards the Orthodox and immigrant slum-neighbourhoods they encountered, which were typically a chaotic mess, and perhaps reinforced the anti-Semitic tropes that circulated at the time. However, Margaret claimed that, despite the mess, the Jewish Quarter actually experienced much less infant diarrhoea than the neighbouring non-Jewish districts, which she attributed to the stringently observed yet protective laws of *kashrut* upheld by the foreign poor:

> They keep their meat and their milk pans separate and that really forces them to wash them properly. They wash everything under the tap. If they haven't got two bowls like one has now, milk and meat, they're washed under the tap so that it didn't touch anything and they'd put them away in the cupboard.[196]

Despite the challenges for émigré Jews, upholding socio-religious conducts meant that mortality rates were, in some instances, more favourable than the more affluent districts of North Manchester during the early years of the twentieth century. In fact, the death rate of the slum areas was recorded at 5, which was less than half of the death rate for 'salubrious Kersal' (being 13).[197] By the end of 1908,

[193] M182/3/4: 1907–1908.
[194] M182/3/4: 1907–1908; see also M182/3/2: 1883–1884.
[195] Margaret 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 MJM J143; Williams 2011.
[196] MJM J143.
[197] M182/3/5: 1907–1908.

the death rate had dropped to 5.18 per thousand people from 8.89 per thousand in the previous year, much to the pride of the Board's Medical Officer.[198]

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 holding 'verminous people.'[199] The imperative of surveying the Jewish poor began to ease by the twentieth century with steady improvements in the structural conditions surrounding the slums, such as demolishing the iconic back-to-back slum houses as well as re-draining and re-building neighbourhoods to combat overcrowding (see National Archives n.d. A). 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.'[200]

Deploying established Jewish Health Visitors to inspect their poorer and 'foreign' co-religionists in and around the slums 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). Except assimilating the immigrant Jewish population was not only in the interest of local government and its public health agenda, but also for the settled or 'native' Jewish elite and their concerns of positionality and representation given their own process of integration vis-à-vis the mainstream.

Standing in contrast to historical narratives of Jews being forcibly contained in ghettoes on the margins of society, Jewish Manchester is a story of socioeconomic confinement to the slums by virtue of being a largely immigrant and urban poor. As Veena and Ranendra Das have written, the urban poor live in a materially and socially defined space in which subjectivity is a visceral part of everyday life, giving rise to a particular way in which 'the body speaks' (2007: 66–67). Pressed on to bones of children in the slums, rickets was a classic example of what Fassin calls the 'embodiment of inequality,' and, similar to the HIV and AIDS epidemic in South

[198] M182/3/5: 1907–1908.
[199] M790/2/6: 1984.
[200] M790/2/6: 1984 (emphasis added). I italicise 'assimilated' here to emphasise how the strategy undertaken by the Jewish elite and their allied organisations had apparently achieved the end goal of incorporating the 'foreign' or 'alien' Jews into Manchester's Anglicised Jewish social body.

Africa, proves how 'disease clearly does not just involve a pathological process that attacks the physical body but also reveals a historical truth that exercises the social body' (2003: S5).

The surveillance of poor neighbourhoods has performed a historical and vital role in the production of statistics, usually as a means of assessing the risk posed to the wider population (see Hyatt 1999). 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.

Public health, as mentioned, is a body that takes issue with the culture of individuals and "communities" in order to improve their lives or longevity (Fassin 2004). However, this promise of healthfulness demands an uncompromising state of 'compliance' with biomedical protocols. Rather than submitting to its authority, the intention of biomedicine is for individuals to 'see the value to the self of being compliant' (Whitmarsh 2013: 313). By consuming health information (the 'authoritative knowledge' produced by the biomedical authority), a 'subjectivity of compliance' is cultivated to convince people of the need to dispense with 'cultural traditions, family habits, or beliefs' (see Whitmarsh 2013: 313). Conducts that are grounded in a socio-religious cosmology become the archetypal target of public health and its demand for compliance and complicity with its services, fulfilling its role as a key constituent in the governmentalisation of the state.

Eric Stein has argued that the Indonesian colonial administration used social elites as local 'hygiene *mantris*' (hygiene 'technicians') to persuasively (or by coercion) circulate health education, earning them the reputation of 'technicians of messing up other folks' business' as acts of health surveillance came to be viewed as 'unwanted violations of privacy' (2009: 550). Resistance and fears of 'hygiene *mantris'* on home visits were often regarded as 'stupidity,' epitomising and reinforcing social stratification where village elites were positioned 'in the role of "biological patrons" who were invested in monitoring and cultivating the healthy bodies of subordinates than in seeing to their material well-being' (Stein 2009: 557).

Similar to the 'hygiene *mantris'* (Stein 2009), the MJLVA were social elites who sought to coerce émigré and poor Jews into accepting public health interventions on behalf of the local authority as a means of contagion control at the time, but also as an attempt to integrate them into the body of the nation. Not confined to the former Jewish Quarter, the local authority in present day Manchester continue to view Anglicised Jews as a 'passport' to reaching the Haredi settlement — a strategy which 'culturalises'[201] and marginalises the intended targets of intervention.

Gehah: Bridging distances in health

Epidemiological changes over time have meant that the local authority is currently concerned with non-communicable diseases among the Haredi settlement, as Greater Manchester is a region characterised by significant and graded levels of deprivation and deficits in health. As mentioned, the Jewish settlement 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 stroke, 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 (see Public Health England n.d. C), falling short of the national average of 79.5 and 83.2 respectively (over the same period). The burden of premature mortality outcomes in the area has led to the development of local health promotion programmes, one of which targets the Haredim of Manchester, and is thus continuous with the historical role performed by the MJLVA as a technique of public health surveillance within 'hard to reach communities.'

Since 2013, one of the councils responsible for areas 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

[201] Term taken from Fassin (2004).

uptake of the NHS Health Check[202] programme among men and women aged forty and above. The peer-led programme focused on promoting health information for cardiovascular disease, diabetes, and cancers, which remain the leading causes of morbidity and premature mortality in the Greater Manchester region.

The programme can also be viewed in a broader context of health economics in a drive to "cut costs" by prevention rather than curative treatments, and I call the Jewish wing of the region-wide project '*Gehah.*'[203] Attempts to reach the Haredi Jewish audience and publicise health messages through *Gehah* are comparable (but not identical) to the established and nation-wide NHS programme 'Change4Life.' Over the course of my fieldwork I accompanied the Jewish activists of *Gehah* as they staged various health forums and attempted to distribute health material within local synagogues, homes, educational institutions, and also a council-managed library.

The health authority arguably saw *Gehah* as strategic for itself as well as the interests of the Jewish "community." By using Jewish volunteers the local health authority saw itself as having a 'significant resource and passport' in order to access 'community networks' — especially one that is viewed as being hard to reach — and in turn 'local people were in charge of the process of gathering solutions [to significant health challenges]' (NHS Health Check 2014). However, the vast majority of *Gehah* volunteers were typically Anglicised and integrated Jews, with only a few exceptions. It became increasingly clear that the majority of volunteers did not always fully understand the complexities and sensitivities of the context in which they sought to work. The construction of 'communities' in health promotional work can then have the repercussion of *misrepresenting* the very people they seek to reach out to — potentially pushing them to a further 'distance,' as this section exemplifies.

Championing the cause of *Gehah* was Simon, who has since passed away, but at the time of the fieldwork was well into his eighties. He was keen to take me under

[202] An NHS programme designed to prevent heart disease, stroke, diabetes, and other age-related diseases. Everyone aged between forty and seventy-four who have not previously been diagnosed with these conditions, or are at risk of developing them, will be invited for a health assessment.
[203] One participant 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.'

his wing and perform his trusted tactics for selling health, an expertise developed over his life's work in trade and commerce. I accompanied Simon and another male volunteer 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. Simon arrived at the centre dressed in a dark beige suit and wearing a black velvet *kippah*, he looked dapper but a stark contrast to the Orthodox and Haredi men he was attempting to engage in conversation.

I was curious to know from the *Gehah* volunteers what challenges and barriers to optimising health in the Jewish settlement allegedly existed. Simon 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, as well as certain culinary traditions such as eating *cholent*[204] (or *chamim*) on *Shabbat*. He went on to share 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 therefore followed the same logic of acting against foreseen risks.

Leaflets informing Orthodox and Haredi constituents of health events organised by *Gehah* were often accompanied by Biblical Hebrew or Yiddish references (Figure 12), 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). Simon would often mobilise Biblical references during conversations with passer-byers, such as 'we want you to

[204] *Cholent* is the Yiddish or Ashkenazi pronunciation, *chamim* (also *chamin*) is the Sephardic or Hebrew pronunciation. This is a stew that is first heated before the beginning of Shabbat on Friday evening until the next day when it is eaten for lunch. It is typically a heavy meaty dish.

live to 120'[205] or 'it is written "to guard yourself,"'[206] which can be interpreted as asserting a religious rationale in the prevention of non-communicable disease.

Figure 12: 'Guard yourself, and guard your soul,' circulated by *Gehah*.

Contesting Gehah volunteers

What Simon 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 work, *davening* (Hebrew, praying), 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-byer 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?

[205] A reference to Moses, who is said to have died at the age of 120. A common saying to observant Jews on birthdays is 'may you live until 120,' which also indicates how life is numbered.
[206] A reference to the doctrine in Judaism that the body is a gift from God and must be cared for.

> 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*[207] 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.

The above quotation demonstrates an intense distrust and lack of confidence in the biomedical authority and healthcare provider in England, which is informed by his claim that pharmaceutical moguls profit from human morbidity and mortality. Rabbi Kaplan's allegation should not be dismissed as "conspiracy," especially if we consider previous investigations into 'killer commodities' (Singer and Baer 2009) or gross violations of medical ethics in research (see Reverby 2011). Rabbi Kaplan then dismissed the 'authoritative knowledge' that is produced by the NHS, arguing that saturated fat (which *schmaltz* contains) is not a causal risk factor for coronary heart disease.[208]

Whereas previous studies have explored how explanatory models of illness can be informed by religion or how *frum* Jews attempt to reconcile Haredi worldviews with certain treatment plans (cf. Shaked and Bilu 2006; Coleman-Brueckheimer and Dein 2011), some of the Haredi Jews I interviewed had accessed current discourse in 'popular science' when attempting to evaluate nutritional practices. The British nutritionist Patrick Holford was one source of authoritative knowledge for Rabbi Kaplan, and Holford's literature was frequently placed in my hands during interviews with Haredi constituents and was also identified in my local *frum* GP's consulting room when attending an appointment. It is arguably the case that certain degrees of "secular" knowledge are made available and information is indeed filtered within the frontiers of the Haredi social body, though this may not necessarily be in tune with NHS health messages.

[207] Rendered chicken fat, common in traditional Ashkenazi cooking.

[208] 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 2014a).

On another occasion I accompanied Dr Harris, a (non-Haredi) Jewish GP, as she targeted a Haredi and Hassidish neighbourhood with promotional material for an upcoming *Gehah* ladies health event. Whilst stopping Mrs Lisky, a Hassidish resident of an Edwardian-era terrace, the two fell into awkward dissent over the alleged consequences of preventive health services — especially relating to mammography and immunisations (see Chapter Six).

In a similar fashion to Rabbi Kaplan, Mrs Lisky voiced her criticism and intense distrust of the biomedical authority in a follow-up interview where she claimed that 'the medical establishment also works for money and therefore you can't rely on what they say about health either.' She told me that she has never discussed her concerns 'with people, you can't discuss things with people [medical 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 reluctance to engage with NHS services can be attributed to irreconcilable ideas of 'authoritative knowledge.'

"Unveiling" ignorance

Whilst attending one of the monthly meetings between *Gehah* volunteers and officials from the health authorities in 2014–2015, the team were discussing a prototype for a bowel cancer-screening leaflet targeting the Jewish population (Figure 13). The Jewish volunteers contributed to the design of the draft, and suggested to include the message 'be a "*ner tamid*"[209] to your family,' which can, in this instance, be interpreted as being a constant model and example of health to younger generations. When discussing the flyer, one *frum* volunteer 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.'

What is also curious about the draft design is the way the mother, who is intended to be a typical Orthodox or Haredi mother, is drawn. Her hair is covered

[209] Hebrew, eternal light or flame. A *ner tamed* is placed in all synagogues and are never extinguished or switched off.

out of modesty (*tzniut*), as is customary of women in this subgroup. Except her hair is partly exposed and covered with a veil which more closely resembles the style of head-dress worn by Muslim women from the overlapping South Asian minority population, who, as discussed in Chapter Three, can be viewed with deep suspicion and prejudice amongst this Jewish settlement. During this consultation with public health representatives I commented on the close resemblance of the mother's hair-covering to the veil worn by the local South Asian minority. It was only then that the Jewish volunteers, who had claimed to 'know our community,' suggested that the mother should instead wear a snood — resembling more closely the hair-covering practices of Haredi women. The design then underwent subsequent changes (see Figure 14), and at the time of writing (May 2016), was yet to be distributed.

This episode "unveiled" the ignorance of *Gehah* volunteers to the nuanced, but highly sensitive, markers of Haredi cultural norms in which health conducts are evidently grounded. In attempting to use Jewish volunteers as a 'passport' to reaching 'communities,' the local health authority is arguably at risk of alienating Haredi Jewish constituencies further by not fully understanding their needs.

One of the few religiously observant volunteers at *Gehah* told me that the low numbers of Orthodox women which its events attract are indicative of a deficit in the service, and perhaps poor relation with the Haredi settlement. When enquiring how effective the peer-led health promotional team were, one Haredi local 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*.

Dr Harris 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.

The delivery of healthcare services in Jewish Manchester is therefore entrenched in 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')[210] émigré and Haredi Jews in ways that are historically contiguous. With the growing Haredi presence in the UK, Jews from the broader population have expressed concern and unease about the extent to which the Haredi minority are 'integrated into British society, and apprehension about a potentially unwelcome change in the religious, educational, economic, and occupational profile of British Jewry' (Staetsky and Boyd 2015: 2). Led by non-Haredi Jews from the settlement, *Gehah* illustrates how health forms part of a recurring strategy to integrate previously 'foreign,' but now pious Jews who are positioned as being beyond the "reach" of the state (but also a threat to the established Jewish order). The example of the MJLVA and especially *Gehah*, with its strategies of 'culturalising'[211] Haredi Jewish cultural conducts, either by use of language, Yiddishisms, or erroneous and exaggerated representations, demonstrates how attempts to "reach" out to the margins can have a recoiling effect — especially when the intended 'targets' of intervention feel misunderstood or misrepresented.

[210] See Lila Abu-Lughod (2002), also discussed in Chapter One.
[211] Cf. Fassin (2004).

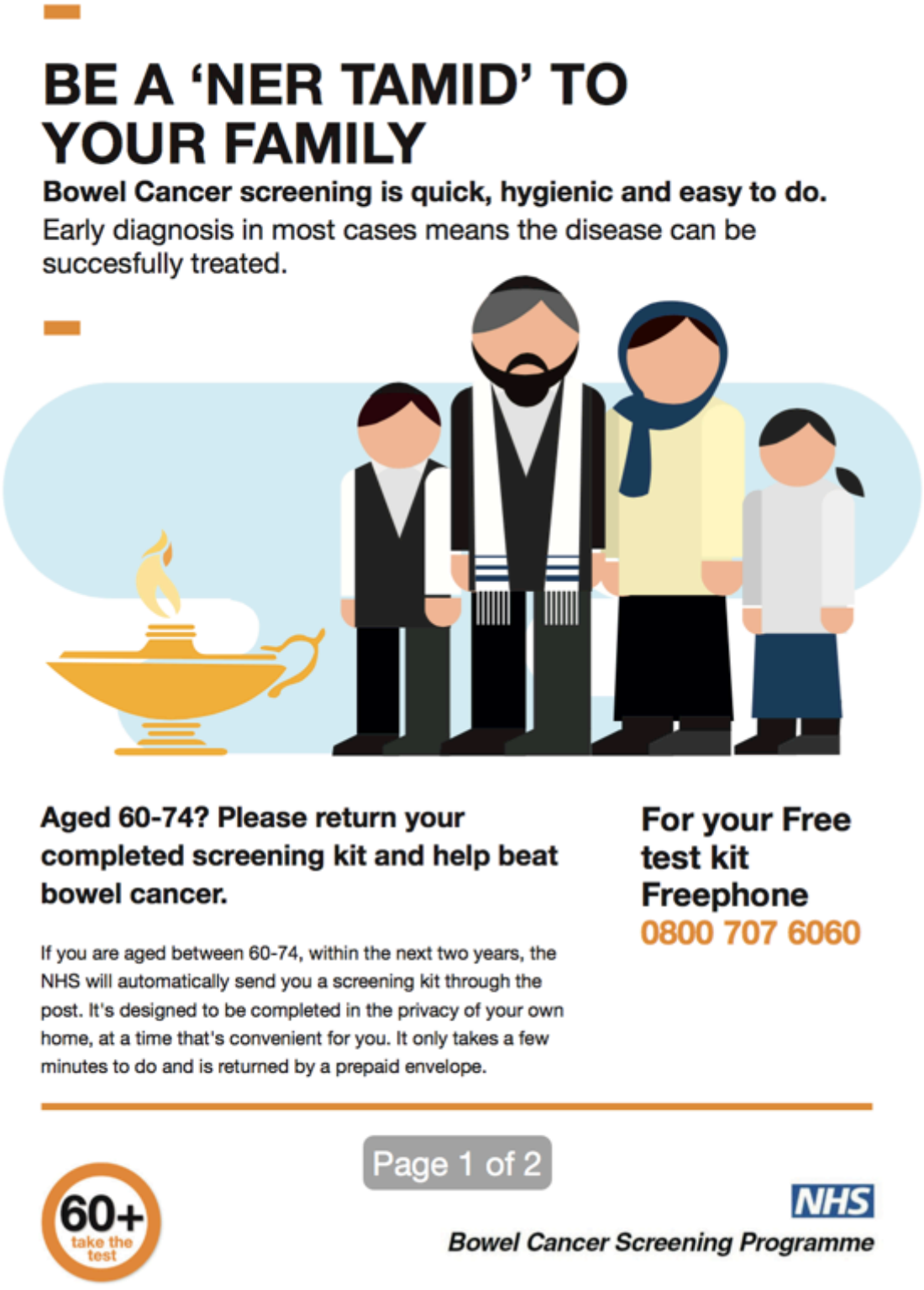

Figure 13: Initial design for bowel cancer prevention leaflet, informed by *Gehah* volunteers.
Credit: Pennine Care NHS Foundation Trust.

בס"ד

בֵּר הי בִּשְׁמַת אָדָם

THE SOUL OF THE HUMAN BEING IS THE LIGHT OF HASHEM

Bowel Cancer screening is quick, hygienic and easy to do.

Early diagnosis in most cases means the disease can be successfully treated.

Aged 60-74? Please return your completed screening kit and help beat bowel cancer.

If you are aged between 60-74, within the next two years, the NHS will automatically send you a screening kit through the post. If you aged 75 or over, you can request a kit by phoning the **Freephone number 0800 707 6060**. It's designed to be completed in the privacy of your own home, at a time that's convenient for you. It only takes a few minutes to do and is returned by a prepaid envelope.

For your Free test kit Freephone 0800 707 6060

60+ take the test

NHS

Bowel Cancer Screening Programme

Figure 14: The revised version of the bowel cancer screening leaflet as of June 2016.[212]
Credit: Pennine Care NHS Foundation Trust.

[212] The amended design was awaiting final approval from local rabbinical authorities and the *Gehah* team at the time of writing this thesis. Note the change in the mother's headdress, and the change of 'be a "*ner tamid*" to your family' to 'the soul of the human being is the light of *HaShem.'*

Health and the Haredi cosmology

The relation between health and the Judaic cosmology is used as a point of departure in this section to critically engage with the claim that Haredi Jews are hard for the public health authority to reach. Conflicts between the Judaic and biomedical cosmologies can occur because of opposing constructions of care, which, for observant 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 present implications for the *halachic* governance of a Jewish body, and has been a recurring issue for Jews in Manchester to access 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 therefore 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.

Healthcare, as mentioned, has served as an enduring marker of marginality for the Jews of Manchester. The establishment of the aforementioned Manchester Victoria Memorial Jewish Hospital at the turn of the twentieth century did not entirely allay the challenge of reconciling competing constructions of bodily care in the biomedical and Judaic cosmologies. Certain medical procedures were quickly found to be insurmountable challenges for the Jewish hospital when attending to the needs of the religious practitioners it was designed to serve. This was especially the case when the body became entangled in a cosmological conflict between biomedical aspirations and *halachic* imperatives. For instance, one Medical Report from 1908 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.[213]

[213] 362.1 M64: 1907–1908.

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. The contest over the body (and indeed the social body) suggests that the Jewish hospital — established with the needs of the Jewish minority in mind — found itself caught between its mandate and modernity, and epitomises the contested positionality of Jews in Manchester at the time.

Attempts to negotiate certain areas of science and technology between biomedical authorities and minority religious groups are not confined to the historical Jewish Quarter, but remain an unresolved issue, and low responses to certain health services are, in my view, incorrectly framed as an issue of 'compliance.' The Orthodox and Haredi Jewish example demonstrates how culturally specific and organised services operate with the intention of mediating mainstream health provisions as well as addressing their perceived shortfalls, which is discussed in the context of *Hatzolah*[214] (a Haredi ambulance service). I go on to argue how the direct intervention of rabbinical authorities in the design and delivery of healthcare services forms part of a broader strategy of *immunity*, protecting the Haredi social body from external threats that 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 then 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.

[214] Rescue. Referred to locally in the Ashkenazi pronunciation, rather than the Sephardi pronunciation of *Hatzalah*.

Within weeks of moving to the field-site 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 Haredi local used his mobile telephone to summon *Hatzolah*, the rapid response service that has been established by prominent members of the Jewish settlement, and forms part of an international Haredi brand to provide emergency medical care for Jewish bodies. Like many aspects of Orthodox and Haredi social organisation, *Hatzolah* is powered by (male) volunteers and funded by a redistributive economy. The service is sponsored mostly by a local benefactor but also receives smaller donations through the religious imperative of *tzedakah.*[215] Call-outs are then bestowed at no cost to those in need of emergency medical assistance.

Hatzolah volunteers offer a twenty-four hour and seven days a week service, and are also authorised by rabbinical authorities to work on *Shabbat* and religious festivals.[216] The drivers have a rapid and unparalleled arrival time — within minutes — compared to NHS ambulance services. The advantage here is that *Hatzolah* divisions are attending to emergency calls within the same bounds as the Jewish neighbourhoods in which volunteers live. All vehicles and ambulances are fitted with emergency medical equipment such as basic life support kits, resuscitation equipment, oxygen, and defibrillators, and volunteers receive on-going life support training. Aside from their specialism in emergency care, an additional benefit is the perceived feeling that *Hatzolah* provides a 'culturally appropriate' and Jewish service.

The Haredi rapid response team is viewed as 'culturally appropriate' partly because its volunteers may speak vernacular languages (Yiddish and to a lesser extent Modern Hebrew),[217] but more specifically they are identifiable as an internal service. *Hatzolah* divisions elsewhere have been instituted out of the concern that

[215] 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. Some Jewish individuals and families would then elect to fund *Hatzolah* by way of this obligation.

[216] Jews are forbidden to work on *Shabbat* and *Yamim Tovim* (particular days within religious festivals). Exemption from this law is granted to those working in medical services as the imperative of saving a human life overrides ritual observance of *Shabbat* or *Yamim Tovim*.

[217] *Hatzolah's* (London) promotional and fundraising videos feature Haredi locals calling the emergency line and speaking in Yiddish to the operator.

certain Jews (especially *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. Volunteers are, for instance, clearly identifiable by a black velvet *kippah* and a Hi-Vis jacket labelled with '*Hatzolah'* (in English and Hebrew) and 'EMT' (emergency medical technician) as well as a six-pointed 'star of life.'

The Jewish organisation also works in collaboration with mainstream emergency services, and *Hatzolah* brigades in Canada have previously partnered with fire and rescue services to undergo specialist training in multi-agency emergency response practices (Newman 2014). Services which provide emergency care in private ambulances until the arrival of NHS teams are not unusual in the UK, especially if we consider that the British Red Cross and the Saint John's Ambulance Service[218] have a historical presence as a paramedic body.

Establishing an intra-group rapid response service is arguably a method to meet perceived shortfalls and failings of the state, especially as *Hatzolah* were brought to North London in 1979 after two Jewish individuals succumbed to heart attacks whilst waiting for NHS ambulances to arrive (see Ryan 2003).[219] The fatally slow arrival time that led to the (possibly avoidable) deaths of these two Jewish locals can be interpreted as contravening the *halachic* obligation to preserve life (*pikuach nefesh)*, which underlines the aforementioned view of Haredi Jews having heightened expectations of health services. Since these failures of the state to manoeuvre within infrastructural confines and rapidly mobilise and respond to emergencies at the 'hard to reach' margins, *Hatzolah* ambulance brigades have been instituted in Jewish settlements across North London (Golders Green, Hendon, and Edgware), Gateshead, as well as North Manchester. For these reasons, the Haredi

[218] The role of the Saint John's Ambulance (n.d.) fundamentally changed following the institution of the NHS in 1948, whereas prior to this date it was the only ambulance service operating in the country (also providing free medical care since Victorian Britain).
[219] The model of *Hatzolah* was brought to London from Haredi settlements in the United States.

volunteers and the service itself are viewed with an enormous sense of pride (*'naches'*) within the settlement (see Figure 15).[220]

The examples of *Hatzolah* as well as the establishment of the Jewish hospital at the turn of the twentieth century illuminate the recurring ways in which culturally specific care is a margin between integration and autonomous protection for the Jews of Manchester. On the one hand, *Hatzolah* demonstrates how Haredi Jews now materialise the *halachic* imperative of *pikuach nefesh* in ways that the state are not perceived or trusted as being able to do. On the other hand, the *Hatzolah* brigade exemplifies how emergency 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 — which I continue to discuss in the context of primary care.

[220] As *Hatzolah* are also known to attend to non-Jewish victims in the area, it resembles ZAKA, the Haredi-led disaster victim identification organisation, which demonstrates how the Haredim in Israel have come to play an unusually public and outwardly looking role (Stadler, Ben-Ari, Mesterman 2005). Conceived in response to the alleged incapacity of the Israeli state to manage the aftermath of terrorist attacks, *ZAKA*'s volunteer taskforce meticulously recover the biological remains of disaster victims — including remnants belonging to suicide bombers — as a 'sacred' act (Stadler 2006). Both *Hatzolah* and *ZAKA* exemplify 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.

Figure 15: '*Hatzalah* Go' board game, available in Jewish Manchester.
Photo credit: Ben Kasstan, September 2014.

Helping and healing in primary care

Rabbi Silberblatt is a respected authority within — and activist on behalf of — the Haredi and Hassidish constituencies. He is (what one of my other research participants refers to as) 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.'[221] Rabbi Silberblatt is often the 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 the biomedical authority to secure the rights and needs of Haredi Jews, whilst also

[221] *Askon (sing.*), *askonim* (pl). Ashkenazi pronunciation, *Askan(im*); Sephardi pronunciation. From the root word '*Asuk*,' meaning "busy" or "involved with" (see Lightman and Shor 2002).

managing the degree to which their bodies are incorporated within the mainstream biomedical culture.

The continued and projected growth of Jewish Manchester's population (discussed in the previous chapter) led Rabbi Silberblatt to foresee an already overstretched local health service struggle to meet their increasing needs. In his mind, this presented a 'danger' of having a 'growing population without an adequate GP [general practice] 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.

These dangerous implications for health that the growing Haredi settlement faced then inspired Silberblatt to wage a long-running campaign for the construction of a 'one stop health shop' called the *Arukah* Centre.[222] 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 another 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 cosmology. Whereas the term 'holistic' care — concerning the person 'as a whole' and thus inclusive their religious or spiritual needs — has circulated in government discourse concerning hospital care (see Collins et al. 2007: 12), Haredi Jews can expect primary care services to comply with the standards of bodily governance dictated by the Judaic cosmology.

The conceptualisation of the *Arukah* Centre as an attempt to provide healthcare services that are conducive to the Haredi governance of the body and soul can then be placed in a broader anthropological discourse of encounters

[222] The *Arukah* Centre was under construction at the time of writing this thesis.

between the 'medical system' and 'health cosmology,' the former being a vehicle to counter poor health and the latter being concerned with recovering the balance of physical, social, and spiritual integrity (see Ovesen and Trankell 2010: 6). Understanding this difference requires us to step beyond the concept of 'the body proper' — particularly Cartesian constructions of the body as separate from the mind, and matter from spirit — towards a focus on 'how human life can be and has been constructed, imagined, subjectively known — in short, lived' (Farquhar and Lock 2007: 2).

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 arguably constitutes a form of pluralism or syncretism of knowledge-systems concerning governance of the body. In healthcare systems such as the NHS, biomedicine enjoys a monopoly over health provisions and exerts a dominance over parallel or 'heterodox' medical cultures or knowledge systems that reflects social stratification more broadly, but this is equally a dominance that has been challenged by socioeconomically or ethnically marginalised groups (cf. Baer, Singer, and Susser 2003). Prominent authorities in the Haredi minority, such as this *askon*, are arguably demonstrative of this struggle by demanding a standard of service from the national health provider in order to meet their heightened expectations of bodily care.

The 'intervention' of Rabbi Silberblatt (as well as the work of Haredi 'maternity carers,' whom I discuss in Chapter Five), can be understood in a broader body of research that investigates the agency of healers to negotiate opportunities for engaging in arenas of medical pluralism and bodily governance. Studies have shown how healers attempt to manipulate agency whilst resisting incorporation or assimilation into the hegemonic culture of biomedicine, giving 'rise to the interaction of therapeutic assemblages that extend beyond simply "traditional" and "biomedical"' (see Hampshire and Owusu 2013: 248). Haredi *askonim* (as well as maternity carers) can then be cast against this backdrop, where expertise is acquired (and at times appropriated) often by mobilising repertoires of 'scientific' knowledge to legitimise their conducts (cf. Hampshire and Owusu 2013).

Initially envisaged as a privately managed medical practice tailored to the specific needs and obligations of religious Jews, the *Arukah* Centre would

conveniently bring together services that are otherwise fragmented 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 privately 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 and negotiating the particular sensitivities of its religious minority group.

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, and contentious 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). Immodesty in dress probably refers to the comportment of women from the deprived area's overlapping non-Jewish population, who share the same primary care services but not the same commandment to conceal the body. It was not uncommon for these women to be referred to vernacularly as '*shiksas*'[223] 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'* in which socially constructed ideas of 'purity' and 'danger' have the potential to encounter each other (cf. Douglas 2002 [1966]).

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

[223] Yiddish, derogatory term for a woman positioned as being non-Jewish. From the Hebrew term '*sheketz*,' meaning impure or abominable. Incidences when a Jewish woman was referred to as a *shiksa* were regarded as particularly offensive, and were usually accusatory, suggesting that she had behaved in a '*goyish'* or non-Jewish manner.

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 value' (Rabbi Silberblatt). The etic representation of Haredi Jews being 'hard to reach,' which implies an attempt to evade healthcare services, is therefore at conflict with the emic 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 no different to the broader Jewish population (which, in Chapter Six, I discuss in the context of childhood immunisations).

Constructing a health centre that would accommodate the needs of the local Jewish population had benefits in countering the discomfort that the Haredim otherwise experienced 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 intervene with the *halachic* commands and conducts governing the body.

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 non-Haredi physicians to make health decisions that are "*kosher*" and made 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. 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 compromise of, 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*.

Dr Seiff's remark therefore alludes to how practicing medicine as a *frum* physician in the NHS does not allow for the integration of biomedical and *halachic* knowledge (as well as value-) systems when caring — or perhaps healing (*arukah*) — Jewish bodies.

Halachah and family planning

Dror is a formerly-Haredi research participant who had been going 'off the *derech*'[224] over the course of my fieldwork. During one of our many discussions, Dror recalled how his family's health and wellbeing needs were circumscribed by *halachah* and also *hashkafot* 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,' Dror had apparently requested a referral to an NHS psychologist 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 psychologists. The reasons for withholding this request for referral, according to Dror, were because such psychologists would not be *frum* and would therefore hold opposing views to that of a Haredi *hashkafah,* 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, Dror declined on the basis that (from his past experience) Haredi

[224] 'Off the *derech'* literally translates as to go off the path. It is a common and relational saying in the Haredi world to describes somebody who is viewed as becoming non-Haredi. It is also used pejoratively to describe Haredi people who not only become secular, but also Orthodox or modern Orthodox.

hashkafot and social codes of conduct 'did not allow you to explore forbidden stuff.'[225] Dror's encounter unravels the complexities of culturally specific care in the observant Jewish context, which is evidently not only about delivering healthcare services that are *halachically*-acceptable but also withholding those that challenge the established norms and worldviews of the social body. Culturally specific care can then be understood as lending autonomy to rabbinical authorities, who manage the accessibility of healthcare services to comply with their interpretations of the Judaic cosmology, which can come at the expense of individuals in the social body.

The field of family planning and birth spacing technologies[226] (BST), discussed in more detail in Chapter Five, is presented here as it forms a particularly sensitive and complicated area of primary care for Haredi Jews. The contention lies primarily in the fact that BST can 'interfere[s] with Jewish beliefs, values, and *halachah'* (Rabbi Silberman). Male condoms are interpreted as being forbidden because of the *halachic* imperative to not destroy 'seed'[227] 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.

Dror described the birth of his second child as 'traumatic' for his wife, and they later visited the same Haredi 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

[225] Described by 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.
[226] 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.
[227] *Hashchatat zera*: onanism.

to continue was not granted by their rabbi.[228] Dror's experience illustrates the complexities that Haredi men and women can face when negotiating primary care services with rabbinical authorities or Haredi GPs. 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.[229] 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 an overriding duty or obligation. Dror's account would instead suggest that Haredi medical professionals can respond with resistance to the biomedical authority as a form of cosmological intervention in instances when established *hashkafic* norms or *halachic* interpretations are infringed.

'Kosher medicine'[230] and culturally specific care

Haredi Jews are known to involve a religious authority or 'culture-broker' as part of their healthcare decision-making strategies,[231] and these arbiters enable the social body to access and negotiate mainstream biomedical services whilst maintaining a level of autonomy and self-insulation (cf. Coleman-Brueckheimer, Spitzer, and Koffman 2009). However, not all healthcare professionals may be willing to work

[228] Female contraception is 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 contraception until breastfeeding has ceased (NHS 2014b). Similar incidences of rabbinical authorities refusing to allow uptake of BSTs has also been reported in the mainstream press (see Howard 2015).

[229] The primary role of the GMC is to protect patients by regulating standards for doctors and medical students in the UK.

[230] Term borrowed from Tsipy Ivry (2010).

[231] When meeting with Rabbi Silberblatt, for instance, our interview was interrupted several times by Haredi locals telephoning for his advice on what treatment or course of action to request (or demand).

with (or accept intervention from) an *askonim* because of their 'nonprofessional 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).

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 (see 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 (or 'cultural competency') 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 are considered independently. The incorporation of '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.

An *askon* or 'culture-broker' might have undergone extensive study of *halachot* or may even be an ordained rabbi[232] who cooperates with healthcare professionals (see Greenberg and Witztum 2001). *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, but 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 a rabbi or holds rabbinical ordination) and one's own rabbinical authority.

[232] Here I refer to a rabbi who holds *smichah* (rabbinical ordination) but may not necessarily be practicing in a congregational capacity.

Whereas rabbinic rulings are considered binding and potentially hazardous if their decisions prohibit certain treatments,[233] 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 within healthcare decisions can therefore be interpreted as precarious because, in 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). 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). The incorporation of such technologies within health systems 'reproduces' as well as entangles biomedical, political, cultural, moral, and economic interests and implications concerning the social body and that of the nation. However, the rabbinical and biomedical cosmological negotiations which are involved in '*kosher* medicine' might also extend to what are otherwise relatively *routine* areas of primary care, such as reproductive choices, family planning, and childhood immunisations.

Culturally sensitive care in the form of '*kosher* medicine' therefore does not always acknowledge or allow for the needs of individual patients, and can, as Tsipy 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, Dror's experience illustrates how there is

[233] 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.

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.

Historical and ethnographic studies narrate how colonialism (as well as strategies of 'internal colonialism') bring about the forced coexistence between 'indigenous' and biomedical systems of knowledge, provoking particular responses on the part of local or subjugated populations. Biomedical interventions and domination deployed as part of the (internal) colonial order — and more importantly, the responses they engender — reflect a historical concern with the politics of the body (cf. Davidovitch and Greenberg 2007; Durbach 2000; Pandya 2005).

Studies have narrated how this interaction can result in the selective use of medical interventions, but also the active avoidance and outright rejection of those that violate or contravene local conceptions of the body (Ovesen and Trankell 2010). Rather than being conceptualised as an act of resistance against the biomedical authority, the intervention of Haredi religious authorities might instead be described as an act of cultural 'refusal' (cf. McGranahan 2016; Scott 2009) 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) when treating health and the body, the negotiated outcome of which is regarded as 'culturally specific care.'

Biomedical deference to *halachic* custodianship of the body can then be viewed as counter-balancing its dominance, as medical practitioners re-formulate care decisions to be culturally-specific (cf. Ivry 2013). This can be advantageous in upholding the interests of the social body, but consequently come at a compromise to that of the individual. The side-effects of culturally-specific care draws on a deeper discussion of how elements of Haredi health cultures can (re)produce vulnerabilities that are created by the social body's quest for autonomy and self-insulation.

Self-insulation and vulnerability

Rabbi Silberblatt perceived certain areas of NHS health information and posters in current GP surgeries as being irrelevant to the health conducts of Haredi Jews, inappropriate to their worldviews, and not always culturally appropriate which apparently 'compromises on religious values.' For Rabbi Silberblatt, this meant that health information that targeted the Jewish constituency should be more 'relevant.' Certain areas of public health interest that were viewed as controversial or compromising consisted of health material that was not '*tznius*' (perhaps by including images of women), reproductive health and family planning, and drugs and alcohol abuse.

However, conversations with mothers in Jewish Manchester highlighted the realities of "risky" behaviours that Orthodox and Haredi youths can engage in, including smoking, alcohol and drug abuse, and unsafe (as well as pre-marital) sex. The fact that Rabbi Silberblatt considered some health promotional material as irrelevant to the lifeworlds of Orthodox and Haredi Jews, was, for one mother, bound up in a larger 'inability to admit that whatever is going on in general society must be going on here.' The frontier area in which Haredi Jews can be exposed to 'general society' then sees a channelling of conducts which the Haredi establishment arguably prefer to ignore, portraying relevant information and services as *irrelevant*. The Haredi preference for protection and degrees of avoidance from the outside world that was discussed in Chapter Three consequently presents a threat from within. There were children 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 during *Shabbatot* and *Yamim tovim*. As I was told by one 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 the *Shidduch*[234] process. 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. As Levana, a convert to Haredi Judaism who has since become more 'modern Orthodox,' 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 in 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.

The fact that Haredi Jews form a 'very insular and protected community with very little outside knowledge' (Rabbi Silberblatt) creates a cycle of vulnerability based on their own preference for, and strategies of, self-insulation. The process of channelling information in and out of the Haredi social body may prevent marginalised individuals *within* the group from accessing NHS information that can actually be very 'relevant.' It is here that we clearly see the social manifestation of autoimmunity, as strategies to protect the Haredi social body become so severe that 'immunitary' responses to preserve collective life and create 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 [2004]).

'The NHS don't understand us'

Silberblatt implied that Haredi and Hassidish Jews were 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.

[234] 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.

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 also the fact that boys are taught Yiddish as a first language in some Hassidish circles. The resurgence of speaking Yiddish as a first language amongst the Hassidim means that, in some cases, girls converse more fluently in English whereas boys might only learn to speak English as a second language, which arguably forms part of a broader strategy of self-insulation or 'dissimilation.'[235] 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, and an 'outsider' (or non-Haredi Jew) might be viewed with caution, with either scenario having the potential to present implications for treatment regimes.

The selective-exclusion of Yiddish and Ivrit for Silblatt points to more than a cause of inequality between Jewish and non-Jewish patients, and this was instead seen to be entrenched in 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 anti-Semitism, therefore indicating how mainstream healthcare services are regarded as being oiled with prejudice by 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. The need for an internal source of provision is due to the particularly acute repercussions for informed consent and understanding how medical procedures will be carried out. Moreover, the perceived role that language performs in excluding

[235] In my experience, some Hassidish girls have a 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 (2000: 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.'

Haredi Jews from NHS services and the consequent preference it has created for the *Arukah* Centre is deeply reminiscent of familiarity in language and culturally-specific care as being the driving force in establishing the Manchester Victoria Memorial Jewish Hospital at the turn of the twentieth century.

Discussion

Although public health operates on the 'moral assumption that response to the perceived suffering of others is a worthy action' (Hahn and Inhorn 2009: 4), this has often resulted in 'interventions' that target the conducts of ethnic or religious minority groups. Public health has performed a historically persistent role in attempting to not only survey but also 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 (see, for example, Henderson, Millett, and Thorogood 2008; Bonevski et al. 2014). However, the term 'hard to reach' is not without controversy, 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 heath services and protocols is highly valued by the biomedical establishment, 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.

Conceptualising groups as "hard to reach" is intimately tied up with issues of marginality as a perceived relational position to biomedicine as a 'centre,' and the consequent 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 perhaps 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).

Responses towards healthcare providers in historically subjugated populations have been traced to the implication of biomedicine in politically-enforced racial segregation (see Holloway 2006). However, perceptions of distrust are not limited to these extremes and may also be a latent concern for groups who are now considered 'hard to reach.' The 'Orthodox Jewish community' and the Gypsy and Traveller population are two examples of minority groups who are encompassed within this category, and both have experienced institutionalised racialisation and marginalisation, which could affect their perceptions of external services such as healthcare.

The 'hard to reach' label that features in public health discourse is therefore 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 enables mainstream healthcare services to be accessible for Haredi Jews. However, culturally specific care can also mean that rabbinical authorities maintain a sense of "herd *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 [2002]: 174).

Biomedical techniques and technologies, such as contraception, expose the Haredi body to contested guardianships as well as exposure to the outside that come 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 [2002]). Chapter Five advances the notion of 'immunitary interventions' in the specific context of maternal and infant care, as areas of biomedicine are feared to disrupt the cultural and biomedical perpetuation of the Haredi minority.

Chapter Five

Maternal and infant care

The Judaic cosmology places an exceptional emphasis on procreation and fertility, and this chapter investigates how the mandate to 'be fruitful and multiply' has been translated in the culture of reproductive care in Jewish Manchester. A focus on reproductive cultures and conflicts positions the Haredi body under the gaze of both the biomedical and Judaic cosmologies, and more specifically as a contested area of intervention. I first narrate how émigré Jewish women encountered opposition to maintaining certain bodily conducts (which define a body as Jewish) at a time when the biomedical authority was viewed as being entrenched with anti-Semitism. The historical marginality that characterised Jewish birthing experiences in local hospitals at the turn of the twentieth century is discontinuous with the contemporary work of Haredi woman who hold a multiplicity of roles surrounding birth — such as doulas, midwives, and infant feeding supporters — and nowadays perform an important role in negotiating the delivery of NHS maternity care.

The culture of reproductive care in Jewish Manchester is, on the one hand, designed to offset the perceived shortfalls and limits of state-provided maternity services — which do not meet the heightened expectations that Haredi Jews hold when it comes to health and bodily care. On the other hand, the dedicated maternity carers can be understood as affording a degree of protection to the social body and its continuity — and thus emerge as an 'immunitary response' to areas of biomedicine that can threaten collective identity (cf. Esposito 2015 [2002]). Whereas the previous chapter positions healthcare services as one of the few spaces where Haredi Jews and healthcare professionals encounter each other, here I focus on

maternal and infant health as a point of "intervention" for some doulas.[236] Haredi maternity carers enable local women to navigate and negotiate areas of biomedicine, and I argue that these *frum* doulas occupy a unique space in the body of anthropological work that is concerned with the politics of reproduction and maternal care.

The chapter is approached through three main avenues: Firstly by constructing a narrative of historical obstetrics and reproductive care in the former Jewish Quarter of Manchester. I juxtapose this archival material with a discussion of antonymic conceptualisations of 'interventions' in Jewish Manchester today, illustrated in the specific context of Haredi responses to caesarean sections, as well as antenatal surveillance and birth spacing technologies. The final section explores the broader culture of reproductive and post-natal care that Haredi Jewish women navigate, including birth spacing technologies and infant feeding.

Historical obstetrics

The early twentieth century brought a previously unseen focus on infant life and child health, bound up in ideas of a healthy and numerous population being a 'national resource' (Davin 1978). England's falling birth rate was viewed as an issue of national security and was central to imperial ambitions because 'population was power' (Davin 1978: 10). Manchester, in particular, was the site of national scrutiny owing to the poor quality of its population as a war resource, caused by the structural conditions of industrialisation in the region (Pickstone 2005). 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.

[236] Labour supporters in Jewish Manchester typically described themselves as 'doulas' (rather than '*meyaledet,*' which is the Biblical Hebrew for 'midwife' — or, more literally, 'birther' or 'she who brings to birth'). The term 'doula' is etymologically and historically Greek, from the root of 'slave' or 'slavish work' (see Raphael 1969: 293–294). Being a 'doula' was later viewed as an honourable title, bestowed on a woman who would support a mother and her new born, for example, by cooking or caring for the baby whilst the new mother slept: the doula was not necessarily a midwife, would provide her services voluntarily, and would customarily have a coffee with the new mother (and family) before leaving (see Raphael 1969: 294). Nowadays a doula holds professional training qualifications, works alongside a midwife during hospital or home births, and provides non-medical support to a woman before, during, and after labour (see National Childbirth Trust 2016a).

The development of biomedically-ordered obstetric and maternity care has been considered a hallmark of the 'medicalisation of health and human welfare, and of life itself' (Oakley 1984: 1). Accompanying the significant drop in maternal and infant mortality recorded over the course of the twentieth century is the less positive side-effect that women and their bodies have become intensely vulnerable to biomedical domination and technological supervision and management.

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 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. Childbirth was previously a domain managed almost exclusively by women and midwives (old English, 'with woman'), where men intervened only in 'difficult' labours — which could end fatally for the mother or baby (or both) (see Johanson, Newburn, and Macfarlane 2002). Reproductive cultures, conducts, and identities consequently changed as:

> the management of birth shifted from informal, working-class, female, neighbourhood authorities to formally trained and licensed midwives, health visitors, nurses, and physicians. Childbearing women made the transition from mothers to patients. (Beier 2004: 379; see also van Hollen 2003; Oakley 1984)[237]

Homebirth was typical up until the early twentieth century. Émigré Jewish women would probably have depended on the services of a local Jewish midwife, which might have harked back to social organisation in the *shtetls* of Eastern Europe or because of a mistrust of state maternity services — as has been claimed elsewhere.[238] Sidney Taylor recalled life in the former Jewish Quarter, and said, 'you know the "*heimeshe*" people, they always have somebody that they know from the

[237] For an in depth historical discussion of medical care of pregnant women and infant health, see Oakley 1984.

[238] Mistrust has been described in the context of émigré Jews in Ireland during the nineteenth and early twentieth centuries, with Ada Shillman being a celebrated Jewish midwife in Dublin (see Birzen 2015; Rivlin 2011).

"*heim*"[239] that is always at [their] beck and call' and who would serve the local area.[240] Émigré Jewish women likely brought this *heimish* birthing tradition with them, though subsequent and Anglicised generations apparently had 'newer ideas'[241] (or had perhaps assimilated the ideal that hospitals were a 'modern' way to birth). It remains unclear the extent to which the biomedicalisation of reproduction and the 1902 Midwives Act, which sought to regulate, professionalise, and supervise midwifery practice in England (see Reid 2011), affected Jewish midwifery and childbirth conducts at this time.[242]

However, by 1921, Jewish labours at Saint Mary's Hospital were increasing, which suggests a shift in Jewish childbirth customs from the home to the hospital.[243] Fraught encounters between Jews and medical professionals at Saint Mary's Hospital occurred at this time regarding the *brit milah* (circumcision) of Jewish male infants on the wards.[244] During the early decades of the twentieth century it was fairly routine for women to remain in hospital for a week to ten days following childbirth.[245] The *brit milah*, undertaken on the eighth day of an infant's life, would have fallen during this period of maternal recovery. 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 *halachah* and the cosmological governance of the male Jewish body.[246] It was later claimed that the hospital authorities did not object to the performance of the circumcision per se, but according to archival records, it was the 'crowding together on the

[239] Yiddish: home. 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 immigrants 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.*'
[240] MJM J294.
[241] MJM J294.
[242] The 1902 act made a three-month training compulsory, which later raised to six and then twelve months. Established midwives without qualification were permitted to continue practising as long as they were registered and 'of a good character' (Reid 2011: 2).
[243] MJM J294; M443: 1921. The Manchester Victoria Memorial Jewish Hospital, introduced in Chapter Four, did not have a maternity ward of its own.
[244] M443: 1921.
[245] MJM J273.
[246] M443. A *brit milah* can only be delayed for medical reasons, such as neonatal jaundice.

occasion of a large number of Jews and making themselves merry'[247] — which can be inferred as the gathering of a *minyan*[248] for the ceremony.

Even when taking this justification at face value, the medical objections still resulted in a challenge to the bodily covenant of circumcision. What may have been an initial push towards a hospital-based birthing culture amongst Jewish women had consequently brought their male infants under liminal jurisdiction. The cosmological order that they were born into had become subordinate to an authority that decided if and when their bodies could be 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.[249] The archival record that is available offers delimited scope to grasp the lived experience of encountering the state through maternity services. The record, for instance, describes that a conflict was experienced when physicians objected to the circumcision being performed in the local hospital, but not *how* this contest over Jews bodies was experienced and lived by these émigré and local Jewish parents.

Maternity services would have been, probably, one of the first times that émigré Jewish women and the state would have encountered each other during the early twentieth century, in ways that are similar to the experience of Haredi Jews in the present day. The self-sustaining nature of the former Jewish Quarter would have reduced the need to rely on external services, especially as émigré Jews worked in trades with Jewish employers (Chapter Three), there was a Jewish hospital, the

[247] M443.

[248] 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 (M443). Thus a *brit milah* does not require a *minyan* according to some interpretations of *halachic* law. However, at the time of this research, information distributed by *rabbonim* to *frum* women in Manchester and London (entitled 'maternity issues and *halachah'*) note that if a *brit milah* occurs while a woman is still an in-patient, 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.' It can then be inferred that the preference to have a *minyan* at a *brit milah* is nowadays presented as a normative fulfillment of *halachic* law for Haredi Jews in England. 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 submission of Jews to the biomedical authority.

[249] Cf. Kaufert and O'Neil 1990, who also discussed this issue in the context of analysing obstetric records and understanding the implications of state attempts to control Inuit childbirth.

Jewish Board of Guardians had its own Chief Medical Officer, Jewish Health Visitors would survey the slums to encourage compliance with preventive and public health requirements (Chapter Four), and children would attend Jewish schools (albeit with an Anglicising agenda, Chapter Six). Objection to the *brit milah* being performed whilst women recovered on maternity wards would have then been a serious (reproductive) conflict to arise at the time.

Assimilating the margins is an example of how, in the words of Veena Das and Deborah Poole, 'sovereign power exercised by the state is not only about territories; it is also about bodies' (2004: 10). Conducts that govern individual bodies and demarcate the identity of the social body (as an 'ethnic-religious boundary marker') can be viewed as being incompatible with, and contrary to, ambitions of nation building, positioning certain bodies as 'sites of contesting powers' (Merli 2008). Reproduction — with all its connotations of biologically and culturally birthing the social body — is one particular site of contestation between local and biomedical cosmological orders (Ginsburg and Rapp 1995; Merli 2008). In a campaign of 'internal colonialism,' biomedicine becomes an indispensible 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 contests to prevailing norms are 'reproduced.'

'Emergency midwifery' and mortality

Dr Louis Rich, a Manchester born Jewish doctor, recalled a time when the quality and expertise of biomedically-ordered antenatal care was nascent. After completing his medical training in 1933, Rich later joined the Blackburn Royal Infirmary as a house physician. A ritual of the senior clinicians was to delegate 'emergency midwifery' cases to the most junior physicians on duty, indicating the relatively low status position of maternal health and mortality in the scale of concerns during the modernising framework of biomedicine:

> They didn't care if a woman died, [if] she died, they buried her. If a baby died, well that's nothing it's only a baby, we've got too many babies anyway. So they gave it to the most junior man. (Dr Louis Rich)

Early emergency obstetric care was institutionally underfunded and fraught with danger, partly because of the absence of blood transfusion services but also the performance of the vertical caesarean section.[250] The method of this caesarean involved a vertical incision from the navel to the pubis (the mid-segment of the uterus) rather than the contemporary alternative of a Pfannenstiel incision across the pubis hairline (horizontal, lower-segment). The prevalence of rickets and its impact on pelvic development in women meant that induced labours and vertical caesarean sections were fairly common 'practice' for junior physicians. Though some hospital births were scheduled in advance (or those that could not safely be conducted at home), a large proportion of hospital births resulted from failed attempts on the part of doctors when using forceps on home visits.[251] The latter scenario often had fatal implications and could result in infant-destructive operations, which were once preferred over caesarean sections in historical obstetrics (see also Shorter 1997; Rohilla et al. 2015). As Dr Rich explained in his oral history:

> The result is that we were compelled to do what we would call craniotomies. We used to have to break the baby up inside the uterus and bring it out in pieces because we had no blood transfusion — we had no sulphonamides and no antibiotics. So in order to prevent the womb from becoming septic we used to just break the baby up and take it out. That was the only way of saving her [the mother's] life.[252]

One tragic incident of maternal mortality to affect the Jewish settlement was the death of nineteen-year-old Molly Taylor on 12 May 1934. In his oral history, Sydney Taylor attributed the death of his wife to failings in maternity care and described

[250] MJM J273: Regarded by Rich as the 'classic' caesarean section. He described the Pfannenstiel (horizontal) incision as being 'a much safer operation because you didn't lose as much blood.' 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 the vertical incision less safe. However, it is important to note that contemporary studies conflict with Rich's claim that the Pfannenstiel reduces blood loss, as it requires more dissection and can thus cause greater blood loss (see Simm and Ramoutar 2005). Studies have argued that obstetricians prefer to attempt the Pfannenstiel incision rather than the vertical, as the latter can present increased maternal morbidity as well as increasing the risk of the incision scar rupturing in subsequent pregnancies (see Patterson, O'Connell, and Baskett 2002 for a review). The Pfannenstiel incision is nowadays more commonly practiced in NHS hospitals (see NHS 2014c).
[251] MJM J273.
[252] MJM J273.

how the event was the source of much discontent between the Jewish settlement and the local authority at the time.[253] He recalled how Molly had elected in advance to labour in Saint Mary's Hospital, which was then known for being a specialist maternity unit in Manchester.[254] 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 was redirected to Crumpsall Hospital[255] in a 'jerky' ambulance (characteristic of the formative years of twentieth century biomedicine), where she died from delayed obstetrical shock due to 'insufficient care' (see also Pickstone 1985).

The incident provoked staunch criticism from both the Jewish population and local women's advocacy groups. 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 'possibly' being anti-Semitic, which he considered to be symptomatic of the biomedical authority at the time:

> It was a very difficult atmosphere in the 1930s. The amount of anti-Semitism was enormous. The British Medical Association was the most anti-Semitic 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. (MJM J273; see also Karpf 2002)

The perceived entrenchment of anti-Semitism 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, or at least appeasing, towards the rise of National Socialism in Germany. However, articles had featured in

[253] MJM J294.
[254] See also MJM J273: Rich arranged to observe obstetric cases as there was 'always something going on at St Mary's, either a forceps or a caesarean.'
[255] Crumpsall Hospital (North Manchester) is approximately six miles in distance from Saint Mary's Hospital.

prominent medical journals before political events in the 1930s, which, by contemporary standards, might 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).

The harrowing reflections and testimony shared by Dr Rich demonstrates the hegemony of biomedicine and how its practitioners were entrusted with the traditional attributes of sovereign power. It is for this reason that Rich clearly stated, by 'the very nature of the profession they've got such power over people. They've got power of life and death.'[256] The authority invested in the medical establishment and its command over 'life and death' testifies to what Michel Foucault elaborated theoretically in terms of 'biopower,' as a political strategy of co-option to achieve the complete 'subjugation of bodies and the control of populations' (Foucault 1978: 140).[257]

Revising the traumas of early twentieth century maternity services through Dr Louis Rich's oral history as well as the tragic death of Molly Taylor elucidates how a sanctioned form of violence was an inherent part of the historical conquest of women's bodies and the medicalisation of pregnancy and childbirth. Medical science and its claims of superior (or authoritative) knowledge have paradoxically institutionalised a safer and technocratic birthing culture that is accompanied by harmful obstetrical procedures. In the present-day context of the United States, Robbie 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 [1992]: 2). Not simply a 'discipline' of biomedicine, obstetrics and reproduction are caught in the gaze of intersecting disciplinary powers in that they birth the body of the individual, the social group, and the nation. Targeting the reproductive conducts of women from

[256] MJM J273.

[257] Foucault's theoretical elaboration of the 'right of death and power over life' was first published (in French) in 1976 (see Foucault 1978 [1976]). Rich's oral history was recorded in 1980.

poor, minority, and marginal(ised) groups has therefore been argued to be a strategic area of state interest (see Hyatt 1999; Merli 2008).

Haredi doulas and midwives

The cosmological imperative to perpetuate the Jewish social body (as imparted through authoritative interpretations of religious scriptures) has, in turn, given rise to a protective culture of reproductive care in Jewish Manchester today. A network of qualified Haredi doulas and registered NHS midwives (referred to collectively as 'maternity carers' in my thesis)[258] form the heart of this reproductive culture, and attempt to meet the antenatal, labour, and post-natal needs of local Jewish women. Religiously observant doulas and midwives are strategic (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). The *frum* doulas are, on the one hand, advantageous for the local NHS authority because they can contribute to making mainstream maternity services more accessible for Haredi Jews. On the other hand, state maternity services can be understood as warranting an immunitary intervention on the part of these doulas, in order to support Haredi parents who need to navigate and negotiate areas of health and bodily care that can be at odds with the *halachic* governance of Jewish bodies (as I discuss later in this chapter).

Several of the maternity carers I met would frame their roles by making explicit reference to Shiphrah and Puah — who are the two ancient Hebrew midwives that continue to 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 Shiphrah 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.

[258] I also group *frum* doulas and midwives as 'maternity carers' in many instances to maintain their anonymity and prevent them from being identifiable.

> 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*] Exodus 1:15–20)

Meirah, an experienced doula in the Manchester settlement, elaborated on the excerpt by saying that the Pharaoh King of Egypt had ordered the Hebrew midwives to practice infanticide on all boys because of a prophecy that 'there would be a leader rise up in the Jewish nation,' who, as the narrative goes, was Moshe (Moses). The culture of having Jewish maternity carers, one doula told me, '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 culture. More specifically, in comparing her role as a doula with that of the Hebrew midwives, Meirah alludes to an enduring need to challenge and subvert regimes that are seen to dominate Jewish births, or worse, limit them altogether.

Many of the Haredi doulas and midwives I met would cast their maternal care work against the historical roles of these 'God fearing women,' which positions maternal heath and bodily care as imperative to protecting the continuity of Haredi Judaism. Moreover, doulas would describe their work in ways that situate the importance of reproduction in the Judaic cosmology, such as their journey to hospital as being a '*shlichut*' — a term that implies being 'sent' on a mission. One of the reasons that make Jewish midwives extremely popular and favoured in the constituency is because 'from a spiritual point of view, it's so nice to know that this baby is born with only Jews around it' (Shifrah, midwife).[259] The preference for women to be supported through labour by Jewish maternity carers is historically continuous considering the push to establish a Jewish hospital during the formative

[259] I have named this research participant after Shiphrah, the ancient Hebrew midwife, as for me, she brought to life the narrative inscribed in the Torah. I have maintained a nuanced difference in spelling (Shifrah/Shiphrah) to offer a distinction between references to the ancient Hebrew midwife and my research participant.

years of the twentieth century and the demand for culturally specific care among émigré Jews (see Chapter Four).

The added advantage to training as a midwife is its enduring 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 *Mashiach*[260] and the ushering of the Messianic era, which will, in short, gather and repatriate the Jewish exiles to *Eretz Yisrael*[261] as well as see the eventual resurrection of all the Jewish dead:

> 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, because everyone will be healthy, whereas midwives, there will always be a need for midwives. (Shifrah)

As both a registered midwife and Haredi Jew, Shifrah positioned her work in the Judaic cosmology and as an imperative for both the wellbeing of local Jewish women and the group's eternal perpetuation. She considered midwifery as having both medical and spiritual attributes, and described the role as being a 'messenger for God's holy work.'

Differences remain between *frum* midwives and doulas despite being brought together under the collective term of 'maternity carers' in this thesis. Midwives in the UK must complete a three-year university degree at an accredited institution (leading to registration with the Nursing and Midwifery Council)[262] in order to practice. Midwives are trained to conduct clinical examinations, oversee the labour process and identify issues, 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 (see Royal College of Midwives n.d.). Entry into formal midwifery training means that *frum* women encounter particular challenges when aspiring to attain qualifications

[260] Literally, anointed one (commonly translated as 'Messiah' in English) who is descended from the revered King David (also *Moshiach*).
[261] *Eretz Yisrael* refers to the Biblical land of Israel, not the Israeli state's current and contested borders.
[262] See Nursing and Midwifery Council (2016), which regulate nurses and midwives in England by setting the standards of education, training, and conduct.

outside of the Haredi settlement, in ways that are contiguous with the historical issues that prospective Jewish nurses faced in Manchester (Chapter Four). Primarily, attending university can present an issue of contravening established gender norms. Keturah (a midwifery student) said that it was 'not the done thing' for Orthodox girls in Jewish Manchester to study midwifery and nursing at local universities, though it is 'becoming more acceptable.'[263]

Haredi women who do pursue midwifery or nursing training at university straight after their preparatory stage at 'sem'[264] and *before* marriage are, according to one student midwife, very much in the minority in Jewish Manchester. However, 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 expectations of marital roles — which can contravene socially-constructed ideals of gender in the Haredi world. Shifrah trained as a midwife before marriage in order to avert these potential moral conflicts:

> What happens during those three or four years [of university and training]? Are they going to have kids in between? Are they going to abstain [from sexual relations]?[265] 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.

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 social expectations. It is perhaps for these reasons that there are more doulas than registered midwives and nurses serving the Jewish settlement in Manchester.

[263] Whilst it is considered more acceptable for *frum* women to pursue undergraduate studies through the Open University (a public distance learning institute) after marriage, this is not an option for midwifery studies due to the practical nature of the course.
[264] Not all Seminaries will encourage *frum* young women to pursue a secular education or training afterwards, and may instead promote marriage after sem.
[265] Birth spacing technologies are usually only accessible with rabbinical consent, which can be withheld (see Chapter Four), demonstrating how professional training presents implications for the *halachic* jurisdiction over health and bodily care.

Rather than undertaking a three-year degree, doulas and infant or 'human milk feeding'[266] supporters are able to undergo shorter periods of training and assessments in order to be peer-supporters through mainstream organisations such as the National Childbirth Trust (NCT), Le Leche League, and The Breastfeeding Network (as well as receiving some on-going training from the *frum* midwives). In theory the role of a doula is primarily a supportive one, rather than applying biomedical knowledge or circulating medical advice to pregnant mothers. Often the Haredi doulas draw on a wealth of personal experience, with some having up to ten children themselves.

The senior doulas (and also infant feeding 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 aromatherapy, homeopathy, hypnotherapy, and massage. These Jewish birth supporters do not exist in isolation, and were modelled on a pre-existing Haredi maternity service 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 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,[267] the *frum* doulas hold a significant amount of status, not only within Jewish Manchester, but also the NHS hospitals they work in. The doulas are, in the eyes of some NHS professionals, apparently viewed more favourably than private midwives who are remunerated for their services by clients.

[266] References to 'human milk feeding' rather than 'breastfeeding' in this chapter are taken from Penny Van Esterik's preference to use the term 'human milk' rather than 'breastmilk,' as 'we don't call cows' milk udder milk — why stress the container over the species?' (2015: XV). However, it is important to note that the breast is not only a 'container,' as feeding by way of the breast produces hormonal stimulation that can result in a powerful emotional bond between a mother and baby (Hrdy 2009: 72), although there is considerable diversity in women's embodied experience of nursing and the relationships formed with infants (Schmied and Lupton 2001). I prefer to make reference to 'human milk feeding,' rather than 'breastfeeding,' the latter of which places a conceptual focus on women's bodies — presenting implications for socially constructed ideas of modesty.

[267] 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.

That being said, the doulas do not form one integrated maternity service. Two main, but nuanced, strands of care are available in Jewish Manchester — a situation that occurred after two senior doulas, who were previously associates, held diverging views of how to most appropriately offer maternal and infant support, and consequently split. I was told by the co-ordinator of one of these two groups that doulas support, on average, three hundred Jewish births every year (Mrs Herskovitz), which indicates the prominent place of *frum* doulas in the settlement. The intra-group culture of maternity care is 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). A discontinuity can then be seen in the provision of culturally specific care services in Jewish Manchester over time. Whereas the Manchester Victoria Memorial Jewish Hospital (Chapter Four) became an enabler of 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 cultural control over the reproduction of the social body.

During the course of their pregnancy, women in the Jewish settlement are invited to contact a senior doula (holding a role akin to a 'co-ordinator'), who will then arrange for the most appropriate doula depending on the pregnant woman's needs (or personal request). Once the expectant mother '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 discharge the placenta more promptly, or administering a vitamin K injection to the new born baby. As Mrs Herskovitz, a local doula, 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 rest with the pregnant woman. However, in some cases, the husband can feel they are doing the best thing for their wife by soliciting woman-woman birth support because the *halachic*

governance of pregnancy precludes them from being physically involved. The laws of *niddah* (separation) are the main example of this. Being *niddah* renders a Jewish woman impure (*tameh*) during periods of uterine bleeding, such as menstruation or labour, and a wife and husband are forbidden to engage in any physical contact.[268] Different stringencies are applied to *niddah* and childbirth depending on a family's *hashkafah*: 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 more Haredi and Hassidish women leave their husbands at home.[269] 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 be unable to do, such as massaging and comforting the labouring woman.[270]

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 recalled an instance 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), having not understood the significance of this act:

> 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)

[268] 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 menstruation ends and after post-childbirth 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*.

[269] 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.'

[270] 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 (cf. Dettwyler 2011: 149), which illustrates how Haredi Judaism is not unique in limiting 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.

Having a doula present can then be an immense source of support for a husband, who can find it reassuring that 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.[271] 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 constructs 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 protect 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 [2002]).

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

[271] Cf. Sered (1992), Pious Jews call upon Divine aid in childbirth because it is perceived to be a crucial and precarious event.

carers circulate information from both the biomedical and Judaic cosmologies when preparing women for pregnancy and labour. In integrating these two systems of knowledge that govern childbirth, doulas can provide material on 'advice for optimal foetal positioning' as well as labour positions, but also written guidelines that focus on the implications of pregnancy and reproduction for *halachic* observance.[272]

The guidance available to women also includes the codes of conduct and comportment they are expected to fulfil. Reciting *tefillot*[273] and *davening*[274] for the wellbeing of the foetus and a 'smooth' birth is viewed as an essential act of pregnancy and labour for both men and women. The guidelines also mobilise the teachings of revered historical religious authorities such as Moses Maimonides in encouraging parents to *daven* that their child is specifically 'successful in Torah and *mitzvot,'* with other literature encouraging parents to pray that their child will become a 'God-fearing Jew'[275] — in other words, Haredi. 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.

Women are seen to provide both nutritional and spiritual nourishment to the foetus in her womb (see Yaffe 2012), and are therefore warned against conducts that are considered to adversely influence her or the foetus during pregnancy. Examples 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 fetus.'[276] The guidance can therefore be seen as reinforcing the codes of conduct that perpetuate or reproduce the bounds of the Haredi social body. The guidelines also mobilise references from the *Gemara*[277] when advising women of 'precautions'

[272] 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 the Haredi consortium of synagogues in London. Based in Stamford Hill (London), the Union of Orthodox Hebrew Congregations (UOHC) is the umbrella body, which Haredi synagogues generally align to.
[273] Hebrew: Commonly translated into English as 'prayers,' though lexical differences in meaning remain.
[274] Yiddish: Praying, as above.
[275] See Yaffe (2012: 28).
[276] Referenced in a publication that was produced under the authority of a local rabbi.
[277] 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).

that are associated with pregnancy loss, for instance, stepping on carelessly discarded finger or toe nails.

Particular attention is given to preparing pregnant women for labour by explaining the laws governing *Shabbat*, and when they 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 responsibility to 'preserve life' — and the labouring 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.[278] Documents that do not have a direct relation to the labouring mother's health cannot be signed by a Jewish mother on *Shabbat*, 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.

It is arguably the case that there are opposing constructions of modesty between the maternity carers and rabbinical authorities, which have implications for the potential to have discussions about reproductive choices 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

[278] 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.

carers as to when education about women's development and health should begin, as Shifrah 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 (Shifrah, midwife). However, Haredi women are far from unique in concealing news of a pregnancy during the first trimester. It is common for women to delay the announcement of a pregnancy until antenatal scans have been performed, particularly the twelve-week scan, as the first trimester is a precarious time for foetal development and is the period in which around three in every four miscarriages occur (see National Childbirth Trust 2016b; NHS 2015a). The difference for Haredi 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 can be common to both biomedical and local cosmologies (as Kastrinou 2016: 86–87 also discusses in the context of the Druze of Syria). Shifrah 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*[279] when you are a God fearing Jew, as Shifrah 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 (cf. Sered 1992: 24–26).

[279] Congratulations (also *mazal tov*).

Avoiding antenatal surveillance

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,[280] which Mrs Salamon[281] (a local childcare worker), described as a naivety towards the risk and uncertainty that pregnancy can present. The active avoidance of 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:

> They 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."

However, active avoidance of antenatal screening services is not simply a manifestation of religious 'fatalism' on the part of pregnant Haredi women, as Mrs Salamon implied, but also a result of guidelines that are circulated in order to uphold the *halachic* governance of pregnancy. Chapter Four illustrated how certain areas of healthcare or health delivery strategies are viewed as culturally inappropriate 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 senior doulas presents pregnant women with a handbook entitled 'maternity issues and *halachah*' (endorsed by the London consortium of Haredi synagogues), 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.

[280] See NHS (2014d). 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).

[281] Mrs Salamon positioned herself as being 'at the bottom end of the Haredi spectrum' (but working with families from across the Jewish settlement).

> 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)

It can be inferred that antenatal screening services do not contravene *halachah* or social codes per se, but the results of surveillance technologies might lead parents to make decisions — or be presented with options — that can. Technologies of antenatal surveillance 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 of the social body as a whole. The advice circulated by rabbinical authorities therefore informs parents that they have the right to decline an invitation for antenatal screening tests because of the consequences that screening technologies can pose — or rather what they have the potential to *reveal*. 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 Ann Oakley:

> 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. (1984: 2)

Rather than holding a 'fatalistic' attitude towards pregnancy and the potential for antenatal services to reveal a disability, it is perhaps the case that there are opposing constructions of 'protection' at play when reproducing the social body and that of the nation. The purpose of performing 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 surveillance 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' (see 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 (see Rapp 1999).

Rather than being rejected outright, antenatal screening regimes have been described as a 'spiritual ordeal' for Haredi women in Israel, and are selectively-accepted because of the ramifications they can present for both the lives of religious women and the social body as a whole (see 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 (cf. Ivry, Teman, and Frumkin 2011; see also Ivry 2010). Reproductive interventions entail a dispute on 'birth control' in which the pregnant body 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 *askonim*, rabbinical authorities, and maternity carers. The culture of biomedical technology (which antenatal screening services constitute) are negotiated in the form of 'selective-acceptance' — and are thus simultaneously incorporated but also resisted into the Haredi social body — as they can have the potential both to protect but also destabilise the Haredi lifeworld.

However, studies have shown that abortions are not unheard of for some Haredi women in Israel, with *rabbonim* granting dispensations (or exerting pressure to take dispensation for an abortion) in certain circumstances (Ivry 2009; Ivry, Teman, and Frumkin 2011).[282] It is important to reiterate here that rabbinical authorities interpret the body of religious texts that inform the Jewish cosmology,

[282] Examples included a foetus being diagnosed with fatal diseases (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: 1532).

and it is this interpretation that formulates a *psak* (ruling of *halachic* law), as I discuss elsewhere in this thesis (see Chapters Four and Six). 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).

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 a 'reproductive catastrophe' (see Ivry 2009: 201). Responsibility is presented as safeguarding a woman's healthy pregnancy but also the concern for how the social body (or that of the nation) is reproduced — all of which 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 what Tsipy Ivry (2009) describes as a 'politics of threatened life.' 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). Through technologies of prenatal surveillance and diagnoses, pregnant women take on the role of a 'moral pioneer' or 'moral philosopher' where they are tasked with policing the (socially-constructed) 'standards for entry into the human community' (see Rapp 1998: 46). Technologies of antenatal surveillance can then be understood as forming part of a broader immunitary apparatus with which the preservation of individual and collective is hinged upon, as the potential threat of a reproductive catastrophe for the body of the nation warrants a protective — and destructive — response (cf. Esposito 2015 [2002]).

Birth support and 'interventions'

Using the example of caesarean sections, as well as epidurals, I present the term reproductive interventions as entailing opposing constructions between the state and the Haredi minority. Whereas the former view 'reproductive interventions' as an apparatus of the biomedical obstetric culture to safely birth the body of the nation, the latter can be seen as an 'intervention' to negotiate biomedical care with the Judaic cosmology and its governance of Jewish bodies. I then discuss the work of *frum* doulas in relation to the broader anthropology of reproduction and birth, and argue that they challenge existing categories of labour support.

The aforementioned sensitivity that surrounds the education of bodily (and especially reproductive) processes and care in the Haredi lifeworld can mean that doulas are particularly supportive for *primagravida* women when helping them to understand the culture of NHS maternity services. Moreover, the doulas can also help Jewish mothers to be more assertive in their requests or needs — which is viewed as a requirement when encountering the NHS.

The demand for Jewish doulas can be attributed to the standard of NHS maternal health service provisions that fall short of local expectations. One Haredi mother, for instance, described midwives in the NHS system as being more for 'safeguarding' than 'support' — a role, the latter, that 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).

Constant economic cutbacks to the NHS welfare budget and organisational changes in midwifery care, have, in turn, provoked different conceptualisations of maternity roles between NHS midwives and *frum* doulas. However, doulas do not intend to be seen as a replacement maternity service, but are instead complementary and supplementary in meeting the perceived limitations of what the state is able to provide (such as care). As I was told by Mrs Herskovitz, 'we're not

taking places of anybody, we're working together.' Midwifery, a more senior 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.' However, 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.[283] 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 also task themselves with overseeing the technologies of childbirth — which are considered to be the hallmark of maternity care in the biomedical cosmology — to ensure that women are labouring safely.

The structural and organisational changes to NHS midwifery services and the perceived risk of subsequent malpractice have prompted local *rabbonim* to say to labouring women, '"take somebody with you," because they [the *rabbonim*] see what goes on' (Mrs Herskovitz). Considering recent media reports have claimed that maternity units in the UK are dangerously under-staffed due to nation-wide shortages of maternity doctors (see Campbell and Duncan 2016), the concerns of religious authorities in Jewish Manchester should not be dismissed as a mistrust based on suspicion or hearsay. Despite the reservations of senior doulas 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 'could go wrong' (Mrs Herskovitz). 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

[283] Mainstream media articles published during my research narrated how midwives struggled with the burden of paperwork and administrative duties in the NHS (see Philby 2013; The Guardian 2015).

home birth (Shifrah),[284] 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 had an impact on the relations and encounters 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. Whilst the doulas told me that a key part of their role is mediating encounters and relations between the midwife and the Jewish mother, there is 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.

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." Healthcare professionals, in some

[284] The view that home births are not 'cultural' in Jewish Manchester to some extent mirrors the low levels in England as a whole, where 2.3 per cent of pregnant women laboured at home (see Office for National Statistics 2014). Although, as will be discussed later, doulas held different opinions of homebirth, with other service-providers advocating for complementary therapies and approaches at home, thus indicating how maternity carers do not constitute a uniform service.

instances, apparently included the doulas, or they intervened, in clinical decisions surrounding labouring Jewish women. Meirah 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 Meirah, 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 by the biomedical and Judaic cosmologies) are enacted, contested, and negotiated.

The approach that some doulas take in 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. Tivkah 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 birth supports to occasionally overstep. NHS workers have made complaints against doulas in the past, which can require mediation by a lead and coordinating maternity carer with the hospital authorities.

Pain, fear, and epidurals

Some maternity carers offer private birthing courses to expectant parents with a complete antenatal and postnatal preparation, not as an opportunity to educate, but to give confidence in 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 the body, but also the biomedical monopoly over childbirth that sees labour confined to hospital maternity wards. According to one doula, 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, senior doula). Mrs Gross upheld the view that

women have a smoother birthing experience when they are more comfortable and safe. For this reason she encouraged home births rather than in an unfamiliar environment, such as a maternity ward, and she was the only doula I encountered who would endorse this.

Fear is dealt with by, as Meirah explained, framing reproduction as a religious domain because God chose to maintain jurisdiction over it, rather than delegate it to his angel messengers. Childbirth — along with rain and the Biblical splitting of the *yam suf*[285] — are the 'three jobs that *HaShem* never gave to any messengers.' The presence of God during childbirth is a point that Meirah 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.'

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' (Meirah), the doulas task themselves with empowering and supporting women to gain the self-confidence to believe they can labour, sometimes with a restrained use of biomedical 'interventions.' In cases where expectant mothers 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.' Rather than attributing fear of labour to inexperience, this midwife claims it is the reduced flows of non-Haredi knowledge and information pertaining to the process of childbirth and bodily care that can affect the confidence of a *primagravida* woman and her capacity to labour vaginally. For these reasons the maternity carers place an emphasis on antenatal classes, whether those provided by local public services, or classes that are privately held by Jewish midwives.

Intervention on the part of maternity carers manifested over conflicting views on the provision of epidurals for pain relief. One *frum* midwife would attempt

[285] The event in *Shemot* (Exodus), where the *Yam Suf* ('Red Sea') is Divinely parted to allow the ancient Israelites to escape the charging Egyptians forces.

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 reproductive interventions for pain relief and acknowledging that it is a personal choice for labouring women. In contrast, Meirah encouraged labouring mothers *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 labouring women — 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.' Whilst paracetamol is an over the counter pharmaceutical in the UK, Meirah also advocated against institutionalised pain relief, including epidurals, which are made routinely available to labouring women by maternity staff:

> I had a mother come to me and say, "oh my darling, 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, "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 health conducts which might conflict with biomedical standards of practice.

Caesarean section

In a cosmology that upholds the view that women have 'been given organs [by God] to give birth naturally' (Shifrah), 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 the mother's future reproductive potential, and by virtue of this, the endurance of the Haredi social body.

Meirah 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 — which is an issue because 'you can only have so many caesareans.' There is evidence to suggest that multiple repeat caesarean sections (five or more) are associated with significantly increased risk of maternal complications, including a higher incidence of uterine rupture, blood loss, haemorrhage, and admission to critical care units (Cook et al. 2012; Nisenblat et al. 2006). It is consequently 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 (see Rashid and Rashid 2004). Thus it is possible for caesarean births to impose a limit on a mother's reproductive potential. Considering interpretations of the Biblical mandate to reproduce and 'multiply' the social body, it is abundantly clear why, 'in the *frum* world, people would rather not have caesareans' (Meirah).

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 (see 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 Meirah would reassert when called upon for maternity advice.

Meirah narrated several instances when she challenged the judgement of medical professionals that recommended birth by caesarean section, and in particular when she accompanied a first-time mother with an undiagnosed breech to the maternity unit:

> 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 Meirah portrayed herself as asserting her authoritative knowledge of birth over both the pregnant inpatient as well as healthcare professionals, formulating and pressing the patient's 'choice' in order to challenge a clinician's decision to perform a caesarean.[286] Thus contestations of 'authoritative knowledge,' as upheld by proponents of either the biomedical or Judaic cosmologies, are enacted on the bodies of Haredi Jewish women.

Meirah'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).[287] 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). Meirah 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.'[288] Rather than being an issue of need in most cases, Meirah claimed that it was 'easier' for obstetricians to 'perform the evil' than oversee a vaginal labour — which is constructed as risky, unpredictable, and litigious in the biomedical worldview.

Having Haredi doulas as a source of "intervention" in clinical encounters and as a general presence in maternity wards has, according to Mrs Herskovitz, caused the rate of caesareans births in Jewish Manchester to plunge to just three per cent compared with the national average that she cited as being thirty-three per cent. The potential to 'cut' local caesarean rates by having a doula is mobilised as a source

[286] 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.'

[287] Current statistics for England's national average for caesarean births are 24.6 per cent, amounting to one in four births by operative intervention (see Macfarlane et al. 2015). The WHO (2010) maintains that national rates of caesarean sections exceeding fifteen per cent of all births cannot be medically justified.

[288] Emphasis added.

of conviction in the group's need for a culture of maternity care, and Mrs Herskovitz told me 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)

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' (see 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' (Meirah [emphasis added]). Meirah presents herself as having responsibility for managing the course (and perhaps choice) of a woman's labour, which might otherwise be considered the prerogative of a midwife. The supportive and activist 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 Meirah's aversion to caesarean sections lies in the fact that the surgical procedure can adversely "intervene" in the reproductive rite that is bestowed on a male first-born (*bechor).*[289] Whereas the *brit milah* is a widely known male reproductive conduct in Judaism, relatively less attention is focused on the *'Pidyon HaBen'* ceremony (redemption of the first born son), which is held when a *bechor* is thirty days old. However, the rite of birth is only held under certain

[289] Hebrew, *Bechor* is commonly 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.

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.[290] 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' (Meirah). Interpretations of what constitutes the opening of a Jewish womb can be so stringent that even if a male firstborn is born by caesarean, a *Pidyon HaBen* would not be conferred upon a subsequent male to be born vaginally.[291]

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. The archival and ethnographic juxtaposition of this chapter therefore demonstrates how Jews in Manchester have been faced with a historically continuous negotiation when choosing hospital births, which are viewed as a safer option, yet can present a challenge to bodily and reproductive conducts that define and perpetuate identity.

Opposing conceptualisations of reproductive care

The perceived need for intervention during childbirth on the part of doulas is a result of the cardinal place of reproduction in the Judaic cosmology. As has been argued in

[290] 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.

[291] 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.

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 the Haredi doulas, medicalised childbirths have been left devoid of care and support and instead overshadowed by the 'safeguarding' ethos of biomedical maternity care. However, a Haredi culture of maternal care is not resistant to medicalisation, and neither is it de-medicalised, a point also reiterated by Tsipy Ivry and colleagues (2011). On the contrary, I was told that rabbinical authorities view hospitals as a safer option for Haredi women to labour in. The difference is that the biomedical culture of maternity care falls short of local expectations and also requires negotiation — in both cases to comply with the Judaic cosmology. Reproduction and reproductive care is then best interpreted as having opposing constructions 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).

Consideration of obstetrics as a biomedical discipline can be conceived as part of the broader anthropological study of how political regimes (whether through colonialism or "internal colonialism") control how the body of the nation is reproduced. The biomedical domination of reproduction is clearly seen in the construction of "professional" midwives as the norm, and "traditional" (also "indigenous") midwives as subordinates, when the difference between these two etic categories might instead lie in opposing conceptualisations of care. Moreover, the category of "traditional" midwives is both reductionist and misleading for several reasons. Not only does the it amalgamate the diversity in which maternity care is practiced (physiologically and spiritually) outside of the biomedical cosmology, the emphasis on being a 'traditional' midwife also does not account for the complex ways in which birth attendants may operate within their own systems of authoritative knowledge, and also sit in relation to biomedical practice.

The preference for Haredi Jews in Manchester to use doulas alongside mainstream midwives can be entrenched in a broader body of anthropological work that explores how reproductive care is negotiated between state-mandated and

local midwives. Carol Laderman has narrated how the ritual expertise and birthing conducts that *bidan kampung* (Malay 'village midwife') specifically offer to labouring women (such as postnatal health and bodily conducts) often mean that their services are sought in preference to, or in conjunction with, government midwives in Malaysia (1983: 104). However, across the geo-political border in Thailand, *the bidan kampung* can hold a revered role among the Malay Muslim minority, but have simultaneously been co-opted and marginalised in the mainstream healthcare system as a means of controlling, subordinating, and eventually ending their activity (see Merli 2010).

State attempts to control the conducts of local maternity carers is typical of the aforementioned conceptualisation and configuration of 'traditional' midwives and health workers as a resource for the delivery of biomedical strategies, which attempts to 'show "respect" for "other cultures" while still controlling them' (Pigg 1995: 52). Midwifery has been incorporated into modern biomedicine because it enables the state to control birth and the culture in which the body of the nation is reproduced, and 'local' or 'traditional' midwives consequently assimilate biomedical standards in their maternal care work, often through professional training (see, for example, Sargent and Gulbas 2011: 296; Davis-Floyd, Pigg, and Cosminsky 2001).

The role of maternity carers in the Haredi context challenges these existing anthropological conceptualisations and dichotomies, as well as confronting the few definitions of a doula's responsibility based on anthropological work, being:

> solely to attend to the birthing woman and her non-clinical needs during the birthing event, such as physical and emotional support. The doula's goal is to help the woman have a safe and satisfying childbirth as the woman, in particular, defines it. (Hunter 2012: 316)

Unlike previous studies, which assert that doulas are hired as 'paraprofessionals' and remunerated to provide a personal level of care that is not standard practice in hospitals (cf. Hunter 2012), the Haredi doulas provide a freely available service and perhaps view care as having a culturally specific dimension. Whilst it cannot be denied that the Haredi doulas perform a formative and formidable role in supporting labouring women, some go beyond this position by intervening in clinical encounters

using their appropriated knowledge of medical terminologies and procedures. Reproductive 'interventions' then take on antonymic conceptualisations, being practiced by the state in its interest of managing the body of the nation, but also the Haredi doulas in attempting to birth the social body according to the Judaic cosmology.

I argue that the Haredi maternity carers in Jewish Manchester advance past conceptualisations of labour support (especially the few that concern doulas) given their specific intentions and mission to oversee the birth of the Jewish social body within the biomedical order, and especially as they form part of a larger immunitary strategy 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 knowledge and bodily governance. 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 thus stands in opposition to previous studies which chart how midwives become incorporated in the biomedical culture or 'discipline' of obstetrics.

Postnatal and infant care

With the exception of a few senior carers, the work of doulas generally finishes after childbirth and then the 'breastfeeding supporters' (or 'infant feeding supporters,' as some preferred to be called) provide the majority of postnatal care in Jewish Manchester. These women were also in a strategic position to identify postnatal concerns such as the need for birth spacing technologies and maternal convalescence, and it is in such contexts that the senior carer acts as point of referral when directing women to rabbinical authorities or peer-led support groups. 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, often struggle to understand the cultural context in which they work.

Health Visitors ordinarily form the frontline of public health surveillance in the UK, especially to monitor the health and wellbeing of children less than five years of age and also assess '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 surveillance apparatus, and arguably supervise how parents "reach" state expectations of childhood development, which has implications for how the body of the nation is reproduced.

Mrs Yosef, a senior maternity carer, 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 Health Visitors and Haredi Jews is not specific to the case of Manchester, and has been observed in previous studies conducted in the UK. Some Haredi mothers have described a 'fear' that Health Visitors 'look around your house and judge you' (Wineberg and Mann 2016: 28), which suggests that Health Visitors may be viewed as an apparatus 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 Haredi 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 Haredi 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 infant care and bodily governance may then underlie the conflicts observed between Haredi Jews and NHS Health Visitors.

By being internal to the Haredi settlement, the *frum* maternity carers are able to navigate the socio-religious diversity and fulfil a postnatal role that NHS-employed 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 Yosef).

Surveillance of the Jewish minority has deep historical resonance and harks back to the formative years of Jewish Manchester, and illustrates the continuity between the historical Jewish Ladies Visiting Association (see Chapter Four) and the contemporary role of *frum* maternity carers in meeting the changing 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 internal services are seen to exceed the standard of care provided by the state and also afford a degree of protection against 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.

Convalescent homes

Anglicised Jews in the early twentieth century identified a need to institute a post-natal home for convalescence and respite as an intermediary maternal health and wellbeing service at a time when hospitals would only admit mothers and neonates in cases of illness. Maternal 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.'[292] Recognising that mothers needed support beyond childbirth, Margaret Langdon led attempts to gather funds for the institution of a maternal rest home in 1920 for (married) Jewish women, also admitting non-

[292] M182/3/1: 1872–1873.

Jews depending on capacity,[293] as part of the United Sisters' Maternity Society.[294] Jewish mothers would be expected to make a small contribution to the cost of their care,[295] which was subsidised by subscriptions made by the broader Jewish population in Manchester (in ways that are continuous with the funding of Haredi services such as *Hatzolah*, see Chapter Four).

The home was initially instituted as a summer retreat in Cheshire (north west England), which is near to Manchester, with the intention of 'restoring to health the most precious members of the community, the mothers of a future generation.'[296] Unique for the era in admitting women together with their babies, the home was a pioneering enabler of maternal and infant health and was unparalleled by locally-provided mainstream care.[297] The maternal rest home can be conceived as a culturally appropriate (or culturally specific) service offering both preventive as well as curative care,[298] running along 'orthodox Jewish lines' and perceived as being the only suitable service for Jewish mothers and babies.

Given the dusty, crowded, and insalubrious nature of the slums, the home later opened in the autumn, winter, and spring months for 'convalescent children of school age' in 1929.[299] Following treatment at local clinics or the Jewish hospital, for what can be assumed to be respiratory diseases and consequent 'debility,' the retreat was seen as a vital and urgent rehabilitative service 'to ensure the permanent recovery of the child.'[300] The routine of rest, wholesome food, and fresh air meant that it was a 'regular occurrence,' and perhaps expectation, that children would gain weight during their average rehabilitative stay of three and a half weeks, as records from 1937 claim.[301]

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[293] 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.
[294] MJM J143; C15/3: 1920, 1929. Later appearing in annual reports as '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.
[295] C15/3: 1922.
[296] C15/3: 1920.
[297] C15/3: 1922.
[298] C15/3: 1923. The aim of the convalescent home for mothers was to 'restore them to health.'
[299] C15/3: 1929.
[300] C15/3: 1933; 362.1 M64: 1924.
[301] C15/3: 1937.

Judaism and Jewish establishments therefore had a visceral concern with what Robbie Davis-Floyd and Carolyn Sargent have described in the broader study of the anthropology of birth as the 'cultural control of human perpetuation' (1997: 6). The culture of post-natal 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 through the management of a reproductive culture.

Similar to the historical context of Jewish Manchester, immigration to London's East End brought a growing presence of émigré families, which, in turn, presented Jewish reproductive cultures as a concern for both the biomedical authority and the social body. Susan Tananbaum (1994) has explored the distinction and, in some instances, discordances, 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 amongst their 'foreign' co-religionists. The reproductive conducts among émigré Jews were arguably a point of scrutiny and pejorative discourse during the formative decades of twentieth century, with the alleged '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 the growing Haredi minority, which is portrayed as having among the highest birth rates in the country and interpreted as a challenge to the dominance of the broader non-Haredi Jewish population (discussed later in this chapter).

In revisiting the birthing conducts and controversies of Jewish Manchester's past, 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). Perhaps in response to the formative standard of maternal and infant care at the turn of the twentieth century, the Jewish

constituency developed culturally specific maternity care services to safeguard and buffer mothers from the insalubrious conditions of industrialised Manchester.

Concerns of birthing the Jewish social body underlined the development of historically significant and culturally specific child health and wellbeing interventions when attempting to mitigate morbidity and mortality associated with maternal and infant health. The comparable 'interventions' instituted in Manchester and London may have had quite a significant result, especially as infant mortality in the Jewish East End of London was apparently (even in the 'worst slums'), in the absence of any records, perceived to be comparatively lower than the regional average (Dulberg 1909).

Offering a historical parallel with the maternal rest home instituted at the turn of the twentieth century for the 'foreign' and working poor is a dedicated post-natal service for Jewish women in the present day, which illustrates the continuous attempts of the social body to manage its reproduction and perpetuation. A distance away from Jewish Manchester sits a postnatal rest home called *Shalom Bayit*[302] (peace of the home), which is designed specifically to offset the challenges of motherhood for Haredi women and the care of their infants aged up to five weeks.

Funded solely by one of the constituency'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,[303] but the majority of the women who visit *Shalom Bayit* are Orthodox or Haredi because 'if you're not in a community, you probably won't know about it' (Mr Attias). The service is only open to Jewish women because of the expense of running such a 'luxury' (as one mother who stayed at *Shalom Bayit* described it), which can

[302] A pseudonym.
[303] Priority is given to women who reside outside of London, primarily because a fee-paying Jewish maternal rest home already exists in the London-region.

be understood as a historical departure from the maternity care home instituted in 1920. 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 one Haredi woman, 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* also 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 health care 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. He went on to imply that the 'traumatic experience' of birth is not sufficiently alleviated by NHS maternity staff, in what Mr Attias implies to be an absence of post-birth 'care' to women — or what might instead be interpreted 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."

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).

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 and Hassidish sub-groups in Jewish Manchester, *Shalom Bayit* then enables women to be 'given a chance to get healthy and strong again' (Mrs Epstein). Moreover, it is viewed as an imperative counter-balance to the reproductive and familial pressures that women face when Haredi women oppose the use of birth spacing technologies on cosmological grounds. An incomplete image of the Haredi lifeworld is presented in constructions of Haredi Jews as being 'hard to reach,' which 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 far exceeds the standard offered by the state.

The 'social womb' is described by Penny Van Esterik (2015) as the first six months of 'person making' (which nurtures and moulds an infant into a social and cultural being), and human milk-feeding, which, during this period stimulates maternal-infant co-dependence and intensifies the process of 'personing.' Postnatal services in Jewish Manchester might be seen as a culturally specific strategy of nurturing maternal-infant co-dependence and processes of personing in the womb of the Haredi social body. I argue that institutions such as *Shalom Bayit* form part of a broader strategy to create a protective womb and controlled 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 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 [2002]: 123).

Infant feeding and modesty

Human milk feeding (cf. Van Esterik 2015) is a physiological process that is significantly shaped and defined by cultural norms. The rules and social codes surrounding reproduction and milk feeding are instituted by men and reinforcing of

male-dominated institutions in many societies (see Kitzinger 1995; Maher 1995 [1992]). Haredi Judaism is no exception, as rabbinical law (or its current interpretations) and social codes of conduct determine the practice of milk feeding. Just as in broader UK society, the role of breasts in infant feeding is overshadowed by it 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 feeding among Haredim 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 senior 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 Herskovitz). The challenge for infant feeding supporters such as Shoshannah (a non-Haredi maternity carer) is that, by the time she is connected with a mother, it is at the point where she is struggling to nurse and 'when they're just about to give it up' — rather than forming part of an antenatal preparation programme. Shoshannah informed me that, 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.[304]

Mrs Yosef patiently told me, the young male student, 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

[304] This is likely a reference to global attempts led by the World Health Organization to encourage mothers to nurse exclusively for six months (see WHO n.d.).

how this depletion affects mothers (see 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 consequently increases 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 coverage and the implications for stimulating human milk feeding are probably not specific to the Haredi context, but are compounded by 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 health is not routinely included in the curriculum.

Shoshannah 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 Haredi maternity carer, because learning about pregnancy and related issues before *frum* girls are married is culturally unacceptable, 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 *rov*[305] or *rebbetzin* respectively for a series of around ten (often quite pricey) *chosson* and *callah* (groom and bridal) lessons.

[305] Rabbi, usually denoting a personal relationship with a rabbi or even a learned man who offers spiritual mentorship (also *rav*).

Preparatory marriage lessons do not, however, teach about sexual and reproductive health, thus delaying the stage in which Haredi men and women encounter such 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 young Haredi Jews from learning about areas that are constructed as being an aspect of marital life. 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 Four, it is also apparent in the context of primary care, where religious authorities have attempted to filter public health material directly related to reproductive care.

Issues with infant feeding could also be tied up with what Shoshannah described as 'misconceptions' concerning *tzniut* and comportment*,* which may be complicated by the fact that *halachot* are practiced with stringencies rather than as a standard. Nomi told me that an 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 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. So not that somebody would feel comfortable doing that in *shul* but you could potentially do it and it's not an issue of *tznius*. (Shoshannah)

The social constructions of modesty can present competing conceptualisations of the breast — as having sexualised and nurturing roles — which Shoshannah attempts to decouple for Haredi women by referring to Moses Maimonides (Rambam), the revered Jewish medieval scholar and physician. Moreover, the prevailing social codes that circumscribe human milk feeding 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 conceptualized 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). It may be possible that contemporary taboos surrounding exposure of the breast for milk feeding in the Haredi cosmology might present discontinuities with how the breast (for the purpose of infant feeding) is represented 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 ritually wash hands,[306] as one would in the morning, and thus the conduct applies to women when touching the breast to feed. Though, as Shifrah 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 human milk feeding 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 milk feed 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 her 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 choosing to cover themselves whilst feeding outside the home. The implication of modesty for public feeding is a point of frustration for some maternity carers, with Shifrah stating: 'I'm a true believer that we all feed. We

[306] *Negel vasser* (also *netilat yadayim)*.

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 human milk feeding in public can, for some Haredi women, interfere with interpretations of what constitutes *tzniut* is bound up in a deeper discussion of how 'public' and 'private' space is culturally constructed — and how the body can be entangled between the two. Milk feeding 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' (cf. Maher 1995 [1992]: 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

With childbearing viewed as the cardinal role of Haredi women, 'contraception' is a sensitive area of primary care that is negotiated between Haredi women, senior doulas, medical professionals, and religious authorities — as mentioned in Chapter Four. In this section I discuss how the term 'birth spacing technologies' (BST) 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. Moreover, BST comprise an area of postnatal care for married Orthodox and Haredi 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 BST 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.[307] 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 BST that also affect insemination —

[307] See Feldman (1992) for a detailed discussion on *halachic* jurisdiction of birth control.

such as the intrauterine device (IUD) — are therefore unsuitable for *frum* Jewish women. The combined oral contraceptive pill (commonly referred to as 'the pill') prevents the ovaries from releasing an egg 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 1968: 248). Thus the areas of reproductive and postnatal care that is made *available* to *frum* women through primary care services does not necessarily mean it is *acceptable* to use according to the Judaic cosmology — or authoritative interpretations of the Judaic cosmology.

Tikvah and Sivan are *frum* maternity carers who support the increased uptake of BST amongst young Haredi families, a trend they describe based on anecdotal evidence. 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:

> 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 disgusted 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?
>
> Tikvah: Women don't cope as well, you see something like fasting on *Tisha B'Av*,[308] 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.
>
> Sivan: And the rabbis are understanding that.

[308] 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.*

It is important to note that the laws and prohibitions concerning BST are not changing per se, but the interpretations of *halachah* formulated by rabbinical authorities are becoming more flexible in some areas that can impact maternal health and wellbeing. As Tikvah and Sivan 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 BST 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 mean 'it's fine to go to your rabbi if you don't cope' (Tikvah) in order to seek permission to access BST. Although some *rabbonim* can be sensitive to appeals for BST, the emphasis here, Mrs Yosef 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 Yosef)

Although Mrs Yosef claims that it is Haredi women who propagate the expectation and preference for large families, it is the *rabbonim* who 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 Goldblatt when describing the need for a 'culturally appropriate' primary care service in Jewish Manchester that was, in a sense, "*kosher*" (see Chapter Four). In particular, BST are not accepted by (or accessible for) many Hassidish Jews. One Satmar *rebbetzin* made this clear, when she informed me that social and economic challenges remain for

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 midwife to the Haredi minority, Tikvah 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 (see 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 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 to access family planning then 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 BST, 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.'

Reproductive conducts in the Haredi context of Israel have shown that rabbinical dispensation can be sought for temporary use of 'pregnancy spacing' (rather than 'contraception') but steps to indefinitely prevent pregnancy were regarded as unacceptable (Birenbaum-Carmeli 2008). In 'conceiving' family planning as means of spacing rather than limiting pregnancy is perhaps similar to encounters

of family planning in other socio-religious traditions, which, as discussed in the context of Iran, is 'intended not to discourage mothering but to manage it' (see Kashani-Sabet 2011: 192). Language and conceptual framing of reproductive interventions is therefore an important aspect of how birth control is negotiated as an arena of health and bodily care for religious groups.

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. Through migration, Malian women encounter notions of reproductive rights that cause established Islamic teachings to be negotiated (see Sargent 2006). Here, state contraceptive agendas are viewed by some migrants in the broader context of French racism and hostility towards minorities, with some Malian women viewing birth control as an institutionalised attempt to restrain their growing demographic (see 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 might then be viewed as an intervention and strategy of 'internal colonialism'[309] when seeking to reach the margins of the state, which become represented as being (over-)populated by migrant and minority groups. Managing populations then takes on opposing constructions between the state and the Haredim. Whereas the former view 'contraception' as a strategy of population control, the latter view reproduction as a technique to secure and protect the continuation of Haredi Judaism, which consequently sees access to birth spacing technologies, as a reproductive right, regulated by male rabbinical authorities, rather than the state.

As outlined in my introductory chapter, 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 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 natality that is of relevance to this

[309] Term borrowed from Scott (2009).

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 constructed as a threat to the body of the nation.

Although the overall Jewish population may appear to have a higher fertility level 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 positionality.

Discussion

NHS maternity services are viewed as the safer option for Haredi Jewish women to labour 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 [2002]). Exemplary of this encounter is the contest in 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' has consequently manifested in the form of a self-protective "social womb" (cf. Esposito 2015 [2002]; 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. Maternal services (as constructed in the biomedical cosmology) are made available in controlled or "*kosher*" forms, preventing a dangerous diffusion of reproductive interventions or knowledge that could be accessed freely by Haredi Jews. The Haredi culture of maternity care illustrates how immunitary defences against perceived contagions 'must partially and preventively incorporate what negates it' (cf. Esposito 2015 [2002]: 56).

Whereas past studies usually focus on how the delivery of care to observant Jews can be affected by the *halachic* issues that govern pregnancy and childbirth (see Bodo and Gibson 1999; Feldman 1992; Semenic, Callister, and Feldman 2004), the conducts that constitute a Jewish culture of reproductive care are rarely discussed. Birth support amongst the Haredim of Manchester is bound-up in spiritual, scriptural, and social codes of conduct which all provide a strategy to control their biological and social reproduction.

Criticisms of the Haredi Jewish lifeworld usually focus on its 'ultra-Orthodox' socio-religious codes of conduct and self-insulating positionality, 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 Three and Four). The culture of reproductive care and peer-led support that surrounds pregnancy, labour, and postnatal care is one specific example that underscores how Haredi women actualise their higher expectations of health and bodily care.

The minority group's relation with the mainstream healthcare provider is in fact negotiated and mediated through internal authorities, either by (male) religious leaders or the (female) senior maternity carers — two examples offered in this chapter. Haredi maternity carers are therefore a prime example of how, as Stefan Ecks and William Sax put it, marginality involves 'points of crossing, paths of entry,

and potential inversions' (2005: 208). Moreover, the Haredi maternity carers are significant gatekeepers into 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. All areas of reproduction and reproductive care are negotiated in relation to the Haredi worldview. 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.

Chapter Six

Childhood immunisations

Low uptake of childhood immunisations appears to be one of the main reasons why Haredi Jews are represented as being 'hard to reach' in public health discourse, and their 'non-compliance' with immunisation schedules is often attributed to 'culture' or religious 'belief.' Jewish Manchester exemplifies that the 'hard to reach' accusation does not reflect a uniform culture of opposition to biomedical interventions among Haredi Jews, as I encountered a range of standpoints among parents who refused, delayed, and partially or completely accepted immunisations. The main aim of this chapter is to critically engage with the above claims by exploring the constructions of *immunity* and regard for immunisations held by Haredi parents in Manchester, and understand how their responses to public health campaigns should be framed.

I argue that parental responses to childhood immunisations in Jewish Manchester reflect a broader preference to negotiate mainstream health services due to opposing views of bodily protection — as put forward by the Haredim and the biomedical authority. Perceptions of immunisations are explored using Roberto Esposito's (2015 [2002]) theoretical paradigm, which signifies the antonymic relation between obligation and exemption (or between *communitas* and *immunitas,* to use his concepts) that is at play in the biomedical and social pursuit of 'immunity' at the margins.

Immunisations are frequently cited as being one of the most effective biomedical interventions available to prevent and arrest the transmission of infectious disease, but fears of contamination and danger have historically undermined 'compliance' with immunisation policies in England. The process through which the Jews of Manchester negotiate routine immunisation schedules resonates with previous studies conducted in the broader UK population, which suggests that Haredi minorities are unfairly stigmatised and targeted for their responses to this sensitive area of child health. Local concerns for immunisation

safety should therefore be viewed in the context of Haredi Jews being a minority group in the UK.

My study of childhood immunisations is divided into three main sections: 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 immunisation policies during the nineteenth and twentieth centuries alongside representations of the Haredim as being 'hard to reach,' and finally moving on to frame the views and concerns surrounding immunisations in Jewish Manchester today.

Social immunities

The title of this ethnography points to the antonymic construction of immunities between Haredi Jews and the state, which is brought to life through Esposito's (2015 [2002]) paradigm. On the one hand, the public health authority arguably view immunisations 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 'herd' or 'social' immunity).[310] Whilst parents who exempt their children from the citizenly responsibility to accept immunisations are dispersed across the state, it is arguably the case that the Jewish minority has historically been singled out as being disruptive to the body of the nation (Chapters Three and Four), and now 'hard to reach,' perhaps because they are identified (and identifiable) as a target for intervention.

On the other hand, 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 (which has an impact on their relation to healthcare services). The strategies of self-protection and immunitary reactions employed by the Haredim demonstrates how, as Donna 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-

[310] Immunity, as expressed previously in this thesis, is a reaction (or intervention) to protect the body of the nation and its attempt to resist or incorporate foreign bodies, which Esposito frames as central to biopolitics.

compliant' with the citizenly ideals propagated by the state evokes a historically contiguous issue of how the Jewish minority is positioned vis-à-vis the state and how they position themselves (see also Chapter Three). One Haredi local (who was "born and bred" in the UK) told me, 'I'm very aware that this is not my country. Here, we're very much a guest in *their* country.'[311] By positioning herself as a 'guest' (rather than a citizen), this local indicates how Haredi Jews may absolve themselves of the moral responsibilities (or obligations) bestowed on the body of the nation, which arguably underlies the accusation of being 'hard to reach.'[312]

Public health discourse refer to 'herd immunity'[313] as the threshold of a population that must be immunised in order to arrest and resist the spread of infection. If a certain proportion of a population are immunised against an infectious disease, protection *may* be afforded to susceptible and vulnerable bodies who cannot be immunised 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 'herd immunity' is left vulnerable if the majority do not accept immunisations. Thus the logic of 'herd immunity' rests on the continued uptake of immunisations, especially those routinely administered (or recommended) during childhood.

Certain infectious diseases require particular thresholds of 'herd immunity' in order to protect the body of the nation from transmission: whereas the threshold for measles, for instance, sits at 90–95 per cent, rubella needs approximately 82–87 per cent of the entire population to be immunised.[314] However, an additional challenge lies in the fact that statistics of national immunisation rates are not an accurate indicator of 'herd immunity' at local levels, largely because immunisation

[311] I italicised 'their' to emphasise how some Haredi Jews might not view themselves as equal citizens of the UK (or even as citizens at all) despite holding British citizenship, and possibly indicating how the Haredi minority dis-incorporates itself from the body of the nation.
[312] See Elisa Sobo who has explored how a shared opposition to immunisations among parents who send their children to Waldorf schools (for 'private alternative' education) can be 'highly social' and demonstrative of good '"Waldorfian" citizenship' (2015, 2016). Thus exemption from one social circuit can give rise to new performances of belonging, indicating how refusal can be generative of 'alternative' obligations (cf. Sobo 2016).
[313] This concept applies only to infectious diseases that are transmissible from person to person, not all immunisation-preventable diseases work according to 'herd immunity' (such as tetanus).
[314] Thresholds taken from Milligan and Barrett (2015: 313).

coverage[315] is not spread evenly across the entire population. The threshold level of the immunised population in relation to the non-immunised is, in reality, not static, but constantly shifting as individuals in the 'herd' move between those who take-up and those who refuse technologies of preventive health.

Publically available records from 2013–2014 demonstrate that MMR coverage in England for children reaching twenty-four months of age was 92.7 per cent (HSCIC 2014), which falls short of the threshold of 95 per cent advocated by the 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 (HSCIC 2014). Moreover, coverage of all routine childhood immunisations in 2013–2014 (when measured at one, two, and five years of age) was lower in England than all other countries in the UK (HSCIC 2014). Considering the stark variability in coverage in England, it could be the case that 'hard to reach' groups compare with parts of the broader or "general" population when it comes to delaying or opposing uptake of immunisations.

Referring to a population as a 'herd' is not value-free, and can be viewed as a form of positioning by the biomedical authority where human lives are collectively framed and compared with subordinated animals. A 'herd,' for instance, can refer to animals that are assembled to facilitate domination (as is the case for livestock). The fatalistic metaphor of a God shepherding a herd might also be imposed on religious followers, but Haredi Jews do not always 'comply' with the dictates of rabbinical authorities when it comes to uptake of health interventions as well as immunisations (discussed in this chapter and Chapter Four). It has been argued that the term 'herd immunity' can be counter-productive for social groups who define themselves by 'going against the herd' and leading an 'alternative' lifestyle which challenges the status quo (see Sobo 2015: 395). Moreover, exclusivity can also see the 'herd' position minority groups as outcasts and pushed to the margins.

[315] In public health discourse, coverage 'is defined as the number of persons immunised as a proportion of the eligible population' (see HSCIC 2014: 14).

Alternative conceptual references for 'herd immunity' include 'health protection target' (see Petts and Niemeyer 2004: 8), and 'community immunity,'[316] the latter of which emphasises the human value of protecting vulnerable groups in a shared environment. However, 'community immunity' conflicts with my aim to problematise the use of 'community' in public health discourse because of the idealised or imagined participation that it implies, but also because of the antonymic relation between '*communitas'* and '*immunitas'* postulated by Esposito (2015 [2002]), which I go on to discuss. Considering how the so-called 'community' does not share a monolithic and favourable view on immunisations — as regional variation in coverage rates might suggest — the term 'community immunity' emerges as particularly untenable. Moreover, as the body of the nation is exclusive and excluding of certain minority groups, the ideal of contributing to a universal level of 'community immunity' seems hard to envisage. For these reasons I instead advocate the term 'social immunity'[317] as an attempt to realign the terms of reference used in public health discourse with the socio-culturally constructed context in which health conducts are always embedded and entangled within.

It is in this conceptual perspective that I engage the complex and antonymic relation between *immunitas* and *communitas* as conceived by Esposito (2015 [2002]). 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 — and is thus 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 [2004]: 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 [2002]: 6). The mainstay 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 (see 2015 [2002]:

[316] 'Community immunity' is a term upheld by The Oxford Vaccine Group, and also mentioned by Sobo (2015).
[317] 'Social immunity' also appears in Leach and Fairhead (2007: 5), but with no elaboration on how the authors interpret this term.

6). By relieving oneself of an obligation 'and placing 'himself or herself outside the community […] they become constitutionally "ungrateful"' (2015 [2002]: 6) — or what public health discourse would describe as 'non-compliant' in the context of opposition to immunisations 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 [2002]: 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* at the margins results in a vulnerability that can have the potential for the social body to be threatened from within (by opposing areas of healthcare). 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 [2002]; Douglas 2002 [1966]).

Framing opposition

Opposition to immunisations cannot be understood as a universal phenomenon (see Davidovitch 2004), and should instead be viewed in a broader socio-cultural construction of the body. Objections to immunisations are 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 constructed.[318] 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

[318] For examples of studies and public health discourse which attribute low immunisation uptake to 'cultural factors' or 'religious beliefs,' see Lernout et al. (2007); Lernout et al. (2009); Top (n.d.); Wineberg and Mann (2016).

for religious individuals to *not* immunise is rarely discussed (see Hobson-West 2003). International public health authorities present conflicting reports between religious motivations and objections to immunisation amongst Haredi Jews, with this being observed, for example, in Haredi settlements in Israel but not in Antwerp (see Lernout et al. 2009; Muhsen et al. 2012). A resolve of this chapter is to illustrate how religious or doctrinal motivations *to* immunise or *not* are expressed, and how these decisions are entrenched in the Haredi Jewish cosmology.

I take issue with the use of 'beliefs' to describe the roots of opposition to biomedical interventions in public health discourse. A 'belief' implies that perceptions of health and the body are malleable and not based on authoritative knowledge, when health conducts[319] 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 places the emphasis 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 Haredi parents (which are common to the broader non-Jewish population) can factor strongly in responses to public health interventions.

Broader anthropological scholarship illustrates how immunisation anxieties are intimately tied to socio-political relations between minority groups and the state. Global concerns that immunisations are, for example, used to control population size — either by way of contraception or by inducing virulent pandemics — are often positioned as 'unusual theories' or dismissed as 'conspiratorial claims' in need of defusing (see Davies, Chapman, and Leask 2002: 24; Kata 2010: 1712–1713). However, relegating immunisation anxieties to the realm of 'unusual theories' or 'conspiratorial claims' points to a broader issue in how the concerns held by the intended targets of immunisation campaigns are handled by public health bodies.

[319] See also Cohn (2014) who has called for health 'behaviours' to be regarded as 'practices.'

What is shelved as 'unusual theories' or 'conspiratorial claims' have, time and time again, proven to be rooted in lived realities of political marginality and domination.[320]

Immunisation anxieties can be placed in a broader concern of population control, through which biomedicine has been viewed as complicit in. Prevailing fears that immunisations are deliberately 'contaminated' with HIV or antifertility properties as a conscious strategy to control the growth of some ethno-religious groups has, in its most extreme case, resulted in the execution of 'polio workers'[321] in Nigeria and Pakistan[322] by militant groups (see BBC News 2013). Polio has surged in Pakistan in recent years, and especially after the Central Intelligence Agency (CIA) had orchestrated a polio immunisation campaign specifically to identify the whereabouts of Osama Bin Laden — resulting in widespread distrust (and an outright ban in one region) on immunisations afterwards (see Gostin 2014).[323] This has resulted in the torture and execution of approximately seventy-one 'polio workers' by militant forces between 2012–2015 (see Kakalia and Karrar 2015), occurring most recently in January 2016 when a suicide bomber detonated himself outside a polio immunisation centre (see BBC News 2016). The tragic irony lies in the fact that successive U.S. administrations have invested heavily in global attempts to eradicate polio (see Conis 2015), thus illustrating an extreme example of how the covert appropriation of immunisation campaigns for political operations can have disastrous and enduring consequences.

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 parental objections in the context of Nigeria were actually much more complex than what this single explanation suggests. Attributing

[320] This is not specific to immunisations per se, but biomedical interventions more broadly. The clandestine attempts of South Africa's former apartheid regime to systematically eradicate the Black population by sterilising women or by deliberately transmitting the HIV infection is one example of this, illustrating how 'people's suspicion of science and medicine, seen as instruments of white domination, takes on a tragic dimension' (Fassin 2003: S8).

[321] Public sector administrators of polio immunisations.

[322] Pakistan and Afghanistan are the only two countries that remain polio-endemic (see WHO 2015).

[323] The Guardian (Shah 2011) reported that the CIA was using immunisation campaigns as a strategy to obtain DNA, and thus locate the whereabouts, of Osama Bin Laden and his family. It was not until 2014 that the Obama administration ended its policy of using immunisation campaigns for the purposes of intelligence (see Gostin 2014).

immunisation refusal to antifertility anxieties obscures the broader concerns of safety held by parents as well as feelings of being disenfranchised by top-down government interventions (Renne 2006, 2009). In a similar way, public health discourse circulates a definitive narrative that the "ultra Orthodox Jewish community" has low immunisation coverage, which can gloss over the diversity of perspectives held by Haredi parents — as I exemplify in the context of Jewish Manchester.

Compliance and coercion over time

Juxtaposing archival and ethnographic material demonstrates how compliance with immunisation policies (to increase uptake) has been cultivated over time — firstly among émigré Jews, and now Haredim — and generates discussion on how responses to immunisation services (which are not in the manner of 'compliance') should be interpreted. Public health formed part of a historical strategy to assimilate difference (Chapter Four), and émigré Jews during the nineteenth and early twentieth centuries were coerced into accepting vaccinations[324] 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'[325] — probably by granting collective protection through social immunity. 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.[326] When attempting to enforce a state of 'compliance' with health interventions amongst the

[324] Edward Jenner derived the term 'vaccination' from the Latin word for cow (*vacca*), by experimenting with the transfer of cowpox matter from one person to another in order to induce immunity against smallpox in 1796. To avoid confusion, I only use the term 'vaccination' in relation to its historical context of controlling smallpox.
[325] See M182/3/1: 1871–1872; also 1875–1876; M182/2/: 1877–1878; M182/3/2: 1887–1888.
[326] 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).

Jewish poor, the Board would use its economic relief as leverage when implementing vaccination and re-vaccination policies.[327] 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*[328] would 'be absolutely stopped' in all cases of 'non-compliance.'[329] Jews who were 'non-compliant,' or who sought exemption from the obligation to be immunised, were then cut off from the structures of communal support.

The Jews' School on Derby Street was an institution not only of education but 'powerful assimilatory pressures' (Williams 1985: 295), where speaking Yiddish was a punishable offence in the classroom as well as the playground (see Null 2007; Williams 1989). 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 testified to biomedical imprints and surveillance. Moreover, the Jewish school, situated in the heart of the slums, worked in collaboration with the Board to implement blanket immunisation 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.'[330] Access to essential relief for the Jewish poor therefore became dependent on compliance and submission to the empowered and authoritative Jewish body as a proxy of the state.

Michel 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 entrenched in a historical pursuit of capitalism, with which modern preventive medicine was cultivated as a technique of subtle subjugation — epitomised by the term 'intervention' (rather than 'service'). Compulsory vaccinations (and now immunisation) programmes can then be interpreted as an imprint of political or

[327] '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.'
[328] Unleavened bread, which Jews are mandated to eat over *Pessah* (Passover).
[329] M182/3/1: 1876–1877.
[330] M182/3/2: 1887–1888.

economic demands on citizens, and featured prominently in historical attempts of colonial regimes to convert the local population into 'governable subjects' and thus control their economic production.[331] Immunisations 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 immunitary reaction to assimilate difference (cf. Esposito 2015 [2002]; see also Chapters Three and Four).

Subjugation is not achieved by a sole act of conquest but is rather the result of compounding acts of domination that totally encompass and engulf the social body. As Foucault argues, domination is not singularly enforced by 'a king in his central position, but [by] subjects in their reciprocal relations; not sovereignty in its one edifice, but the multiple subjugations that take place and function within the social body' (2003 [1977]: 27). Caught in between the objectives of both localised government and their more empowered co-religionists, the Jewish slums are a poignant example of how 'multiple relations of power traverse, characterise, and constitute the social body' (Foucault 2003 [1977]: 24). The strategies of health surveillance conducted by the Jewish Board of Guardians — in its own submissive position to the mainstream authorities and arguably its own ambitions of Anglicising 'foreign' Jews — epitomise how the social body can become an incubator for the modern state, and exemplifies how 'power and control become effects of social production in line with state interests' (Kapferer and Taylor 2012: 8).

'Non-compliant communities'

The historical attempts to coerce émigré and poor Jews into 'complying' with immunisation regimes is contiguous with current representations of Haredi Jews in public health discourse as 'hard to reach,' and the target of intervention for the

[331] As demonstrated by European colonial history, including the French occupation of Cambodia (Ovesen and Trankell 2004, 2010; see also Monnais 2012 for the example of Vietnam).

protection of all. Haredi minorities in the UK today have arguably become entangled in the (failed) attempts of public health bodies to eliminate measles and rubella from the WHO European region, by both the 2010 and then 2015 targets, due to recurring outbreaks.[332] Unsuccessful attempts to achieve these targets are attributed to the insufficient number of children being fully immunised according to schedule (or not immunised at all). Routine childhood immunisations are provided by NHS England at no cost, and the public health authority and healthcare professionals therefore have the responsibility to improve coverage rates and this, in turn, hands parents the responsibility to consent to uptake. Parents who "deviate" from recommended child health guidelines are consequently represented as fuelling the increasing incidences of immunisation-preventable diseases (see Conis 2015), or as Esposito (2015 [2002]: 6) might say, they disrupt the 'social circuit of reciprocal gift-giving' (social immunity).

Over the past decade, recurring outbreaks of measles in Europe (and the implications for overall elimination) have been linked to low immunisation coverage in the 'Orthodox Jewish community' or 'extremely ultra-Orthodox groups' who are portrayed as 'sectarian,' 'specific sub-populations,' or 'non-compliant communities.'[333] A strategy of European public health bodies has consequently been to identify and target specific areas and populations who remain 'at risk for measles' (read: those with low immunisation uptake) and tailor health information and preventive services accordingly (see Steffens, Martin, and Lopalco 2010). The uniform objective is to increase "compliance," which resonates with theories and ethnographic studies that consider public health surveillance as an opportunity to control and contain populations as much as infectious diseases (Foucault 2006; see also Briggs 2003). 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

[332] The UK sits in the WHO European region, which forms one of the six regional WHO offices. The WHO European region is arguably a political and geographical amalgamation as it also includes countries such as Israel. 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.

[333] For examples of the language 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).

through — and for the convenience of — institutions of surveillance such as the public health authority.

Following this line of enquiry, the UK's Orthodox and Haredi Jewish population can then be framed as a specific group targeted for intervention because they appear (or are represented) to have low immunisation coverage. 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 (and thus hindering the responsibility of Public Health England to contribute to the protection of the European 'community'). However, 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 held by Haredi mothers in Manchester reflect those in the broader UK population.

Prevailing representations of Haredi Jews in public health discourse can be placed in a broader discussion of the attempts made by minority groups to settle at the resistive margins of the state, which become a justified site of 'intervention.' The language used to frame Haredi Jews and the consequent ingress of public health can then be grounded in theoretical conceptualisations of sovereignty, which is exercised not only on territories but the bodies and 'the subjects who inhabit it' (Foucault 2006: 135; see also Das and Poole 2004). Applying this theoretical approach elucidates how an immunisation leaves 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-insulating and self-protective is a preventive measure against external influences (which includes the public health authority in some cases, see Stein-Zamir et al. 2007) that are viewed as being a virulent threat to the established socio-religious order. It then becomes clear how immunisations 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 the public health authority to target Haredi minorities they must first be constructed and represented (or re-presented) as a "community" in need of intervention, and then "reached" through tailored information and services (see Figure 16). Though, as we saw in Chapter Four, health programmes can actually *misrepresent* the Haredi minority, which indicates how etic views of the Haredim and their relation to healthcare services can conflict with emic conducts. 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.[334]

Strategies to increase immunisation coverage in the UK are, theoretically speaking, persuasive as there is no formal law or punitive measure to enforce childhood immunisations. In this sense, the health authority attempts to convince the public body of the need for immunisations as a technique to govern individual lives and protect their own health as well as the health of the nation. UK immunisations policies stand in contrast to other countries, where a socio-political contract is explicitly made between government services and parents regarding childhood immunisations. The United States is one example where mandates on childhood immunisations can see children barred from attending state-funded (and also some private) day-care centres and schools, and the Australian government recently announced intentions to withhold welfare benefits from families who refuse

[334] For examples of 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).

immunisations in a policy of 'no jab, no pay.'[335] Immunisations (and state policies surrounding coerced compliance or enforcement) therefore illustrate how opposing conceptualisations of ethical values and bodily autonomy are at play, as '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' (see Petts and Niemeyer 2004: 9).

In the above examples, citizens are literally marked with their responsibility to the state — the "benefits" of citizenship involve a contractual obligation to contribute to social and national immunity against infectious disease. The state then exercises its right to 'discipline' subjects when they reject immunisations at an individual level and thus defy national ambitions of health protection. On the other hand, immunisations are voluntary in the UK but parents are nonetheless encouraged and expected to "comply" (see Hobson-West 2003), leading to implicit pressure directed at parents. Prevention of infectious disease cannot be sustained without a culture of immunisation, indicating how this biomedical technology 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).

[335] Medical exemptions apply in both cases. 'Religious and/or philosophical' exceptions vary across the United States. Mandatory immunisations for school entry vary across Australian states and territories, but in 2015 the Australian government ceased to recognise the only approved religious exemption to immunisations, which was to Christian Scientists (see BBC News 2015; Medhora 2015).

Figure 16: Translated information leaflets for Haredi families in North London (2012).
Credit: The Queen's Nursing Institute.

Etic representations and emic perceptions

Jewish Manchester was recorded as hosting 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).[336] However, this public health account, like so many others, fails to unravel the reasons

[336] 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 immunisation was causally associated with autism (see Pegorie et al. 2014).

for low responses to the MMR. Past studies of primary care coverage to Haredi settlements report conflicting responses to immunisation services, which illustrates the complexity of the topic at hand as well as the critical lens in which representations of Haredi Jews should be viewed.

Whereas many studies claim that there is a lower than average uptake or coverage of immunisations among Haredi Jews, there are past counter-narratives which detail how there are no significant differences when compared with neighbouring populations.[337] Studies conducted in Israel have also failed to clarify whether statistics that describe low immunisation coverage in Haredi settlements are attributed to outright objection or delayed uptake (see Simhi, Shraga, and Sarid 2013: 5), therefore demonstrating how representations of Haredi Jews are worthy of critical engagement. It has been argued that the English health authority possesses a misconceived (and perhaps inaccurate) understanding of the views of Haredi Jews with respect to preventive health services (Cunninghame, Charlton, and Jenkins 1994).[338] I will later discuss how immunisation coverage varies significantly across the UK, which might then suggest that Haredi minorities are perhaps singled out unfairly for low uptake in public health discourse.

The reasons that apparently underlie low acceptance of immunisations amongst the Haredim also remain unclear and conflicting. Infectious outbreaks are recorded (or portrayed) as spreading like "wild fire" 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 likelihood of non-immunised children in Israel as well as Jewish London (Ashmore et al. 2007; Muhsen et al. 2012),[339] 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).

[337] 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.

[338] This study should be viewed in its historical context, being published before the controversial (and falsified) claims by Andrew Wakefield and colleagues (1998) that the MMR immunisation was causally associated with autism).

[339] See also Sobo (2015), who notes that immunisation status may be linked to birth order in families with multiple children attending Waldorf schools in the United States. This suggests that low immunisation uptake amongst larger families may not be a specific association amongst Haredim.

International travel between Haredi settlements is associated with the importation and exportation (or transmission risk) of infectious disease in public health discourse.[340] 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' (Merkal 1997: 4), such as émigré Jews to the United States (see Chapters Three and Four). Public health bodies compare and make inferences between outbreaks of infectious disease 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).[341] However, public health discourse should not misconstrue Haredi Jews as belonging to a global "community" that is either monolithic or a monoculture, and outbreaks as well as immunisation anxieties should be analysed in each individual context.[342]

It is 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 preventive 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

[340] See Cohen et al. (2000); Lernout et al. (2009); Lernout et al. (2007); Stein-Zamir et al. (2008); Stewart-Freedman and Kovalsky (2007), also Baugh et al. (2013).

[341] Drawing international comparisons to represent Haredi Jews as 'non-compliant' with public health services is not limited to immunisations. See also Wright, Stone, and Parkinson, who compare incidences of growth faltering in the Haredi settlement of Gateshead to instances of Munchausen by proxy in Israel, suggesting in an inflammatory way that 'chronic malnutrition may be a feature of Haredi life' 2010: 631).

[342] 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, and they may therefore have lower levels of immunisation uptake compared with other Haredi groups (see Stewart-Freedman 2007). These state-minority relations could be specific to Israel given the opposition to Zionism that is held by some Haredi and Hassidish minorities, and such anti-establishment views were not expressed as a concern by Hassidish parents in Jewish Manchester when navigating immunisation regimes. What is viewed as a matter of recognising the State's authority might instead be understood as a deeply entrenched mistrust in state institutions (such as the health authority), as was expressed to me by some research participants. See Muhsen et al. (2012), who discuss Haredi minorities in Israel as viewing the Ministry of Health with mistrust. See also Kanaaneh (2002: 73–74) who notes that state-sponsored maternal and child health services (especially 'family planning') are viewed with suspicion by the Palestinian minority in Israel ('Israeli Arabs'), with more trust placed in a network of intra-group clinics.

ingress of public health personnel' (Stein-Zamir et al. 2008: 3). Contentions and confrontations in 'the Jewish state' of 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. Although these examples outline the socio-political challenges faced by Haredim in Israel, I deemed it essential to include them in this discussion as they reinforce my argument that extrapolations of international Haredi minorities to those in the UK should be made (and viewed) with caution.

The etic constructions of Haredi Jews being 'hard to reach' and responding to immunisation campaigns with low compliance can be compared and contrasted with the multiplicity of views surrounding immunisations held by parents in Jewish Manchester — which cannot be reduced to a uniform culture of opposition. Immunisations 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 immunisations 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 the culturally specific health periodical, '*Zei Gezunt*,' which collates and screens public health messages from the wider biomedical and therapeutic network for distribution to approximately 2,700 homes in the Jewish settlement.[343] The periodical was used to raise the profile of immunisations following the multi-state outbreak of measles in the United States during the cusp of 2014–2015, and mobilised the position of religious authorities on the issue of immunisations. Of particular interest are the ways in which preventive health messages are made relevant to the Haredi worldview through language: 'the consensus of most *poskim*[344] 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' (see Figure 17). In the absence of a

[343] *Zei Gezunt* is funded by a local health authority and produced by a Haredi organization, which claims, among others, to be representative of the Orthodox Jewish population in Manchester.
[344] *Posek* (sing.), *poskim* (pl.); a *posek* is an interpreter and decider of *halachic* law in cases where the situation is ambiguous, contentious, or without precedent.

centrally recognised or imposed religious authority (as in the case of the Pope for the Roman Catholic Church), the advert asserts the view that *most* (and thus not all) *poskim* advocate immunisation as a "*kosher*" preventive measure. Claiming that the majority of *poskim* rule that parents have a responsibility to accept immunisations suggests that questions surrounding immunisation uptake are related solely to issues of *halachic* status, which, as I emphasise in this chapter, is not the case.[345]

Although the *Zei Gezunt* advertisement is broadcast directly to the settlement through an established channel, others were dispersed through more peripheral lines of communication. The missionising strategies employed by the Chabad Lubavitch[346] outpost in Jewish Manchester is one example, with immunisations referenced positively in their publication that is freely delivered to homes each week.[347] One edition of the circulars raised the issue of immunisation for the purpose of travelling to Israel, which made clear and offered reassurance that immunisations are safe and should not be a source of anxiety in the Jewish constituency.[348] 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 enjoy 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.

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[345] At the time of research, the 'Fluenz' nasal spray was being trialed in children but was the subject of scrutiny as it contained porcine-derived gelatine. The uncertainty surrounding the 'Fluenz' nasal spray prompted Haredi rabbinical authorities to announce that non-oral porcine-derived immunisations were 'absolutely acceptable' and '*kosher*' (see Sheinman 2013, Public Health England 2013a). However, the rabbinical responses did not address any potential safety concerns that Haredi parents may have had.

[346] Chabad Lubavitch are a prominent Hassidish minority who sanction the use of social media and the internet, and also are actively involved in internal missionary work to increase religious observance amongst Jews, but not to attract non-Jews to Judaism (see Dein 2004).

[347] The pamphlet is intended to circulate Chabad interpretations of religious and philosophical teachings.

[348] Article noted, '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.' See Chabad Lubavitch *L'Chaim* issue 855, 23 May 2014. This was possibly in response to traces of polio discovered in multiple sewerage sites across Israel and the occupied Palestinian territories, prompting Public Health England to promote polio immunisation amongst travellers to these regions (see Public Health England 2013b).

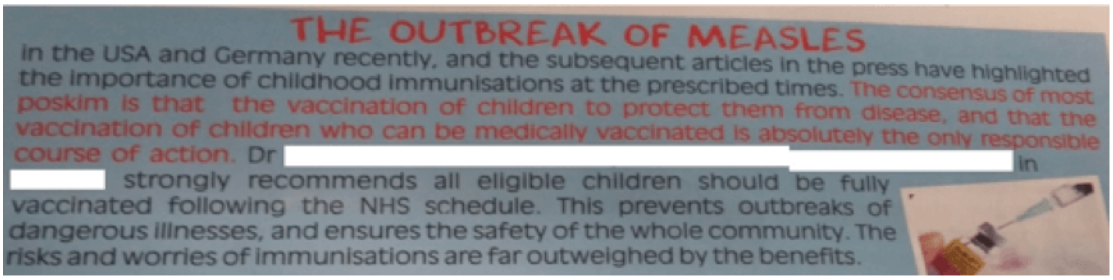

Figure 17: Advert in *Zei Gezunt*.
The advert details how most religious authorities (*poskim*) view immunisations as a parental responsibility.

Pro-immunisation messages in Haredi circuits of information, at times, emphasised how biomedical technologies form part of the cosmology's system of authoritative knowledge. During an interview with a Haredi mother to discuss the subject of immunisations, her husband lent me a book to take home, which was typical of *frum* information sources that attempt to manipulate science and technology to "comply" with the religious cosmology and appear as being enabled by *HaShem*. These form an interesting contrast to the biomedical authority, which, as mentioned, typically expects religious doctrines to be exploited to suit public health discourse (see also Chapter Four). The book I was presented with by this Haredi local mobilised a reference from the Talmud to describe a process akin to post-exposure prophylaxis: 'If somebody was bitten by a mad dog, one should feed him the lobe of that dog's liver.'[349] Thus constructions of authoritative knowledge pertaining to health and bodily care in the biomedical and Judaic cosmologies can relate to each other, rather than be in a state of opposition.

Pharmaceutical moguls have also attempted to manipulate Judaic teachings in order to promote immunisations, notably by an employee[350] of Merck & Co., Inc, 'to paraphrase the Book of Genesis (chapter 4, verse 9),[351] vaccine recipients are their brother's keepers, as contributors to herd protection' (Grabenstein 2013: 2012; see also Stewart-Freedoman and Kovalsky 2007). Such attempts to manipulate religious doctrines to support immunisation strategies are reminiscent of the

[349]Tractate *Yoma* 84, *Seder Moed*; *Talmud*, as cited in Cohen (1997: 66). 'Bitten by a mad dog' can be interpreted as being infected with rabies.
[350] Whilst Grabenstein (the author) includes a disclaimer to makes clear that the article is written in a personal capacity and does not reflect the views of Merck & Co, the extent to which the article was informed by his work with the pharmaceutical giant remains unclear.
[351] Here, God asks Cain where is his brother, Abel, and is used to reinforce the 'Torah's ethic of responsibility for one's kinsman and neighbour' (see Berlin and Brettler 2004: 19).

inherent problems that sit at the intersection of culture, faith, and health. There remains an expectation for religious teachings to be malleable and responsive to the biomedical and public health culture, with little inclination for this to operate vice versa (Chapter Four). Despite the self-proclaimed superiority of biomedical knowledge to manipulate theological teachings to comply with its own outlook, biomedicine is itself a socio-cultural system and a form of ethno-medicine, and thus an 'artefact of human society, founded in a cultural framework of values, premises, and problematics' (Hahn and Kleinman 1983: 306).

The view that Jews are mandated to preserve their health and body (see Chapter Four) was mobilised to justify uptake of preventive technologies as a parental responsibility. Shifrah, a local maternity carer, 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, immunisations are (or should be) sanctioned as they enable Jews to maintain their health, and fulfil religious commandments. Shifrah interpreted immunisations as being an imperative conduct and cosmological obligation, and perhaps also a 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.[352]

Preventive technologies are then conceived as being bestowed by God as a protective mechanism to preserve life (*pikuach nefesh*), which remains a fundamental tenet of Judaism. The claim that immunisations enable Haredi Jews to observe the *mitzvah* of preserving the body is consistent with broader ideas of

[352] Shifrah clearly views immunisations 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 immunised (as opposed to refusing routine immunisations altogether). It is important to reiterate here that (according to analytical precedents set by previous studies, such as Cassel et al. 2006) Shifrah would be grouped and classed as an incidence of 'non-compliance' for not consenting to childhood immunisations according to NHS schedule and instead delaying uptake.

health and bodily in the Judaic cosmology, and is complicit with view of a local Haredi rabbi I interviewed. 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 of the Judaic cosmology to proclaim that immunisations are compulsory. Rather than opposition to immunisations being an issue of 'culture' or religious 'beliefs,' anxieties and responses to immunisation campaigns emerged as a fraught area of childhood and child health for Haredi parents. 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 immunisations that her daughter was offered, apparently because of the risk that she perceived immunisations to pose:

> 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 immunise her daughter is therefore placed in a broader cosmological context of Jewish law and interpretations of how the body and soul is governed. Even though immunisations are *halachically* permissible and therefore 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. 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 individually interpreted and perhaps applied to suit healthcare-related encounters.

These examples illustrate how opposing interpretations of the Judaic cosmology are mobilised when formulating decisions to immunise or object to immunisations, yet each might be seen as taking a "leap of faith" from the other perspective. Studies that cite religious rationales for objecting to immunisations 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 immunisations 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 immunisations was, according to Shifrah, seen to form a 'very small percentage' of Jewish Manchester. Many of the midwives and doulas told me that health information for immunisations did not fall in their remit, and this was instead viewed as a responsibility of a local Haredi-run family wellbeing centre.[353] One doula made a conscious decision to avoid including immunisation advice in her work, partly because it is a responsibility for GP surgeries but also because this particular biomedical intervention is entangled in 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

[353] Local Haredi parents and childcare workers were not convinced of the efficacy of this centre to disseminate child health and development messages to the constituency. Mrs Salamon, a local *frum* childcare worker, was sceptical of whether communication was reaching Haredi parents via the Centre, who instead viewed it as being used as a 'cheap baby-sitting service.' Moreover, the local Health Visitors stationed as part of the in-house baby clinic were seen to be used only by parents '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.'

> immunisations. Obviously with babies and weight gain, definitely that, that's my area because I'm a breastfeeding counsellor. With immunisations it's a bit more sticky, and it's medical, so I really would try to keep out of that. (Mrs Yosef)

Mrs Yosef actively refused to interfere with the issue of immunisations, 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 Yosef does, however, understand the possible implications of her advice: if her guidance should conflict with that provided by medical professionals, they would then incur financial penalty due to lower than anticipated immunisation coverage.

GP surgeries in England have explicit 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 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," as advice from general practitioners is viewed as partial or untrustworthy by parents because of institutionalised financial incentives to immunise children (see Petts and Niemeyer 2004; Poltorak et al. 2005).

GP surgeries under the NHS in England have previously deployed conscious strategies to avoid financial penalty by manipulating immunisation coverage levels. Tactics have included the temporary exclusion of children from patient registers if their parents object to immunisations — in removing these children from immunisation target groups, they would be excluded from calculations of uptake levels and present the illusion that immunisation coverage is higher than it actually is (see Scanlon 2002). The issue of statistics being manipulated to create the illusion of higher coverage levels (for the purpose of securing economic incentives) is then indicative of the scrutiny in which public health data is viewed by the maternity carers. Statistics that are deployed as authoritative knowledge in public health discourse — or the *culture* in which knowledge is constructed — to represent immunisation coverage (as well as the reasons cited for this) is therefore worthy of critical engagement. Considering the political and economic relations that underlie

immunisation services, it is easy to understand why Haredi maternity carers choose to not actively circulate pro-immunisation advice.

Several maternity carers told me that circulating immunisation advice was not their responsibility, but they were nonetheless aware that local mothers held concerns over childhood immunisations. These apprehensions usually gravitated around the fabricated and long-refuted research that the triple-antigen MMR immunisation may be causally associated with autism (see Wakefield et al. 1998). Mrs Yosef 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 Yosef 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 immunisation anxieties certainly do circulate through information sources that are viewed as approved and authoritative (such as *Zei Gezunt*, but also Haredi newspapers and lifestyle magazines). Whilst Mrs Yosef encounters the biomedical authority on a daily basis through her maternal and infant care work, she nonetheless doubts the safety of the MMR immunisation despite the likely access she might have to recent public health communications and scientific assessments since the Wakefield affair. If Haredi Jews in the UK have a residual concern with the MMR immunisation then this should also be viewed in the broader context of them 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 immunisations 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 measles, and the public distrust that underlies low MMR uptake has also shaped responses to subsequent immunisation campaigns (see Stöckl 2010). Lower MMR coverage and the implications for how childhood immunisation campaigns are viewed in England then suggests that the self-protective stance of the Haredim (which, according to Mrs Yosef, makes them less 'up to date with the current research') cannot solely account for mistrust in the MMR amongst *frum* circles.

Negotiating immunisation schedules and recommendations

Studies of immunisations in England have, as mentioned, classified mothers as 'non compliant' if they choose to delay uptake of MMR, object outright, procure separate immunisations for measles, mumps, and rubella, or remain undecided about uptake (such as Cassell et al. 2006). However, Jewish mothers in Manchester demonstrated a preference to accept immunisations at their own pace — as opposed to the schedule constructed by the NHS. Delaying uptake of childhood immunisations straddles the boundaries of 'compliance' and 'non compliance,' as the "intervention" is still accepted yet negotiated on the terms of the parents. Moreover, the term 'underutilization' has also been used to describe parents who delay or refuse immunisation services (Muhsen et al. 2012), but I would instead argue that delaying the stage in which immunisations are accepted does not mean they are under-utilised, but utilised according to the judgement of parents. Representations of low immunisation uptake within Haredi settlements may not accurately reflect the *process* in which parents navigate this complicated area of child health.

Many *frum* maternity carers told me how they often chose to negotiate NHS immunisation schedules when raising their own children, with a general preference to delay uptake of childhood immunisations. Having a growing family led Shifrah to change her views on immunisation over time as opposed to holding a static position on the subject of uptake. When, for instance, her eldest daughter was being

exclusively breastfed and cared for at home (instead of being sent to a communal nursery), Shifrah felt that sufficient immune-protection was afforded and made the decision to delay uptake of primary immunisations. Shifrah's decision subsequently changed when her older children were attending nursery and younger (unimmunised) children were at home:

> My gut feeling is, "she's not in nursery, so she's not exposed to other children and I'm still fully breastfeeding her. I think she'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; she's coming home with goodness knows what and exposing it to our new born. So it [her rationale that underlies immunisation decisions] changes as the situation changes. Nothing is rigid.

Shifrah went on to claim that incidences of delayed uptake were often attributed to the perception held by *frum* mothers that children are 'way too young at six weeks to get a cocktail of vaccines.' Conflicting perceptions of 'protection' can be observed between Haredi mothers and NHS routine immunisations, particularly as 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 [2002]) notion, Haredi women can be understood as claiming exemption from the obligation to immunise according to NHS schedule (and possibly disrupt the protective circuit of social immunity), as an attempt to avoid what they perceive as a disruption to their children's health and development. The view that routine immunisation schedules are a technique of protection is therefore not always an interpretation shared between the state and citizens (the latter being the target of this biomedical and defensive technology).

What is also interesting is the language that Shifrah used to describe her daughter's immune system (as needing to be fortified). She depicts an image of battling entities that are far removed from her child, which can be understood as Shifrah internalising and assimilating biomedical discourse of immune responses in her perception of the body (cf. Martin 1994). Moreover, Shifrah reverses the

concept of the 'herd effect' from being a form of protection to that of risk, as she positions assemblages of the outside as a threat to her daughter's health.

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 was careful when to accept immunisations for her children (which meant that uptake was delayed for some):

> 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.

The decisions that these Haredi mothers formulate are therefore congruent with those observed in the broader anthropological discourse of childhood immunisations, where parents view their children's immune systems as distinguishable from others and thus lie 'at odds with a logic of vaccination among public health institutions premised on homogeneity' (Leach and Fairhead 2007: 46; see also Evans et al. 2001).

Challenging NHS advice

Past concerns of immunisation safety, especially relating to the MMR, meant that it was not unusual for Haredi mothers in Jewish Manchester to cross-examine NHS advice by engaging with broader information sources and social networks. When reflecting on the past MMR controversy as a mother, Mrs Kelner told me:

> Mrs Kelner: 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 continued mistrust in government recommendations concerning immunisations, 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 (cf. Petts and Niemeyer 2004: 12). Evaluating how Haredi Jews respond to immunisation campaigns should then consider how they are a minority group in the UK, which shapes their trust in the state and its health authority.

Considering that many parents in 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), it is easy to infer why parents prefer to place their confidence in the social body and local circuits of information. The social institution of 'MMR talk' is one example of how parents in Brighton seek reassurance in each other concerning healthcare-related decisions; rather than circulating direct advice or peer pressure not to immunise, this involves a process of 'acquiring confidence in one's own position through listening to other's views' (Leach and Fairhead 2007: 63; see also Poltorak et al. 2005).

The decision to 'give' immunisations 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 immunisation decision-making strategies, where the perceived and appreciated benefits of immunisation are considered to be counterbalanced by their 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)

Accepting childhood immunisations was evidently a decision made reluctantly for Mrs Schmidt, indicating her lack of confidence in state healthcare and its associated interventions. Moreover, 'compliance' with NHS immunisations schedules does not mean that parents accept them without any hesitation or concern. The hesitation of this mother to immunise her child echoes findings from the broader UK population, for whom consenting to immunisation does not equate with public trust in healthcare and the medical authority (see Casiday et al. 2006).

Haredi mothers who delay uptake of immunisations viewed themselves as employing a deliberate strategy to avoid administering a 'cocktail' of immunisations until their infants are relatively older and perhaps then able to withstand preventive interventions that have the potential to be 'toxic.' In Shifrah's case, this was carefully decided upon through her own analysis of risk. Views that the immune systems of children might not sit in accordance with NHS recommended guidelines are far from unique to the case of Jewish Manchester and resonate strongly with wider anthropological debates, where '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 immunisations is made by parents and imposed on their infants, the latter of whom bear the implications of any adverse reaction or 'vaccine damage.' However, the decision not to immunise is understood by parents as putting the social body at undue risk. Childhood immunisations then become the point where competing risks and responsibilities intersect, entangling the bodies of the individual, the social, and that of the nation. 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).

The minority of parents who chose not to immunise their children (but might still benefit from social immunity) were regarded as being 'a little bit of a cheat' by

one maternity carer, who viewed the strength of social immunity as resting in the willingness of individuals to immunise:

> 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. (Shifrah)

High immunisation coverage (and the protection this affords to non-immunised children) was one of the many reasons why Leah, a local mother who defined herself as Orthodox, objected to immunisations:

> 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 immunised] 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, Leah's willingness to rely on the social body for her child's immuno-protection indicates a partial appropriation of biomedical information (authoritative knowledge) in formulating her refusal of immunisations. Coverage levels, as I discussed at the beginning of this thesis, vary from place to place, and there is a possibility that Haredi constituencies do not achieve the required threshold to confer social immunity. When immunisation 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 Leah appropriate biomedical facts to inform and justify decisions regarding opposition to childhood immunisations, 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 immunisations are accepted by the ninety-five per cent who comprise her settlement.

Toxic interventions and adverse reactions

The emic perceptions of immunisations presented above indicate that safety concerns feature prominently in how Haredi Jewish parents respond to childhood immunisation campaigns, to which this section advances. The preference to be exempt from immunisation policies (and 'social immunity') has historically affected immunisation uptake levels in England. Resistance amongst the population of England during the nineteenth century demonstrates the climate in which compulsory biomedical interventions were viewed as being laced with socio-political motives. Anti-immunisation discourse that circulated during the nineteenth century is also continuous with the anxieties presented by Haredi parents in Manchester today. I discuss how immunisations were perceived as 'toxic interventions' and the cause of adverse reactions, which raises the question of how healthcare professionals (and the medical establishment) address parental concerns pertaining to immunisation safety. The process in which opinions and authoritative knowledge of immunisations can be circulated in Jewish Manchester demonstrates the social context in which opposition to immunisations emerges.

Techniques of immunisation in the nineteenth and early twentieth centuries would not have resembled the now standard use of syringes, and instead considerable variation existed in the insertion, site, puncture, and pressure of vaccines (see Baxby 2002). It was therefore unlikely that formative strategies of vaccination could routinely penetrate the thin layer of the epidermis (pinpointed as the most effective site and layer for immunisation), and it also became apparent that initial techniques did not engender the total protection that Edward Jenner, who introduced smallpox 'vaccinations,' had claimed (Baxby 2002).

Formative vaccinations to prevent smallpox attempted to induce immunity through the animal-to-human transfer of cowpox matter, yet this was a highly contentious but mandatory intervention in eighteenth and nineteenth century England. Resistance to this novel vaccination was partly because of the prevailing 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).

Resistance to this novel vaccination was partly because of the compulsory nature of the 'intervention' but also the anxiety of contaminating human bodies with animal matter by virtue of the cross-species transfer of cowpox from animals to humans (Durbach 2000). Anti-vaccination material at this time reproduced these concerns by featuring vaccinated humans growing cow heads or bovine features (see Figures 18 and 19). Whilst methods of circulating information have changed radically since the eighteenth and nineteenth centuries, the discourse surrounding anti-vaccination anxieties in the UK remain historically-persistent and remarkably similar to those of the past (Wolfe and Sharp 2002).

Figure 18: 'The wonderful effect of the new inoculation!' 1802.
Caricature of Edward Jenner inoculating patients in the Smallpox and Inoculation Hospital at Saint Pancras, London. The patients are shown growing cow heads from parts of their anatomy following the vaccination. Photo credit: Wellcome Images (V0011069). Originally published by 'Vide: the publications of ye anti-vaccine society,' 1 June 1802.

Figure 19: A vaccinated man grows horns in front of a couple with a lancet, 1802.
Photo credit: Wellcome Images (V0011697).

Current concerns of contamination

The historical anxieties surrounding cross-species contamination through immunisations (introduced above) continued to inform the decisions taken by some Haredi parents in present day Manchester. One Hassidish mother claimed that immunisations 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)

In this instance Mrs Lisky is not opposed to immunisations because of her religious 'beliefs' or any 'cultural factors,' but she presents 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 in which immunisations are cultured. The possibility that immunisations are cultured with animal-derived tissues — which might then contaminate the human body — was a concern for other mothers in Jewish Manchester, and can be entrenched in a broader anthropological (de)construction of the body.

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 demonstrates a permeation of embodied boundaries that is made possible by biomedical technologies, where immunised children arguably come to acquire conceptualisations of the monstrous through an 'adverse reaction.' 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). 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 takes on a paradox for this Hassidish mother, as that which is meant to preserve life is counterbalanced by the potential to endanger it (cf. Esposito 2015 [2002]). The opposition Leah voiced to immunising her child is further demonstrable of this argument:

> Leah: 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?

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

Leah's relative 1: It's cowpox, isn't it, vaccinations?

Leah's relative 2: 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 Leah's relative had claimed immunisations were derived from played a historical role in the development of 'vaccinations' rather than a contemporary one. The anxieties that promote an anti-immunisation stance then point to a partially appropriated and incomplete knowledge of the intricate process in which biomedical technologies are produced. It is also clear that the concern of animal-derived products in immunisations presented an assault to the moral worldview upheld by Leah's family as vegans. Although this view was not common in Jewish Manchester, it certainly resonates with other studies in England. The staunchly anti-immunisation positions held by some Jewish mothers may therefore not be dissimilar to those in broader areas with relatively lower immunisation coverage, such as Brighton (see Cassell et al. 2006).

Public concern surrounding the safety and ethical implications of immunisations are related to the culture in which these biomedical technologies are produced. Viruses for some routine childhood immunisations are pharmacologically "incubated" or processed using human or animal cell-lines (see Oxford Vaccine Group).[354] 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). Cell-lines are a 'technology of living substance' where the boundaries of the body are disintegrated

[354] Routine childhood immunisations which are produced with human derived cell-lines include rubella (forming part of the triple-antigen MMR immunisation). Those which are produced with animal derived cell-lines include the 'five-in-one' DTaP/IPV/HiB (diptheria, tetanus, pertussis [whooping cough], polio, and haemophilus influenzae type b) as well as measles and mumps which form two parts of the MMR immunisation.

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).

The initial trace of human and animal cell-lines are removed when being 'purified' intensively, which means there is no risk of transmitting zoonotic diseases through the manipulation of animal cell-lines for the use of human immunisations. 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 viral immunisations (see Oxford Vaccine Group). The continued use of manipulated cell-lines deriving from aborted foetuses was particularly problematic for Roman Catholic authorities in the Vatican. Such immunisations 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).

The concerns of Mrs Lisky should therefore not be dismissed as conspiracy, since at the core of her refusal to not complete the course of childhood immunisations is a complexly woven debate concerning the pharmaceutical manipulation of foetal and animal tissues and the moral challenge this has raised for religious practitioners of different faiths. Moreover, the aforementioned conceptual reference of 'herd immunity' in public health discourse can then be seen as resonating with the historically contiguous anxieties that surround the transfer of matter between human and non-human species, first through historical techniques of 'vaccination' against smallpox but also the cultural production of immunisations in biomedicine.

Adverse and averse reactions

Opposition to immunisations was often described by parents as arising from what they considered to be past experiences of a 'side-effect' or an 'adverse reaction.'[355] Whilst parents may associate an immunisation with causing a subsequent disruption to their child's health, it is important to note that a reported adverse event does not necessarily implicate an immunisation as the cause (Oxford Vaccine Group). Bodily reactions might, for instance, result from a component of the immunisation itself, an issue in the supply, storage, and cold chain, or an underlying medical condition in the recipient or "target" (see Public Health England 2013c). Parents might view an immunisation as the cause of an adverse reaction, but they might not be able to identify which component (if any) in the immunisation 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 immunisations (and the biomedical technique of inducing immunity) rejected as being a 'toxic' intervention.

Health professionals are, in theory, mandated to log any adverse experiences to immunisations in patient records,[356] but 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 immunisations and the medical establishment. Mrs Kahn was one Haredi mother to recall her son's adverse reaction, but she also felt healthcare professionals handled the situation 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

[355] 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.
[356] 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).

> 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 immunisation safety, because she felt that her son's lived experience of an adverse reaction was being excluded from the biomedical construction of authoritative knowledge. Whilst Mrs Kahn told me how she confronted healthcare professionals on the issue of statistical transparency, other Haredi mothers did not formally report their experiences of adverse reactions. Mrs Newman held particular reservations about the pertussis immunisation despite "complying" with the recommendation from her GP, but her son subsequently experienced what she interpreted to be an adverse reaction:

> Mrs Newman: 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 you [question interrupted]
>
> Mrs Newman: 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 Newman: No, no. I just told them about it [the reaction], but they weren't interested.

These Haredi mothers often chose to delay or withhold immunisations in subsequent children after experiencing what they saw as adverse reactions to 'routine' immunisations (and perhaps also the manner in which healthcare professionals allegedly responded to such episodes). Mrs Kahn withheld all immunisations for her seventh, eighth and ninth children, and Mrs Newman was later selective when it

came to accepting childhood immunisations: she refused the pertussis outright, and delayed the age at which her subsequent six children received all immunisations.[357]

Mrs Kahn and Mrs Newman 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 immunisations with a local *frum* GP, I was told that only a small minority were averse to immunisations 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 Dr Harris as she visited a nearby Hassidish neighbourhood to promote an upcoming ladies' health event arranged by *Gehah* (see Chapter Four). When Dr Harris approached Mrs Lisky with a flyer, the two soon became engaged in an awkward stand off. The Hassidish mother challenged the GP on the perceived risks of biomedical interventions, such as immunisations, and the physician asserted the status of her professional role to counter the claims. Meanwhile, I stood nearby not knowing what to do, but seized the opportunity to request an interview with Mrs Lisky and discuss her anxieties in greater depth.

During our interview a few days later, Mrs Lisky expressed her concern with the willingness of healthcare professionals to promote childhood immunisations without actually being able to explain the process of production. The contradiction she saw subsequently fuelled her mistrust in immunisation safety, but also the nexus between the state, health authority, and 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

[357] 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' (see Loewenthal and Bradley 1996).

> 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 immunisations with suspicion because of contested interpretations — as well as constructions — of authoritative knowledge: whilst they accepted the potential for immunisations to cause adverse reactions in their children, they claimed that physicians did not. The process in which authoritative knowledge concerning immunisation safety is produced and presented to parents is arguably at the heart of this issue, as several mothers in Manchester interpreted the information they received with varying degrees of mistrust. The cultural construction of immunisation 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 is based on lived experience of adverse reactions rather than epidemiological or population-level statistics (Casiday 2008: 130).

The safety concerns held by Haredi mothers in Manchester accord strongly with previous explorations of immunisations 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 immunisations is vital to secure sufficient coverage for social immunity, and immunisations anxieties might be alleviated if parents are more aware of processes to survey the safety of pharmaceuticals and official lines to report adverse reactions (see Casiday and Cox 2006).[358] Not being seen to record adverse reactions and to adequately understand the lived experience of immunisations, as 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).

[358] 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).

Vaccine damaged bodies

Although Haredi mothers in Manchester felt that healthcare professionals did not accept the possibility for immunisations to produce adverse reactions, it is important to note that the state can bear responsibility for 'vaccine damage.' Immunisations mark a collaborative intervention between pharmaceutical, biomedical, and government authorities, although it is the latter that takes on the responsibility for vaccine damages or serious 'adverse reactions.' The UK government offers a designated compensation fund to individuals who are left 'severely disabled'[359] as a result of immunisations (see UK Gov 2016), but this ambiguous and subjective definition has led to several high profile political contestations. The government recognise 'vaccine damage' if occurring in the direct recipient of an immunisation, being affected in utero by an immunisation administered to the mother, or by coming into close contact with somebody immunised orally against poliomyelitis.

The government's 'vaccine damage payment' is a one-off and fixed sum of £120,000 and is paid directly to the 'damaged' recipient (or to a trustee if under the age of eighteen) following complications arising from a specific list of immunisations (listed in Appendix A). The UK government had distributed £3.5m in compensation for vaccine damage between the years 1997–2005, with a total of 917 payments being made since the vaccine damage scheme was introduced in 1979 (see BBC News 2005). However, information relating to the specific immunisations that cause 'damage' and warrant compensation are not released publically by the UK government. It is arguably the case that this information is concealed to avoid a public backlash occurring against implicated immunisations (similar to the public outrage surrounding the MMR which continues to reverberate).

The legitimacy of applications for compensation arising from vaccine damage have been challenged by the UK government's Department for Work and Pensions; the body responsible for administering the Vaccine Damage Payment. Following the hyped swine flu (influenza A H1N1v) pandemic of 2009–2010, the English public

[359] Individuals must be sixty per cent mentally or physically disabled in order to be eligible for the Vaccine Damage Payment (providing that the immunisation was administered in the UK or Isle of Man, or extra-territorially as part of the British armed forces).

health authority first recommended the immunisation of individuals 'at risk' of complications from this strain of influenza and then all children under the age of five in 2009 using Pandemrix (developed by GlaxoSmithKline).[360] The rationale behind the government's approval of this emergency intervention was to afford social immunity and reduce unnecessary burdens on NHS critical care services (see Department of Health 2009), in what was feared to be a dramatic and unprecedented strain of influenza.

A pattern soon emerged that children and youths in England were developing narcolepsy following administration of Pandemrix (consistent with broader reports in Europe), and healthcare professionals were later advised not to administer the immunisation to anybody under the age of twenty. However, the UK government controversially declined several applications for vaccine damages, but the decisions made were later overturned in a tribunal ruling (see Devlin 2015; Dyer 2015). Mistrust in the public health authority and its recommendations for certain immunisations can therefore be understood against this backdrop of safety issues as well as state's attempts to absolve itself from providing compensation to 'vaccine damaged' bodies.

Communicating transparently any associated risks of immunisation and existing procedures to monitor immunisation safety has been argued to be an important aspect of improving trust in the public health authority (cf. Casiday and Cox 2006). Rather than rejecting claims of adverse reactions outright and relegating Haredi parents as '*meshugunahs,*' sources of authoritative knowledge (which are both internal and external to the constituency) should address perceptions or fears of risk — thus enabling parents to feel they are being pointed in the direction of reassurance rather than "harm's way."

[360] See Health Protection Agency (2013). The Health Protection Agency was amalgamated into Public Health England in 2013 by the UK government.

'Power of the mouth'

Some Haredi locals in Manchester would circulate advice contrary to public health opinions, particularly recommendations to avoid immunisations 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 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, immunisation coverage varies throughout the UK.[361] Rubella (also known as German measles) is a highly contagious viral infection that is relatively mild, but can have serious implications if contracted by a pregnant woman. Immunising children against rubella has then less to do with protecting the body of an individual and more the body of the nation, and how it 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.[362] Whereas CRS can occur through maternal exposure to infection during this period, there is no known

[361] 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 RCPH 2015).

[362] 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 (ninety 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 2015c).

risk to foetal health if the mother receives the rubella immunisation (single-antigen or triple-antigen MMR) during pregnancy (see Public Health England 2015). Women are routinely offered a blood test to check for rubella immunity as part of NHS antenatal surveillance efforts, usually at the eight to twelve week stage of pregnancy (although some Hassidish women evade these initial antenatal screening services, as discussed in Chapter Five).

Immunisation anxieties are proliferated and circulated by the 'power of the mouth' in Jewish Manchester, as one participant described, although it is important to reiterate that access to health information in Haredi settlements is not defined solely by insulation from mainstream media or the circulation of rumours.[363] Rumour is often associated with the circulation of immunisation dangers, as mentioned earlier in this chapter, yet the power relations that substantiate and underline hearsay are not always fully considered. Coercive attempts to immunise girls have resulted in rumours that such interventions are for the purpose of mass sterilisation, which is a fear born out of enduring struggles of ethnic survival. Immunisation strategies in Cameroon, for instance, have come to reproduce anxieties about minority-state relations through a certain 'politics of the womb' (Feldman-Savelsberg, Ndonko, and Schmidt-Ehry 2000).

Not limited to immunisations, the broader anthropological discourse has asserted how women's bodies are targeted as sites of socio-political interventions of population control through contraceptive regimes — particularly when attempting to assimilate migrant groups into the body of the nation. The potent and potentially lethal reactions that pharmaceuticals are feared to present can also underlie antipathy, mistrust, and resistance to therapeutic regimes amongst intended "targets." Treatment regimes to control neglected diseases such as schistosomiasis and soil-transmitted helminths in Northern Uganda were viewed as causing infertility and pregnancy loss, fuelling speculation that the central government (as well as international funders of 'development,' such as the United States) were deploying public health regimes as a covert political intervention to reduce population growth

[363] 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).

in regional provinces (Parker, Allen and Hastings 2008). What is 'neglected' in the deployment of biomedical interventions are parental concerns relating to safety, which, similar to issues of immunisations in Jewish Manchester, suggest that therapeutic regimes and strategies of preventive health will not be successful without addressing the anxieties held and circulated by intended beneficiaries. The tendency to frame opposition to preventive measures, such as immunisation (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 fears of politically-motivated interventions.

Immunisations anxieties in the UK more broadly (and their circulation through the "rumour mill") also reveal intense mistrust in government recommendations relating to science and technology (as well as the leverage of pharmaceutical moguls), even amongst parents who consent to immunise children (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* are viewed in the Judaic cosmology meant that some Haredi parents would approach local *rabbonim* with a *shailah*[364] concerning immunisations (Figure 20), especially if they had concerns over safety or had previously experienced what they considered to be an adverse reaction. 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 immunisations for her children.

[364] Hebrew (also *shailoh*); a question put forward to a rabbinical authority that usually entails a *halachic* ruling, but can also be to solicit guidance.

As discussed in Chapter Four, rabbinical authorities and *askonim* are called upon for advice when making healthcare-related decisions; the guidance offered by a rabbinical authority is considered binding (whereas advice that is solicited from an *askon* is not). The particular rabbi who Mrs Kahn approached had apparently said it would be in her interests to consult an Orthodox Jewish physician, who would be *frum* but 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)

However, the contractual agreement which consulting a rabbinical authority involves underlined the reason why Leah chose not to solicit an answer on the issue of immunising her child. I first met Leah one *Shabbat* afternoon at a local Orthodox synagogue and she became interested in my research and specifically perceptions of immunisations in Jewish Manchester. However, it soon became apparent to me that she was seeking for information that could potentially substantiate her decidedly anti-immunisation stance.

Our interview indicated that there was no immediate religious or *halachic* rationale underpinning her objection to immunisations. Instead, she articulated her opposition to immunisations as being more bound up in her family's moral choice to be vegan, which she viewed as presenting heightened ethical obligations to the bodily care compared with *halachah*. It seemed that Leah was interested in extracting contacts and information from myself in order to reinforce her opposition to immunisations, but she was also eager to procure rabbinical guidance on the matter of immunisations whilst circumventing any obligation to act on his advice:

> BK: Did you ever consult rabbinical guidance on the issue of immunisation?
>
> Leah: I don't see how that would come into it.
>
> BK: Were there any religious reasons to not immunise?

> Leah: Nothing to do with it. Have you [to BK] ever come across anything that might be useful in that aspect, where you've found out that a rabbi would support vaccination or wouldn't support vaccination?
>
> Leah's relative: The thing is, if you ask him [rabbi] a question and you want a *psak halachah* [ruling 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 vegan, 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 as vegans.
>
> Leah: 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 Leah'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 immunisations. It can be inferred from this dialogue that Leah refused immunisations because of the ethical standards that she perceived veganism to entail. 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 being an accurate interpreter of the Torah or *halachich* law (see Coleman-Brueckheimer, Spitzer, and Koffman 2009). However, it might also be the case that 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.

Coverage of immunisations in the mainstream Jewish press recently pointed to collaborations between Haredi religious and public health authorities, the former agreeing to endorse immunisations in their constituencies in response to rising

incidence rates of measles (see Sheinman 2013; also Winograd 2013). However, as has been discussed elsewhere, rabbinical endorsement of health strategies does not necessarily mean that Haredi Jews themselves will be convinced of the need to act accordingly (see Coleman-Brueckheimer and Dein 2011).

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, the collusion occurred by 'disguising' public health nurses and doctors 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). Public health discourse that represents Haredi Jews as being 'non-compliant,' 'resistant' or 'hostile' to preventive health services then do not fully account for the complex terrain that religious authorities and parents themselves navigate when dealing with immunisations.

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.' The fact that Haredi individuals are not always complicit with 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.

Figure 20: Authoritative knowledge
Photo credit: Wellcome Images. Photograph by Thomas Farnetti, September 2015.

Discussion

This chapter has critically engaged with the 'hard to reach' trope that is imposed on Haredi Jews by exploring how 'immunity' is a social construction, within which contrasting ideas of bodily protection are at play: 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'),[365] but 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 [2002]) conceptual analysis to the 'hard to reach' representation, it can be inferred that the Haredim are framed 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*).

Immunisations are a lauded public health and protective intervention to arrest the transmission of disease at a population level, but Haredi parents in

[365] 'Contagious communities' is borrowed from Roberta Bivins (2015), who discusses the term in relation to the NHS and migrant groups in Britain.

Manchester prefer to negotiate uptake at an individual level. Portraying opposition to immunisations as being an issue of 'culture' or 'religious belief' fails to grasp how responses to health services (that are not in the desired manner of 'compliance') may result from a contest of guardianship and protection over the body and soul. However, only a minority of the *frum* mothers in Manchester opposed immunisations because of a cosmological mandate, and they would mobilise their interpretations of Judaic teachings to underscore their decisions. Public health discourse and studies are quick to claim that there is no religious or *halachic* basis for Jews *not* to immunise their children (such as Stewart-Freedman and Kovalsky 2007), but the concerns held by Haredi Jews in Manchester were overwhelmingly about safety and fears of toxicity.

Mistrust in immunisation safety as well as the state-NHS-pharmaceutical nexus often led *frum* mothers in Manchester to negotiate routine immunisation schedules rather than refuse them altogether. Haredi Jews in Manchester do not accept childhood immunisations 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 surfaced as a particular source of angst for parents, and in this respect Haredi parents 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 immunisations should therefore be discussed in the context of them being a minority group in the UK.

Haredi minority groups emerge as being unfairly stigmatised as 'hard to reach' in the context of immunisation coverage and the target of intervention, probably because *halachically* observant Jews tend to live in a particular geography rather than being dispersed throughout the state (as others who object to immunisations might be, and as national variation in immunisation coverage indicates). Being portrayed as 'hard to reach' evokes a historical issue of positionality and positioning for the Haredim of Manchester. The juxtaposition of archival and ethnographic material in this chapter (and broader thesis) demonstrates how Jews in England have been the particular targets of public health interventions in ways that

are contiguous over time, which should not be ignored in current representations of the Haredim.

Chapter Seven

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' and outright resistance in some instances. In challenging the view that Haredi Jews are 'non-compliant' with areas of NHS provision, this archival and ethnographic study presents an image of how responses to biomedical interventions should instead be understood. Taken together, the course of my previous chapters describe how the relation between the Haredi settlement and the state is marked by a failure to reach each other's expectations and responsibilities concerning health and bodily care.

I conclude this thesis by tying together the mutual constitution of ethnography and theory presented across the previous chapters using the trope of 'antonymic immunities.' 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 the body — itself being the margin between the Haredim and the state — rest on opposing conceptualisations of preserving 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 thesis articulate how health and bodily care reflect an enduring pressure for 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' (Chapters One and Three). 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.

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

In juxtaposing the past and present constructions of the Manchester settlement, it becomes clear how state healthcare services continue to be viewed by pious Jews as incapable and untrustworthy to care for Jewish bodies in line with the cosmology or culturally specific expectations to preserve life and bodily integrity. The former Manchester Victoria Memorial Jewish Hospital and the current role of Haredi paramedic brigades, *askonim*, and maternity carers reveal 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 'dissimilation' (see Scott 2009), the Haredi context is best described as a pursuit of 'immunity' at the margins 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')[366] 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-insulation and self-protection that is intended to preserve individual and

[366] Term borrowed from Scott (2009: 20)

collective life. The preference for self-protection then 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 the outcast. Self-insulation enables religious authorities to negotiate the health and bodily care services that can be accessed within the social body, which also comes at the expense of individuals. The stringency in which self-insulation is pursued as an immunitary strategy (Chapter Four), can come to present a danger to the Haredi social body from within, in what might be described as an autoimmune reaction (cf. Esposito 2015 [2002]).

Protecting the social body

Haredi authorities and doulas directly intervene in the state provision and delivery of health and bodily care because of the mistrust with which the NHS is viewed as being unable to meet, or understand, the needs of the growing settlement. The Haredi culture of health that I observed in Manchester is best described as a preference to manage and mediate its relation to the biomedical authority rather than evade it altogether. Negotiation 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 Four and Five).

The culture in which NHS maternal 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. 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 high birth rates. However, there is little understanding of how the reproductive care needs of Haredi settlements will be met. Whilst hospitals are 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 socio-political organisation of healthcare — and especially the nature of midwifery. Pious doulas offer a primarily caring role in childbirth whereas the prerogative of NHS midwives is seen to be one of safeguarding — rather than supporting — labouring women.

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 Five). These Haredi maternity carers can be understood as an 'immunitary reaction' to manage the intrusion of mainstream interventions, and enable these external forms of health and bodily care to comply with the Judaic cosmology.

Birth spacing technologies are a routine area of primary care that can contravene the Haredi and Biblical aspiration to 'be fruitful and multiply,' and need to be approached with caution and sensitivity by Haredi couples, religious authorities, *frum* maternity carers as well as general practitioners (Chapters Four and Five). Rather than an outright ban on (female) birth spacing technologies, as is the case for *frum* men, the increasing uptake of 'the pill' might instead indicate a relative degree of flexibility among women who, in public (health) discourse, are otherwise viewed as being "ultra-Orthodox" or "non-liberal." Public health discourse, as Didier Fassin (2001) has argued, amplifies culture as constituting only difference and thus casts a shadow over what might be similar.

The prominent role that religious authorities and doulas perform in Manchester illustrates how maternal and infant care is a carefully navigated area, rather than being a site of outright 'non-compliance' or resistance, and thus offered a backdrop to critically engage with local responses to childhood immunisations.

Childhood immunisations are a lauded public health technology to arrest the transmission of infectious diseases that previously plagued modern societies, 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 immunisation campaigns — such as the MMR.

Immunisations then form part of a broader culture of biomedical hegemony that is viewed with varying degrees of mistrust. Opposition to immunisations among Haredi parents are often rooted in safety anxieties that have been informed by experiences of 'adverse reactions' or a fear of bodily contamination, which resonates with a broader and historical issue of public concern (and resistance) in England (Chapter Six). The intervention of *frum* doulas in state maternity services, as well as the immunisation 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 [1966]; Esposito 2015 [2002]).

Immunising the body of the nation

The Haredi quest for *immunity* and protection, from what it positions as belonging to the outside world, is 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 [2002]: 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). The 'discipline' of obstetrics 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 immunisation regimes, as explained in Chapters Five and Six. From this perspective, immunisation 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.

My interest is the relation between these antonymic immunities. 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 [2002]; McCargo 2011), causing socio-politically constructed expectations of bodily citizenship to be negotiated.

The issues explored and unravelled in this thesis can be entrenched in a broader body of anthropological scholarship that is concerned with attempts of the state to enforce order at its margins, and the complex ways in which minority groups respond to these assimilatory pressures in ways that are persistent over time. Margins are a demarcation of both territories and bodies (Das and Poole 2004), and the maternal 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 [2002]; Lock and Nguyen 2010). My ethnography analyses 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. Moreover, it advances a theoretical framework in which these responses can be understood. The research therefore engages with broader debates in the anthropology of health and its concern with the entanglement of marginality, identity, and bodily counter-conducts.

Sof davar[367]

The pressure for Jewish émigrés to integrate and assimilate in Manchester during the nineteenth and early twentieth centuries resembles the struggles I observed over the course of this three-year research project. Health and bodily care mark an enduring terrain of contention over the body, the guardianship of which is sought by both the cosmology and the biomedical authority in ways that are persistent over time. The struggles I investigate are not confined to the by-gone 'Yiddisher Hospital' that was conceived by émigré Jews who found their way to Manchester. They continue to be at play in the current interventions imparted by religious 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 hospital used to sit is a *Hatzolah* brigade providing free emergency care to a cyclist by the roadside, as was the case for me when I moved to Jewish Manchester in 2014 (Chapter Four). The *frum* doulas and midwives can be found performing a Biblical vow to carefully birth the Jewish social body after a long history of persecution and decimation. 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 — the very site where the 'immunity' of the margins is at stake.

[367] The final or last word.

List of shorthand terms

BST: Birth spacing technologies

CST: Community Security Trust

GP: General practice / practitioner

MMR: Measles, mumps, rubella triple-antigen immunisation

MVMJH: Manchester Victoria Memorial Jewish Hospital

NHS: National Health Service

OfSTED: Office for Standards in Education, Children's Services and Skills.

The Board: Manchester Jewish Board of Guardians for the Relief of the Jewish Poor.

WHO: World Health Organisation

ZAKA: Haredi-led disaster victim identification squad in Israel

Hebrew and Yiddish Glossary

Below is a list of Hebrew and Yiddish terms that appear frequently in this thesis. Definitions or translations will appear in a footnote only in the first instance it is used. Terms which are only used once are explained using a footnote in the relevant page and do not appear below.

- Singular followed by the plural (when relevant).
  Example: Ashkenazi, Ashkenazim.
- When relevant (S) denotes the Sephardi and (A) is the Ashkenazi pronunciation:
  Example: Halachah (S) / Halochoh (A).

Aron Kodesh: Torah ark (in synagogue).

Arukah: Healing.

Ashkenazi, **Ashkenazim**: Jews of Eastern and Central European Jewish origin.

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

Belz: Hassidish group.

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

Brit milah (S), **Bris milah** (A): Covenant, ritual circumcision of male Jewish infants on the eighth day.

Chabad Lubavitch: Hassidish group.

Chesed: Kindness, usually an act of kindness.

Chumrah / **chumrot**: Stringency, usually in how religious law is practiced.

Frum: Pious.

Gehah: One participant 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.'

Gemara: Rabbinic discussions that comprise the *Talmud*. *Gemara* is often used interchangeably with Talmud.

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

Halachah (S), **halochoh** (A): Codex of rabbinical law.
Halachot, **halochos:** Plural (as above).
Halachic, **halachically**: Adjective (as above).

HaShem: The name, synonym for God.

Hashkafah (S), **hashkofoh** (A): Worldview or outlook.
Hashkafot (S), **hashkofos** (A): Plural (as above).
Hashkafic, **hashkofic**: Adjective (as above).

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

Hechsher / **hechsherim**: 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.

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.

Ivrit: Modern Hebrew, official language of the State of Israel.

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

Kosher / **kashrut**: Laws governing food and system of production that are acceptable or approved for observant Jews. Used generally as a term to describe something as acceptable or approved.

Labriut: Hebrew expression 'to health.'

Litvish: (Adjective) Jews originating from the historical region of Lithuania who follow Haredi (non-Hassidish) cultural norms (*minhagim*). This historical region of the Grand Duchy of Lithuania now spans several states, including Lithuania, Belarus, Latvia, and parts of Poland. The Jewish settlement of the historical Lithuania was once a centre of religious scholarship. For the most part, Litvaks (noun) were '*mitngadim'* (also *misnagdim*), meaning opponents (or the opposition) of *Hassidut* (Hassidish philosophy) and its emphasis on mysticism. The Litvaks maintained a *shtark* (strict or pious) culture of *yeshiva* scholarship and study of religious texts, and Litvish *yeshivot* (pl.) continue to form the elite and socio-religious hegemony in Israel. Although Litvaks and Hassidish Jews constitute major branches of the Ashkenazim, there are also other sub-groups such as the *Yekke* (German origin).

Meshuganah: Yiddish, crazy.

Minhag / **minhagim**: Custom in which religious law is practiced.

Mizrahi / **Mizrahim**: Eastern, Jews of Middle Eastern origin.

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 / **poskim**: Decider of religious law (*halachah*) in cases without a precedent or when previous rulings remain inconclusive.

Rabbi / **rabbonim**: Male religious authority.

Rabbanite (S) **/ Rebbetzin** (A): Wife of a rabbi.

Satmar: Hassidish group.

Sephardi / **Sephardim**: Jews originally of Spanish and Portuguese origin.
Sephardic: Adjective (as above).

Shabbat (S), **Shabbos** (A): Sabbath, twenty-five hour period of rest from Friday evening to Saturday evening.
Shabbatot: Plural (as above).

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 / **shidduchim**: System of introducing males and females for courtship and brokering marriage.

Shtark: Strict or pious in religious observance.

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 / yeshivot: Male religious educational institutions which are instrumental in reproducing Haredi socio-religious constructions of normative behaviour. Men generally attend yeshiva until they marry, and then attend the equivalent of post-graduate centres of learning known as a *kollel* or *kollelim* (pl.). Like the world university index, *yeshivot* have their own prestige rankings but are also distinguishable in terms of their socio-religious or ethnic background (such as Litvish, Sephardi, and Hassidic sub-groups). It has become a norm and expectation that Haredi males will attend *yeshivah*, when this was historically an opportunity only for the elite students.

Zei Gezunt: Yiddish expression for 'be well.'

Archival materials

Manchester Jewish Museum

1984.684: Jewish Gazette, 2 July 1931.

1984.684 Jewish Gazette, 13 November 1931).

1984.684: Manchester Guardian, 1 February 1932.

J74: Oral history

J76: Oral history

J143: Oral history

J160: Oral history

J162: Oral history

J192: Oral history

J229: Oral history

J273: Oral history

J279: Oral history

Archives & Local History, Manchester

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: 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.

Manchester University Archive and Records Centre

MMC/8/13: Manchester Medical Mission and Dispensary (Red Bank Working Men's Christian Institute).

References

Abbott, Stephen. 2004. “Lay and Professional Views on Health Visiting in an Orthodox Jewish Community.” *British Journal of Community Nursing* 9 (2): 80–86.

Abramson, Sarah, David Graham, and Jonathan Boyd. 2011. “Key Trends in the British Jewish Community.” *Institute for Jewish Policy Research*. Accessed February 19, 2016. http://www.jpr.org.uk/publication?id=84#.Vl2vgLTA7EY.

Abu-Lughod, Lila. 1998. *Remaking Women: Feminism and Modernity in the Middle East*. Princeton: Princeton University Press.

——. 2002. “Do Muslim Women Really Need Saving? Anthropological Reflections on Cultural Relativism and its Others.” *American Anthropologist* 104 (3): 783–790.

Adichie, Chimamanda Ngozi. 2009. “The Danger of a Single Story” (audiovisual). TED Global, 18:49. Accessed July 1, 2014. https://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story?language=en.

Agamben, Giorgio. 1998. *Homo Sacer: Sovereign Power and Bare Life*. Stanford, CA: Stanford University press.

Alderman, Geoffrey. 1992. *Modern British Jewry*. Oxford: Clarendon Press.

——. 2012. “Black Hats and Jewish Babies.” *The Jewish Chronicle*, April 19. Accessed March 14, 2016. http://www.thejc.com/comment-and-debate/columnists/66629/black-hats-and-jewish-babies.

Alexander, Jennifer, and Paul Alexander. 2002. “Gender and Ethnic Identity among the Lahanas of Sarawak.” In *Tribal Communities in the Malay World: Historical, Cultural and Social Perspectives,* edited by Geoffrey Benjamin and Cynthia Chou, 457–474. Leiden: International Institute for Asian Studies.

Anderson, Benedict. 2006 [1983]. *Imagined Communities: Reflections on the Origin and Spread of Nationalism*. London: Verso.

Anis, Emilia, Itamar Grotto, Larisa Moerman, Bruce Warshavsky, Paul E. Slater, Boaz Lev, and Avi Israeli. 2009. “Measles in a Highly Vaccinated Society: The 2007–08 Outbreak in Israel.” *Journal of Infection* 59: 252–258.

Aran, Gideon, Nurit Stadler, and Eyal Ben-Ari. 2008. “Fundamentalism and the Masculine Body: The Case of Jewish Ultra-Orthodox Men in Israel.” *Religion* 38 (1): 25–53.

Archives Plus. No date. “Early Jewish Settlers.” Manchester Libraries, Information, and Archives. Accessed May 9, 2016. http://www.archivesplus.org/history/early-jewish-settlers.

Arkin, Kimberly. 2014. *Rhinestones, Religion, and the Republic: Fashioning Jewishness in France*. Stanford, CA: Stanford University Press.

Asad, Talal. 2004. “Where are the Margins of the State?” In *Anthropology in the Margins of the State,* edited by Veena Das and Deborah Poole*,* 279–288*.* Santa Fe, NM: School of American Research Press.

——. 2011. “Thinking about Religion, Belief, and Politics.” In *The Cambridge Companion to Religious Studies,* edited by Robert. A. Orsi, 36–57. Cambridge: Cambridge University Press.

Ashmore, J., S. Addiman, R. Cordery, and H. Maguire. 2007. “Measles in North East and North Central London, England: A Situation Report.” *Eurosurveillance* 12 (38). Accessed July 1, 2016. http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=3271.

Association of Social Anthropologists of the UK and Commonwealth. 2011. “Ethical Guidelines for Good Research Practice.” Accessed July 4, 2015. http://www.theasa.org/downloads/ASA%20ethics%20guidelines%202011.pdf.

Baer, Hans A., Merrill Singer, and Ida Susser. 2003. *Medical Anthropology and the World System*. Westport, CA: Greenwood Publishing Group, Inc.

Ballard, Karen. 2004. “Compliance & Concordance.” In *Key Concepts in Medical Sociology*, edited by J. Gabe, M. Bury and M. Elston, 107–112. London: Sage Publications.

Barth, Frederik. 1969. *Ethnic Groups and Boundaries: The Social Organisation of Culture Difference*. Long Grove, IL: Waveland Press, Inc.

Baugh, Vanessa, Jose Figueroa, Joanne Bosanquet, Philippa Kemsley, Sarah Addiman, and Deborah Turbitt. 2013. “Ongoing Measles Outbreak in Orthodox Jewish Community, London, UK.” *Emerging Infectious Diseases* 19 (10): 1707–1709.

Bauman, Zygmunt. 2001. *Community: Seeking Safety in an Insecure World*. Cambridge: Polity.

Baumel, Simeon D. 2003. “Black Hats and Holy Tongues: Language and Culture among British ‘Haredim.’” *European Judaism: A Journal for the New Europe* 36 (2): 91–109.

Baxby, Derrick. 2002. “Smallpox Vaccination Techniques; from Knives and Forks to Needles and Pins.” *Vaccine* 20 (16): 2140–2149.

BBC News. 2005. “£3.5m Paid out in Vaccine Damages,” March 16. Accessed February 10, 2016. http://news.bbc.co.uk/1/hi/health/4356027.stm.

——. 2014. “‘Sickening’ Anti-Semitic attack on Manchester Cemetery,” June 24. Accessed June 22, 2016. http://www.bbc.co.uk/news/uk-england-manchester-27994943.

——. 2015. “Australia to Stop Welfare Cash of Anti-Vaccine Parents,” April 12. Accessed February 15, 2016. http://www.bbc.co.uk/news/world-australia-32274107.

——. 2016. “Bomb near Pakistan Polio Centre ‘Kills 15,’” January 13. Accessed February 12, 2016. http://www.bbc.co.uk/news/world-asia-35299597.

Béhague, Dominique P. 2002. “Beyond the Simple Economics of Cesarean Section Birthing: Women’s Resistance to Social Inequality.” *Culture, Medicine and Psychiatry* 26: 473–507.

Beier, Lucinda Mccray. 2004. “Expertise and Control: Childbearing in Three Twentieth Century Working-Class Lancashire Communities.” *Bulletin of the History of Medicine* 78 (2): 379–409.

Benjamin, Geoffrey. 2002. “On Being Tribal in the Malay world.” In *Tribal Communities in the Malay World: Historical, Cultural and Social Perspectives,* edited by Geoffrey Benjamin and Cynthia Chou, 7–76. Leiden: International Institute for Asian Studies.

Benjamin, Geoffrey, and Cynthia Chou. 2002. *Tribal Communities in the Malay World: Historical, Cultural and Social Perspectives*. Leiden: International Institute for Asian Studies.

Berjon-Aparicio, S. 2007. "Cervical Screening in an Orthodox Jewish Community." *Nursing Standard* 21 (28): 44–48.

Berlin, Adele, and Marc Zvi Brettler. 2004. *The Jewish Study Bible*. Oxford: Oxford University Press.

Bernard, H. Russell. 2011. *Research Methods in Anthropology: Qualitative and Quantitative Approaches,* 5th ed. Plymouth, UK: AltaMira Press.

Bernstein, Deborah. 1981. "Immigrant Transit Camps: The Formation of Dependent Relations in Israeli Society." *Ethnic and Racial Studies* 4 (1): 26–43.

Beyrer, Chris. 2015. "The Art of Medicine: The Proper Study of Mankind." *The Lancet* 386 (10005): 1724–1725.

Biehl, João, and Adriana Petryna. 2013. *When People Come First: Critical Studies in Global Health*. Princeton: Princeton University Press.

Birenbaum-Carmeli, Daphna. 2008. "Your Faith or Mine: A Pregnancy Spacing Intervention in an ultra-Orthodox Jewish Community in Israel." *Reproductive Health Matters* 16 (32): 185–191.

Birzen, Oskar. 2015. "Ada Shillman: The Midwife of Dublin." *Linked in*, July 31. Accessed June 30, 2016. https://www.linkedin.com/pulse/ada-mirrelson-shillman-1859-1933-oskar-birzen.

Bivins, Roberta. 2015. *Contagious Communities: Medicine, Migration, and the NHS in Post War Britain*. Oxford: Oxford University Press.

Bodo, Karina, and Nancy Gibson. 1999. "Childbirth Customs in Orthodox Jewish Traditions." *Canadian Family Physician* 45: 682–686.

Bonevski, Billie, Madeleine Randell, Chris Paul, Kathy Chapman, Laura Twyman, Jamie Bryant, Irena Brozek, and Clare Hughes. 2014. "Reaching the Hard-to-Reach: A Systematic Review of Strategies for Improving Health and Medical Research with Socially Disadvantaged Groups." *BMC Medical Research Methodology* 14 (42): 1–29.

Boyarin, Jonathan. 1988. "Waiting for a Jew: Marginal Redemption at the Eighth Street Shul." In *Between Two Worlds: Ethnographic Essays on American Jewry*, edited by Jack Kugelmass, 52–76. Ithaca, NY: Cornell University Press.

Briggs, Charles L. 2003. "Why Nation-States and Journalists can't Teach People to be Healthy: Power and Pragmatic Miscalculation in Public Discourses on Health." *Medical Anthropology Quarterly* 17 (3): 287–321.

Browner, Carole H., and Nancy Ann Press. 1995. "The Normalization of Prenatal Diagnostic Screening." In *Conceiving the New World Order: The Global Politics of Reproduction,* edited by Faye D. Ginsburg and Rayna Rapp, 307–322. Berkeley: University of California Press.

Buckler, Sarah. 2007. *Fire in the Dark: Telling Gypsiness in North East England*. New York: Berghahn Books.

Campbell, Denis, and Pamela Duncan. 2016. "Is 'Incessant Increase' in Caesarean Births Putting First-Time Mothers' Health at Risk?" *The Guardian*, January 31. Accessed January 31, 2016.

http://www.theguardian.com/society/2016/jan/31/caesarean-health-risks-c-section-first-time-mothers.

Campbell, Timothy. 2008 [2004]. Introduction to *Bios: Biopolitics and Philosophy,* by Roberto Esposito. Minneapolis: University of Minnesota Press.

Cannon, Terry, Alexandra Titz, and Fred Krüger. 2014. "The Myth of Community?" In *World Disaster Report 2014: Focus on Culture and Risk,* 93–119. International Federation of Red Cross and Red Crescent Societies. Accessed July 1, 2015. http://www.ifrc.org/Global/Documents/Secretariat/201410/WDR%202014.pdf.

Casiday, Rachel Elizabeth. 2005. "Risk and Trust in Vaccine Decision Making." *Durham Anthropology Journal* 13 (1).

——. 2007. "Children's Health and the Social Theory of Risk: Insights from the British Measles, Mumps and Rubella (MMR) Controversy." *Social Science & Medicine* 65: 1059–1070.

——. 2008. "Making Decisions about Vaccines: Interactions between Parents and Experts." In *Mother Knows Best: Talking Back to the "Experts,"* edited by Jessica Nathanson and Laura C. Tulley, 124–134. Toronto: Demeter Press.

Casiday, Rachel, and Anthony R. Cox. 2006. "Restoring Confidence in Vaccines by Explaining Vaccine Safety Monitoring." *Drug Safety* 29 (12): 1105–1109.

Casiday, Rachel, Tricia Cresswell, Deb Wilson, and Catherine Panter-Brick. 2006. "A Survey of UK Parental Attitudes to the MMR Vaccine and Trust in Medical Authority." *Vaccine* 24 (12): 177–184.

Cassell, J.A., M. Leach, M.S. Poltorak, C.H. Mercer, A. Iversen, and J.R. Fairhead. 2006. “Is the Cultural Context of MMR Rejection a Key to an Effective Public Health Discourse?” *Public Health* 120: 783–794.

Cesarani, David. 1992. “An Alien Concept? The Continuity of Anti-Alienism in British Society before 1940.” *Immigrants and Minorities* 11 (3): 24–52.

Chan, Tony, George Braitberg, Danny Elbaum, and David M. Taylor. 2007. “Hatzolah Emergency Medical Responder Service: To Save a Life.” *Medicine and the Community* 186 (12): 639–642.

Clark, Morgan. 2009. *Islam and New Kinship: Reproductive Technology and the Shariah in Lebanon*. New York: Berghahn Books.

Cohen, B., R. McCann, C. van den Bosch, and J. White. 2000. “Outbreak of Measles in an Orthodox Jewish Community.” *Eurosurveillance* 4 (3). Accessed February 21, 2016. http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=1675.

Cohen, Julia Phillips, and Sarah Abrevaya Stein. 2014. *Sephardi Lives: A Documentary History, 1700–1950*. Stanford, CA: Stanford University Press.

Cohen, Zamir. 1997. *Science Outdated: How Torah Outpaced Science by 3300 Years*. Jerusalem: The Kest-Lebovits Jewish Heritage and Roots Library.

Cohn, Simon. 2014. “From Health Behaviours to Health Practices: An Introduction.” *Sociology of Health & Illness* 36 (2): 157–162.

Coleman-Brueckheimer, Kate, and Simon Dein. 2011. “Health Care Behaviours and Beliefs in Hasidic Jewish Populations: A Systematic Review of the Literature.” *Journal of Religion and Health* 50: 422–436.

Coleman-Brueckheimer, Kate, Joseph Spitzer, and Jonathan Koffman. 2009. "Involvement of Rabbinic and Communal Authorities in Decision-Making by Haredi Jews in the UK with Breast Cancer: An Interpretative Phenomenological Analysis." *Social Science & Medicine* 68: 323–333.

Collins, Peter, Simon Coleman, Jane Macnaughton, and Tessa Pollard. 2007. "NHS Hospital 'Chaplaincies' in a Multi-Faith Society: The Spatial Dimension of Religion and Spirituality in Hospital." Durham, UK: National Health Service. Accessed July 1, 2016. http://dro.dur.ac.uk/5279/1/5279.pdf?DDD5+DDC115+dan0sml+dan0pjc.

Comaroff, John, and Jean Comaroff. 1992. *Ethnography and the Historical Imagination*. Boulder, CO: Westview Press.

Community Security Trust. 2015. "Antisemitic Incidences: Report 2014." Accessed July 18, 2016. https://cst.org.uk/data/file/5/5/Incidents-Report-2014.1425053165.pdf.

Conis, Elena. 2015. *Vaccine Nation: America's Changing Relationship with Immunization*. Chicago, IL: University of Chicago Press.

Cook, J.R., S. Jarvis, M. Knight, and M.K. Dhanjal. 2012. "Multiple Repeat Caesarean Section in the UK: Incidence and Consequences to Mother and Child. A National, Prospective, Cohort Study." *BJOG: An International Journal of Obstetrics and Gynaecology* 120 (1): 85–91.

Cunninghame, C.J., C.P.J. Charlton, and S.M. Jenkins. 1994. "Immunization Uptake and Parental Perceptions in a Strictly Orthodox Jewish Community in North-East London." *Journal of Public Health Medicine* 16 (3): 314–317.

Das, Veena, and Ranendra K. Das. 2007. “How the Body Speaks: Illness and the Lifeworld among the Urban Poor.” In *Subjectvity: Ethnographic investigations*, edited by João Biehl, Byron Good, and Arthur Kleinman, 66–97. Berkeley: University of California Press.

Das, Veena, and Deborah Poole. 2004. *Anthropology in the Margins of the State*. Sante Fe, NM: School of American Research Press.

Davey Smith, George, Danny Dorling, and Mary Shaw. 2001. *Poverty, Inequality and Health in Britain. 1800–2000: A Reader*. Bristol, UK: The Policy Press.

Davidovitch, Nadav. 2004. “Negotiating Dissent: Homeopathy and Anti-Vaccination at the Turn of the Twentieth Century.” In *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America,* edited by Robert D. Johnston, 11–28. New York: Routledge

——. 2013. “Immigration and the Body Politic: Vaccination Policy and Practices during Mass Immigration to Israel (1948–1956).” In *Migration, Health and Ethnicity in the Modern World*, edited by Catherine Cox and Hilary Marland, 151–173. Basingstoke, UK: Palgrave Macmillan.

Davidovitch, Nadav, and Shifra Shvarts. 2004. “Health and Hegemony: Preventive Medicine, Immigrants, and the Israeli Melting Pot.” *Israel Studies* 9 (2): 150–179.

Davies, P., S. Chapman, and J. Leask. 2002. “Antivaccination Activists on the World Wide Web.” *Archives of Disease in Childhood* 87 (1): 22–25.

Davin, Anna. 1978. “Imperialism and Motherhood.” *History Workshop* 5: 9–65.

Davis-Floyd, Robbie. 2003 [1992]. *Birth as an American Rite of Passage*. Berkeley: University of California Press.

Davis-Floyd, Robbie, Stacy Leigh Pigg, and Sheila Cosminsky. 2001. “Introduction. Daughters of our Time: The Shifting Identities of Contemporary Midwives.” *Medical Anthropology* 20 (2–3): 105–139.

Davis-Floyd, Robbie, and Carolyn F. Sargent. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. Berkeley: University of California Press.

Dee, Dave. 2012a. “‘The Sunshine of Manly Sports and Pastimes’: Sport and the Integration of Jewish Refugees in Britain, 1895–1914.” *Immigrants & Minorities* 30 (2–3): 318–342.

——. 2012b. “Sport or ‘Shul’? Physical Recreation, Anglo-Jewry and the Jewish Sabbath, c1880–1945.” *Jewish Historical Studies* 44: 7—26.

——. 2012c. “‘The Hefty Hebrew’”: Boxing and British-Jewish Identity, 1890–1960.” *Sport in History* 32 (3): 361–381.

Dein, Simon. 2004. *Religion and Healing among the Lubavitch Community in Stamford Hill, North London: A Case Study of Hasidim*. New York: The Edwin Mellen Press.

Dein, Simon, Christopher C. H. Cook, Andrew Powell, and Sarah Eagger. 2010. “Religion, Spirituality, and Mental Health.” *The Psychiatrist* 34: 63–64.

Department of Health. 2009. “The H1N1 Swine Flu Vaccination Programme 2009–2010.” UK Government. Accessed February 29, 2016. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_107190.pdf.

Dettwyler, Katherine. A. 1995. “Beauty and the Breast: The Cultural Context of Breastfeeding in the United States.” In *Breastfeeding: Biocultural perspectives,* edited by Patricia Stuart-Macadam and Katherine. A. Dettwyler, 167–216. New York: Aldine de Gruyter.

——. 2011. *Cultural Anthropology and Human Experience: The Feast of Life*. Long Grove, IL: Waveland Press, Inc.

Devlin, Hannah. 2015. “Boy wins £120,000 Damages for Narcolepsy Caused by Swine Flu Vaccine.” *The Guardian*, June 10. Accessed February 10, 2016. http://www.theguardian.com/uk-news/2015/jun/10/boy-wins-120000-damages-narcolepsy-swine-flu-vaccine-glaxosmithkline.

Diamond, Etan. 2008. “Religious Microspaces in a Suburban Environment: The Orthodox Jews of Thornhill, Ontario.” In *Jewish Topographies: Visions of Space, Traditions of Place*, edited by Julia Brauch, Anna Lipphardt, and Alexandra Nocke, 119–138. Aldershot, UK: Ashgate

Dobkin, Monty. 1986. *Tales of Manchester Jewry and Manchester in the Thirties: Commemorative Issue*. Published by Neil Richardson.

——. 1994. *More Tales of Manchester Jewry: Commemorative Issue*. Published by Neil Richardson.

Douglas, Mary. 2002 [1966]. *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*. New York: Routledge.

Dulberg, J. 1909. “Jews and Alcoholism.” *The British Medical Journal* 1 (2522): 1095.

Durbach, Nadja. 2000. "'They might as well Brand us': Working-Class Resistance to Compulsory Vaccination in Victorian England." *The Society for the Social History of Medicine* 13 (1): 45–62.

Dyer, Clare. 2015. "UK Vaccine Damage Scheme Must Pay £120,000 to Boy who Developed Narcolepsy after Swine Flu Vaccination." *British Medical Journal* 350: h3205. Accessed February 10, 2016. http://www.bmj.com/content/350/bmj.h3205.

Ecks, Stefan. 2005. "Pharmaceutical Citizenship: Antidepressant Marketing and the Promise of Demarginalization in India." *Anthropology & Medicine* 12 (3): 239–254.

Ecks, Stefan, and William Sax. 2005. "The Ills of Marginality: New Perspectives on Health in South Asia." *Anthropology & Medicine* 12 (3): 199–210.

Eidelman, Arthur I. 2006. "The Talmud and Human Lactation: The Cultural Basis for Increased Frequency and Duration of Breastfeeding among Orthodox Jewish Women." *Breastfeeding Medicine* 1 (1): 36–40.

Eilberg-Schwartz, Howard. 1992. *People of the Body: Jews and Judaism from an Embodied Perspective*. Albany: State University of New York Press.

Endelman, Todd. 2002. *The Jews of Britain, 1656–2000*. Berkeley: University of California Press.

Eriksen, Thomas Hylland. 1991. The Cultural Contexts of Ethnic Differences. *Man* 26 (1): 127–144.

——. 2010 [1993]. *Ethnicity and Nationalism: Anthropological Perspectives*. London: Pluto Press.

——. 2015 [1995]. *Small Places, Large Issues: An Introduction to Social and Cultural Anthropology,* 4th ed. London: Pluto Press.

Esposito, Roberto. 2008 [2004]. *Bios: Biopolitics and Philosophy.* Translated by Timothy Campbell. Minneapolis: University of Minnesota Press.

——. 2010 [1998]. *Communitas: The Origin and Destiny of Community*. Translated by Timothy Campbell. Stanford, CA: Stanford University Press.

——. 2015 [2002]. *Immunitas: The Protection and Negation of Life*, trans. Zakiya Hanafi. Cambridge, UK: Polity Press.

European Centre for Disease Prevention and Control. 2012. Review of Outbreaks and Barriers to MMR Vaccination Coverage among Hard-to-Reach Populations in Europe. Accessed May 30, 2016. http://ecdc.europa.eu/en/publications/Publications/MMR-vaccination-hard-to-reach-population-review-2013.pdf.

Evans, Maggie, Helen Stoddart, Louise Condon, Elaine Freeman, Marg Grizzell, and Rebecca Mullen. 2001. "Parents Perspectives on the MMR Immunisation: A Focus Group Study." *British Journal of General Practice* 51: 904–910.

Fader, Ayala. 2009. *Mitzvah Girls: Bringing up the Next Generation of Hasidic Jews in Brooklyn*. Princeton, NJ: Princeton University Press.

Farquhar, Judith, and Margaret Lock. 2007. "Introduction." In *Beyond the Body Proper: Reading the Anthropology of Material Life*, edited by Margaret Lock and Judith Farquhar, 1–24. Durham, NC: Duke University Press.

Fassin, Didier. 2001. “Culturalism as Ideology.” In *Cultural Perspectives on Reproductive Health,* edited by Carla Makhlouf Obermeyer (ed), 300–317. Oxford: Oxford University Press.

——. 2003. “The Embodiment of Inequality: AIDS as a Social Condition and the Historical Experience in South Africa.” Special issue, *EMBO Reports* 4: S4–S9.

——. 2004. “Public Health as Culture: The Social Construction of the Childhood Lead Poisoning Epidemic in France.” *British Medical Bulletin* 69 (1): 167–177.

Fassin, Didier, and Estelle d’Halluin. 2005. “The Truth from the Body: Medical Certificates as Ultimate Evidence for Asylum Seekers.” *American Anthropologist* 107 (4): 597–608.

Faubion, James D. 1993. *Modern Greek Lessons: A Primer in Historical Constructivism*. Princeton: Princeton University Press.

Feldman, David M. 1968. *Marital Relations, Birth Control, and Abortion in Jewish Law*. New York: Shocken Books.

Feldman, Perle. 1992. “Sexuality, Birth Control and Childbirth in Orthodox Jewish Tradition.” *Canadian Medical Association Journal* 146 (1): 29–33.

Feldman, W. M. 1926. “Alien Immigration into Great Britain.” *The British Medical Journal* 1 (3395): 166–167.

Feldman-Savelsberg, Pamela, Flavien T. Ndonko, and Bergis Schmidt-Ehry. 2000. “Sterilizing Vaccines or the Politics of the Womb: Retrospective Study of a Rumor in Cameroon.” *Medical Anthropology Quarterly* 14 (2): 159–179.

Flanagan, Sarah M., and Beverley Hancock. 2010. "'Reaching the Hard to Reach' — Lessons Learned from the VCS (Voluntary and Community Sector). A Qualitative Study." *BMC Health Services Research* 10 (92): 1–9.

Forster, N., S.M. Carr, M. Lhussier, A. Bancroft, and S. Kemp. 2015. "Exploring Notions of 'Community' in the Case of Gypsy and Traveller Health." Poster presented at annual Fuse Public Health conference on The Politics of Healthy Change, Newcastle (UK), June 23–24.

Foucault, Michel. 1978 [1976]. *The History of Sexuality, Vol. 1: An Introduction,* 1st American ed. New York: Pantheon Books.

——. 2003 [1977]. *Society must be Defended: Lectures at the Collège de France, 1975–1976,* ed. Mauro Bertani and Alessandro Fontana, trans. David Macey. London: Penguin Group.

——. 2006. "Governmentality." In *The Anthropology of the State: A Reader*, edited by Aradhana Sharma and Akhil Gupta, 131–143. Malden, MA: Blackwell Publishing.

Gardner, Benjamin, Anna Davies, John McAteer, and Susan Michie. 2010. "Beliefs underlying UK Parents' views towards MMR Promotion Interventions: A Qualitative Study." *Psychology, Health, & Medicine* 15 (2): 220–230.

General Medical Council (GMC). 2013. "Good Medical Practice." Accessed December 1, 2015. http://www.gmc-uk.org/guidance/good_medical_practice.asp.

Gilman, Sander L. 1992. "The Jewish Body: A Foot-note." In *People of the Body: Jews and Judaism from an Embodied Perspective*, edited by Howard Eilberg-Schwartz, 223–241. Albany: State University of New York Press.

Ginsburg, Faye, and Rayna Rapp. 1991. “The Politics of Reproduction.” *Annual Review of Anthropology* 20: 311–343.

——. 1995. *Conceiving the New World Order: The Global Politics of Reproduction*. Berkeley: University of California Press.

Golding, Louis. 2006 [1932]. *Magnolia Street*. Nottingham, UK: Five Leaves Publications.

Gonen, Amiram. 2006. “Between Torah Learning and Wage Earning: The London Experience and Lessons for Israel.” *The Floersheimer Institute for Policy Studies,* 4/23e. Accessed December 1, 2015. http://archive.jpr.org.uk/download?id=2294.

Gordon, Daniel, Jo Waller, and Laura A.V. Marlow. 2011. “Attitudes to HPV Vaccination among Mothers in the British Jewish Community: Reasons for Accepting or Declining the Vaccine.” *Vaccine* 29: 7350–7356.

Gostin, Lawrence O. 2014. “Global Polio Eradication: Espionage, Disinformation, and the Politics of Vaccination.” *The Milbank Quarterly: A Multidisciplinary Journal of Population Health and Health Policy* 92 (3): 413–417.

Grabenstein, John D. 2013. “What the World’s Religions Teach, Applied to Vaccines and Immune Globulins.” *Vaccine* 31: 2011–2023.

Greenberg, David, and Eliezer Witztum. 2001. *Sanity and Sanctity: Mental Health Work among the Ultra-Orthodox in Jerusalem*. New Haven, CT: Yale University Press.

Hahn, Robert A., and Marcia Inhorn. 2009. *Anthropology of Public Health: Bridging Differences in Culture and Society*. Oxford: Oxford University Press.

Hahn, Robert A., and Arthur Kleinman. 1983. “Biomedical Practice and Anthropological Theory: Frameworks and Directions.” *Annual Review of Anthropology* 12: 305–333.

Hakak, Yohai. 2009. “Haredi Male Bodies in the Public Sphere: Negotiating with the Religious Text and Secular Israeli Men.” *Journal of Men, Masculinities, and Spirituality* 3 (2): 100–122.

——. 2012. *Young Men in Israeli Haredi Yeshiva Education: The Scholar’s Enclave in Unrest*. Leiden: Brill.

Halliday, Fred. 1992. “The Millet of Manchester: Arab Merchants and Cotton Trade.” *British Journal of Middle Eastern Studies* 19 (2): 159–176.

Halliday, Josh. 2016. “Headstones Smashed in ‘Sickening Antisemitic Act’ at Jewish Cemetery.” *The Guardian*, May 19. Accessed June 22, 2016. https://www.theguardian.com/uk-news/2016/may/19/jewish-headstones-smashed-cemetery-abhorrent-antisemitic-manchester.

Hampshire, Kate R., and Samuel Asiedu Owusu. 2013. “Grandfathers, Google, and Dreams: Medical Pluralism, Globalization, and New Healing Encounters in Ghana.” *Medical Anthropology* 32 (3): 247–265.

Hampshire, Kate, and Bob Simpson. 2015. *Assisted Reproductive Technologies in the Third Phase: Global Encounters and Emerging Moral Worlds*. New York: Berghahn Books.

Hanson, Suzanne, Lauren P. Hunter, Jill R. Bormann, and Elisa J. Sobo. 2009. “Paternal Fears of Childbirth: A Literature Review.” *The Journal of Perinatal Education* 18 (4): 12–20.

Haraway, Donna J. 1991. *Simians, Cyborgs, and Women: The Reinvention of Nature*. New York: Routledge.

Harper, Ian. 2010. Extreme Condition, Extreme Measures? Compliance, Drug Resistance, and the Control of Tuberculosis. *Anthropology & Medicine* 17 (2): 201–214.

Health Protection Agency. 2013. "Pandemic Flu Vaccination Linked to Narcolepsy in UK Children." UK Government. Accessed February 29, 2016. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_107190.pdf.

Health and Social Care Information Centre (HSCIC). 2014. "NHS Immunisation Statistics: England 2013–14." UK Government. Accessed February 11, 2016. http://www.hscic.gov.uk/catalogue/PUB14949/nhs-immu-stat-eng-2013-14-rep.pdf.

Heggie, Vanessa. 2005. "Jewish Medical Charity in Manchester: Reforming Alien Bodies." *The Bulletin of the John Rylands Library* 87 (1): 111–132.

——. 2011. "Health Visiting and District Nursing in Victorian Manchester; Divergent and Convergent Vocations." *Women's History Review* 20 (3): 403–422.

——. 2015. "Aliens, Immigrants, Religion, and the Health Service in Britain." *The Guardian*, July 28. Accessed July 1, 2016. https://www.theguardian.com/science/the-h-word/2015/jul/28/aliens-immigrants-religion-and-the-health-service-in-britain.

Hemmings, Colin P. 2005. "Rethinking Medical Anthropology: How Anthropology is Failing Medicine." *Anthropology & Medicine* 12 (2): 91–103.

Henderson, Lesley, Christopher Millett, and Nicki Thorogood. 2008. “Perceptions of Childhood Immunization in a Minority Community: Qualitative Study.” *Journal of the Royal Society of Medicine* 101: 244–251.

Hobson-West, Pru. 2003. “Understanding Vaccination Resistance: Moving Beyond Risk.” *Health, Risk & Society* 5 (3): 273–283.

Holloway, Karla F. C. 2006. “Accidental Communities: Race, Emergency Medicine, and the Problem of PolyHeme.” *The American Journal of Bioethics* 6 (3): 7–17.

Holman, Christine, and Naomi Holman. 2002. “Torah Worship and Acts of Loving Kindness: Baseline Indicators for the Charedi Community in Stamford Hill.” *Institute for Jewish Policy Research.* Accessed February 19, 2016. http://archive.jpr.org.uk/download?id=1300.

Howard, Sally. 2015. “‘When Western Women Stop being objectified, they can Criticise us.’ Orthodox Jewish Women Fight Back.” *The Telegraph*, June 21. Accessed September 28, 2016. http://s.telegraph.co.uk/graphics/projects/the-life-of-ultra-orthodox-jewish-women/index.html.

Hrdy, Sarah Blaffer. 2009. *Mothers and Others: The Evolutionary Origins of Mutual Understanding*. Cambridge, MA: The Belknap Press of Harvard University Press.

Hunter, Cheryl. 2012. “Intimate Space within Institutionalized Birth: Women’s Experiences Birthing with Doulas.” *Anthropology & Medicine* 19 (3): 315–326.

Hyatt, Susan Brin. 1999. “Poverty and the Medicalisation of Motherhood.” In *Sex, Gender, and Health,* edited by Tessa M. Pollard and Susan B. Hyatt, 94–117. Cambridge: Cambridge University Press.

Ineichen, Bernard, Mary Pierce, and Ross Lawrenson. 1997. Jewish and Celtic Attitudes to Breast Feeding Compared. *Midwifery* 13: 40–43.

Inhorn, Marcia C. 2015. *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai.* Durham, NC: Duke University Press.

Inhorn, Marcia C., and Soraya Tremayne. 2012. *Islam and Assisted Reproductive Technologies: Sunni and Shia Perspectives*. New York: Berghahn Books.

Ivry, Tsipy. 2009. "The ultra-Sonic Picture Show and the Politics of Threatened Life." *Medical Anthropology Quarterly* 23 (3): 189–211.

——. 2010. "Kosher Medicine and Medicalized Halacha: An Exploration of Triadic Relations among Israeli Rabbis, Doctors, and Infertility Patients." *American Ethnologist* 37 (4): 662–680.

——. 2013. "Halachic Infertility: Rabbis, Doctors, and the Struggle over Professional Boundaries." *Medical Anthropology* 32 (3): 208–226.

——. 2015. "The Predicaments of Koshering Prenatal Diagnosis and the Rise of a New Rabbinic Leadership." *Ethnologie Française* 45: 281–292.

Ivry, Tsipy, Elly Teman, and Ayala Frumkin. 2011. "God-Sent Ordeals and their Discontents: Ultra-Orthodox Jewish Women Negotiate Prenatal Testing." *Social Science & Medicine* 72: 1527–1533.

Jackson, Michael. 2012. *Between One and One Another*. Berkeley: University of California Press.

Jacobson-Widding, Anita, 1983. *Identity: Personal and Socio-Cultural, a Symposium*. Uppsala: Uppsala Studies in Cultural Anthropology, 5.

James, R. R. 1928. “The Arrival of the Jews in England.” *British Medical Journal* 1 (3518): 993.

Johanson, Richard, Mary Newburn, and Alison Macfarlane. 2002. “Has the Medicalisation of Childbirth Gone too Far?” *British Medical Journal* 324: 892–895.

Jolly, Margaret. 1998. “Introduction: Colonial and Postcolonial Plots in Histories of Maternities and Modernities.” In *Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific*, edited by Kalpana Ram and Margaret Jolly, 1–24. Cambridge: Cambridge University Press.

Jones, Catherine. 2001 [1977]. *Immigration and Social Policy in Britain*. Abingdon: Routledge.

Jordan, Brigitte. 1989. “Cosmopolitical Obstetrics: Some Insights from the Training of Traditional Midwives.” *Social Science & Medicine* 28 (9): 925–944.

——. 1997. “Authoritative Knowledge and its Construction.” In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives,* edited by Robbie Davis-Floyd and Carolyn F. Sargent, 55–79. Berkeley: University of California Press.

Kahn, Susan M. 2000. *Reproducing Jews: A Cultural Account of Assisted Conception in Israel*. Durham, NC: Duke University Press

——. 2006. “Making Technology Familiar: Orthodox Jews and Infertility Support, Advice, and Inspiration.” *Culture, Medicine, and Psychiatry* 30: 467–480.

Kahn-Harris, Keith, and Ben Gidley. 2010. *Turbulent Times: The British Jewish Community Today*. London: Bloomsbury Publishing.

Kakalia, Spenta, and Hasan H. Karrar. 2015. “Polio, Public Health, and the New Pathologies of Militancy in Pakistan.” *Critical Public Health* 26 (4): 446–454.

Kaler, Amy. 2000. “Fertility Running Wild: Elite Perceptions of the Need for Birth Control in White-Ruled Rhodesia.” In *Contraception across Cultures: Technologies, Choices, Constraints,* edited by Andrew Russell, Elisa. J. Sobo, and Mary S. Thompson, 81—102. Oxford: Berg.

Kanaaneh, Rhoda A. 2002. *Birthing the Nation: Strategies of Palestinian Women in Israel*. Berkeley: University of California Press.

Kapferer, Bruce, and Christopher C. Taylor. 2012. “Introduction: Forces in the Production of the State.” In *Contesting the State: The Dynamics of Resistance and Control,* edited by Angela Hobart and Bruce Kapferer, 1—20. Canon Pyon, UK: Sean Kingston Publishing.

Karam, Azza, Julie Clague, Katherine Marshall, Jill Olivier. 2015. “The View from Above: Faith and Health.” *The Lancet* 386 (10005): e22—e24.

Karpf, Anne. 2002. “We’ve been here before.” *The Guardian*, June 8. Accessed June 30, 2016. https://www.theguardian.com/uk/2002/jun/08/immigration.immigrationandpublicservices.

Kashani-Sabet, Firoozeh. 2011. *Conceiving Citizens: Women and the Politics of Motherhood in Iran*. New York: Oxford University Press.

Kassierer, Moshe Yair, Deborah L. O’Connor, Eva Rutherford, Asaph Rolnitzky, and Sharon Unger. 2014. “Implications for Observant Jewish Families in the Provision of Mother’s own and Donor Milk for their Very Low Birth Weight Infant.” *Journal of Human Lactation* 30 (4): 402–404.

Kasstan, Ben. 2015. “The Taste of Trauma: Reflections of Ageing Shoah Survivors and how they (Re)Inscribe it with Meaning.” *Special issue, Scripta Instituti Donneriani Aboensis* 26: 349–365.

——. 2016. “Positioning Oneself and Being Positioned in the ‘Community’: An Essay on Jewish Ethnography as a ‘Jew-ish’ Ethnographer.” *Special issue, Scipta Instituti Donneriani Aboensis* 27: 264–283.

Kastrinou, A. Maria A. 2016. *Power, Sect, and State in Syria: The Politics of Marriage and Identity amongst the Druze*. London: I. B. Tauris.

Kata, Anna. 2010. “A Postmodern Pandora’s Box: Anti-Vaccination Misinformation on the Internet.” *Vaccine* 29: 1709–1716.

Kaufert, Patricia Leyland, and John D. O’Neil. 1990. “Co-Optation and Control: The Reconstruction of Inuit Birth.” *Medical Anthropology Quarterly* 4 (4): 427–442.

Kidd, Alan, and Terry Wyke. 2005. “The Cholera Epidemic in Manchester, 1831–32.” *Bulletin of the John Rylands Library* 87 (1): 43–56.

Kitzinger, Sheila. 1995. “Commentary.” In *Breastfeeding: Biocultural Perspectives,* edited by Patricia Stuart-Macadam and Katherine A. Dettwyler, 385–394. New York: Aldine de Gruyter.

——. 1997. “Authoritative Touch in Childbirth: A Cross-Cultural Approach.” In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, edited by Robbie Davis-Floyd and Carolyn Sargent, 209–232. Berkeley: University of California Press.

Kosmatopoulos, Nikolos. 2010. “The Gaza Freedom Flotilla: Ethnographic Notes on ‘Othering Violence.’” *Anthropology Today* 26 (4): 26–29.

Kushner, Tony. 1989. “Beyond the Pale? British Reactions to Nazi Anti-Semitism, 1933–1939.” *Immigrants and Minorities* 8 (1-2): 143–160.

Kushner, Tony, and David Cesarani. 1992. “Alien Internment in Britain during the Twentieth Century: An Introduction.” *Immigrants and Minorities* 11 (3): 1—22.

Laderman, Carol. 1983. *Wives and Midwives: Childbirth and Nutrition in Rural Malaysia*. Berkeley: University of California Press.

Landecker, Hannah. 2007. *Culturing Life: How Cells became Technologies*. Cambridge, MA: Harvard University Press.

Leach, Melissa, and James Fairhead. 2007. *Vaccine Anxieties: Global Science, Child Health, and Society*. London: Earthscan.

Lernout, T., E. Kissling, V. Hutse, and G. Top. 2007. “Clusters of Measles Cases in Jewish Orthodox Communities in Antwerp, Epidemiologically Linked to the United Kingdom: A Preliminary Report.” *Eurosurveillance* 12 (46). Accessed February 21, 2016. http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=3308.

Lernout, T., E. Kissling, V. Hutse, K. De Schrijver, and G. Top. 2009. “An Outbreak of Measles in Orthodox Jewish Communities in Antwerp, Belgium, 2007–2008: Different Reasons for Accumulation of Susceptibles.” *Eurosurveillance* 14 (2). Accessed February 21, 2016. http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=19087.

Liedtke, Rainer. 1998. “*Jewish Welfare in Hamburg and Manchester, c. 1850–1914*.” Oxford: Oxford University Press.

Lightman, Ernie S., and Ron Shor. 2002. “Askanim: Informal Helpers and Cultural Brokers as a Bridge to Secular Helpers for the Ultra-Orthodox Jewish Communities of Israel and Canada.” *Families in Society* 83 (3): 315–324.

Local Government Association and Public Health England. 2013. “Measles: Frequently Asked Questions.” UK Government. Accessed May 30, 2016. http://www.local.gov.uk/c/document_library/get_file?uuid=57b1c5fc-2d8e-417f-9c7a-8f273fca7dbb&groupId=10180.

Lock, Margaret. 1993. “Cultivating the Body: Anthropology and Epistemologies of Bodily Practice and Knowledge.” *Annual Review of Anthropology* 22: 135–155.

——. 2007. “Alienation of Body Parts and the Biopolitics of Immortalized Cell Lines.” In *Beyond the Body Proper: Reading the Anthropology of Material Life,* edited by Margaret Lock and Judith Farquhar, 567–583. Durham, NC: Duke University Press.

Lock, Margaret, and Judith Farquhar. 2007. *Beyond the Body Proper: Reading the Anthropology of Material Life*. Durham: Duke University Press.

Lock, Margaret, and Vinh-Kim Nguyen. 2010. *An Anthropology of Biomedicine*. Chichester, UK: Wiley-Blackwell.

Loewenthal, K.M., and C. Bradley. 1996. “Immunization Uptake and Doctors’ Perceptions of Uptake in a Minority Group: Implications for Interventions.” *Psychology, Health & Medicine* 1 (2): 223–230.

Macfarlane, A.J., B. Blondel, A.D. Mohangoo, M. Cuttini, J. Nijhuis, Z. Novak, H.S. Olafsdottir, J. Zeitlin, and the Euro-Peristat Scientific Committee. 2015. Wide Differences in Mode of Delivery within Europe: Risk-Stratified Analyses of

Aggregated Routine Data from the Euro-Peristat Study. *BJOG: An International Journal of Obstetrics and Gynaecology* 123: 559–568

Maher, Vanessa. 1995 [1992]. *The Anthropology of Breast-Feeding: Natural Law or Social Construct*. Oxford: Berg.

Mahmood, Saba. 2005. *Politics of Piety: The Islamic Revival and the Feminist Subject*. Princeton, NJ: Princeton University Press.

——. 2016. *Religious Difference in a Secular Age: A Minority Report*. Princeton: Princeton University press.

Manchester Jewish Studies. No date. "Nathan Laski." Accessed September 30, 2016. http://www.manchesterjewishstudies.org/nathan-laski/.

Manchester University News. 2007. "Majority of Jews will be Ultra-Orthodox by 2050," July 23. Accessed May 8, 2016. http://www.manchester.ac.uk/discover/news/majority-of-jews-will-be-ultra-orthodox-by-2050.

Manderson, Lenore. 1998. "Shaping Reproduction: Maternity in Early Twentieth-Century Malay. In *Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific,* edited by Kalpana Ram and Margaret Jolly, 26–49. Cambridge: Cambridge University Press.

Markel, Howard. 1999. *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892*. Baltimore: John Hopkins University Press.

Martin, Emily. 1990. "Toward an Anthropology of Immunology: The Body as a Nation State." *Medical Anthropology Quarterly* 4 (4): 410–426.

——. 1994. *Flexible Bodies: The Role of Immunity in American Culture from the Days of Polio to the Age of AIDS*. Boston: Beacon Press.

McCargo, Duncan. 2011. "Informal Citizens: Graduated Citizenship in Southern Thailand." *Ethnic and Racial Studies* 34 (5): 833–849.

McGranahan, Carole. 2016. "Theorising Refusal: An Introduction." *Cultural Anthropology* 31 (3): 319–325.

Medhora, Shalailah. 2015. "Vaccination Crackdown: Australia Announces End to Religious Exemptions." *The Guardian*, April 29. Accessed February 15, 2016. http://www.theguardian.com/society/2015/apr/19/vaccination-crackdown-australia-announces-end-to-religious-exemptions.

Medicines and Healthcare Products Regulatory Authority. 2016. Yellow Card. Accessed October 26, 2016. https://yellowcard.mhra.gov.uk/the-yellow-card-scheme/

Merli, Claudia. 2008. *Bodily Practices and Medical Identities in Southern Thailand*. Uppsala: Uppsala Studies in Cultural Anthropology, no. 43.

——. 2010. "Muslim Midwives between Traditions and Modernities: Being and Becoming a Bidan Kampung in Satun Province, Southern Thailand." *Moussons* 15: 121–135.

Messerschmidt, Donald Alan. 1981. *Anthropologists at Home in North America: Methods and Issues in the Study of One's Own Society*. Cambridge: Cambridge University Press.

Milligan, Gregg N., and Alan D.T. Barrett. 2015. *Vaccinology: An Essential Guide*. Chichester, UK: John Wiley & Sons.

Mitchell, William E. 1988. “A Goy in the Ghetto: Gentile-Jewish Communication in Fieldwork Research.” In *Between Two Worlds: Ethnographic Essays on American Jewry,* edited by Jack Kugelmass, 225–239. Ithaca, NY: Cornell University Press.

Monnais, Laurence. 2012. “Traditional, Complementary and Perhaps Scientific? Professional Views of Vietnamese Medicine in the Age of French colonialism.” In *Southern Medicine for Southern People: Vietnamese Medicine in the Making,* edited by Laurence Monnais, C. Michelle Thompson, and Ayo Wahlberg, 61–84. Newcastle, UK: Cambridge Scholars Publishing.

Mookherjee, Nayanika. 2001. “Dressed for Fieldwork: Sartorial Borders and Negotiations.” *Ethnography@TheMillenium: Anthropology Matters* 3 (1). Accessed May 9, 2016. http://www.anthropologymatters.com/index.php/anth_matters/article/view/139.

Muhsen, Khitam, Reem Abed El-Hai, Anat Amit-Aharon, Haim Nehama, Mervat Gondia, Nadav Davidovitch, Sophy Goren, and Dani Cohen. 2012. “Risk Factors for Underutilization of Childhood Immunizations in Ultraorthodox Jewish Communities in Israel despite High Access to Health Care Services.” *Vaccine* 30: 2109–2115.

Museum of Science and Industry (MoSI). No date. *How Manchester Invented the Modern World*. London: Carlton Books.

Myerhoff, Barbara. 1978. *Number our Days*. New York: Simon & Schuster.

Napier, A. David. 2016. “Nonself Help: How Immunology might Reframe the Enlightenment.” In *Living and Dying in the Contemporary World: A Compendium,* edited by Veena Das and Clara Han*,* 354–366. Berkeley: University of California Press.

Napier, A. David, Clyde Ancarno, Beverly Butler, Joseph Calabrese, Angel Chater, Helen Chatterjee, François Guesnet, Robert Horne, Stephen Jacyna, Sushrut Jadhav, Alison Macdonald, Ulrike Neuendorf, Aaron Parkhurst, Rodney Reynolds, Graham Scambler, Sonu Shamdasani, Sonia Zafer Smith, Jakob Stougaard-Nielsen, Linda Thomson, Nick Tyler, Anna-Maria Volkmann, Trinley Walker, Jessica Watson, Amanda C de C Williams, Chris Willott, James Wilson, and Katherine Woolf. 2014. "Culture and Health." *The Lancet* 384 (9954): 1607–1639.

National Archives. No date A. "Immigration from Eastern Europe." UK Government Web Archive. Accessed May 9, 2016. http://webarchive.nationalarchives.gov.uk/+/http://www.movinghere.org.uk/galleries/histories/jewish/settling/manchester_jewry_2.htm.

——. No date B. 1834 Poor Law. UK Government Web Archive. Accessed October 22, 2016. http://www.nationalarchives.gov.uk/education/resources/1834-poor-law/

National Childbirth Trust (NCT). 2016a. "What is a doula?" Accessed September 19, 2016. https://www.nct.org.uk/pregnancy/what-doula.

——. 2016b. "Pregnancy: Telling your Employer you're Pregnant." Accessed September 19, 2016. https://www.nct.org.uk/pregnancy/how-do-i-tell-my-employer-about-my-pregnancy.

National Health Service (NHS). 2014a. "Saturated Fats and Heart Disease Link 'Unproven.'" NHS Choices, 18 March. Accessed October 21, 2016. http://www.nhs.uk/news/2014/03March/Pages/Saturated-fats-and-heart-disease-link-unproven.aspx.

——. 2014b. "Combined Pill." Accessed October 21, 2016.

http://www.nhs.uk/conditions/contraception-guide/pages/combined-contraceptive-pill.aspx

——. 2014c. “What happens during a caesarean section.” Accessed September 16, 2016. http://www.nhs.uk/Conditions/Caesarean-section/Pages/How-is-it-performed.aspx#procedure.

——. 2014d. “Your Antenatal Appointments.” Accessed January 10, 2015. http://www.nhs.uk/conditions/pregnancy-and-baby/pages/antenatal-appointment-schedule.aspx.

——. 2015a. “Miscarriage: Causes.” Accessed October 21, 2016. http://www.nhs.uk/Conditions/Miscarriage/Pages/Causes.aspx

——. 2015b. “Rubella.” Accessed February 23, 2016. http://www.nhs.uk/Conditions/Rubella/Pages/introduction.aspx.

——. 2015c. “Can Rubella (German Measles) Harm my Baby during Pregnancy?” Accessed February 23, 2016. http://www.nhs.uk/chq/Pages/1104.aspx?CategoryID=54.

National Health Service (NHS) Careers. No date. “Health Visitor.” Accessed July 9, 2016. https://www.healthcareers.nhs.uk/explore-roles/public-health/health-visitor.

National Health Service (NHS) Health Check. 2014. Engaging the Salford Orthodox Jewish Community in the NHS Health Check programme. Accessed October 21, 2016.

New, Suzanne, and Martyn L. Senior. 1991. “‘I don’t Believe in Needles’: Qualitative Aspects of a Study into the Uptake of Infant Immunisation in two English Health Authorities.” *Social Science & Medicine* 33 (4): 509–518.

Newman, Hal. 2014. “New South Wales: Ambulance SW Welcomes Hatzolah to its Volunteer Family.” *Big Medicine* (blog), May 19. Accessed December 1, 2015. http://bigmedicine.ca/wordpress/2014/05/new-south-wales-ambulancensw-welcomes-hatzolah-to-its-volunteer-family/#sthash.YAKJSOtn.dpbs.

Nijhawan, Michael. 2005. “Deportability, Medicine, and the Law.” *Anthropology & Medicine* 12 (3): 271–285.

Nisenblat, Victoria, Shlomi Barak, Ofra Barnnet Griness, Simon Degani, Gonen Ohel, and Ron Gonen. 2006. “Maternal Complications associated with Multiple Cesarean Deliveries.” *Obstetrics & Gynecology* 108 (1): 21–26.

Null, Wesley J. 2007. *Peerless Educator: The Life and Work of Isaac Leon Kandel*. New York: Peter Lang.

Nursing and Midwifery Council (NMC). 2016. “What we do.” Accessed August 30, 2016. https://www.nmc.org.uk/about-us/our-role/.

Oakley, Ann. 1984. *The Captured Womb: A History of Medical Care of Pregnant Women*. Oxford: Basil Blackwell Publisher Ltd.

——. 1993. *Essays on Women, Medicine, and Health*. Edinburgh: Edinburgh University Press.

Office for National Statistics (ONS). 2014. “Births in England and Wales by Characteristics of Birth 2: 2013. UK Statistics Authority.” Accessed July 3, 2016. http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/characteristicsofbirth2/2014-11-17.

Okely, Judith. 1983. *The Traveller-Gypsies*. Cambridge: Cambridge University Press.

——. 2014. “Recycled (Mis)Representations: Gypsies, Travellers, or Roma Treated as Objects, Rarely Subjects.” *People, Place and Policy* 8 (1): 65–85.

Oldstone, Michael B. 2010. *Viruses, Plagues, and History: Past, Present and Future*. Oxford: Oxford University Press.

Ong, Aihwa. 1990. “State Versus Islam: Malay Families, Women’s Bodies, and the Body Politic in Malaysia.” *American Ethnologist* 17 (2): 258–276.

Oxford Vaccine Group. 2013. “Vaccine Side Effects and Adverse Reactions.” Oxford University. Accessed May 31, 2016. https://www.ovg.ox.ac.uk/vaccine-side-effects.

Pandya, Vishvajit. 2005. “‘Do not Resist, Show me your Body!’: Encounters between the Jarwas of the Andamans and Medicine (1858–2004).” *Anthropology & Medicine* 12 (3): 211–223.

Parker, Melissa, Tim Allen, and Julie Hastings. 2008. “Resisting Control of Neglected Tropical Diseases: Dilemmas in the Mass Treatment of Schistosomiasis and Soil-Transmitted Helminths in North-West Uganda.” *Journal of Biosocial Science* 40 (2): 161–181.

Parker, Melissa, and Ian Harper. 2006. “The Anthropology of Public Health.” *Journal of Biosocial Science* 38: 1–5.

Patterson, Leslie S., Colleen M. O’Connell, and Thomas F. Baskett. 2002. Maternal and Perinatal Morbidity associated with Classic and Inverted T Caesarean Incisions. *Obsetrics & Gynecology* 100 (4): 633–637.

Pearson, Karl, and Margaret Moul. 1926. “The Problem of Alien Immigration into Great Britain.” *Annals of Eugenics* 3: 1–76. Accessed July 1, 2016. http://archives.ucl.ac.uk/DServe/dserve.exe?dsqIni=Dserve.ini&dsqApp=Archive&dsqCmd=Show.tcl&dsqSearch=RefNo=='PEARSON/3/14/21/2'&dsqDb=Catalog.

Pegorie, M., K. Shankar, W. S. Welfare, R. W. Wilson, C. Khiroya, G. Munslow, D. Fiefield, V. Bothra, and R. McCann. 2014. “Measles Outbreak in Greater Manchester, England, October 2012 to September 2013: Epidemiology and Control.” *Eurosurveillance* 19 (49). Accessed July 1, 2016. http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20982.

Petts, Judith, and Simon Niemeyer. 2004. “Health Risk Communication and Amplification: Learning from the MMR Vaccination Controversy.” *Health, Risk, & Society* 6 (1): 7–23.

Perez, Barbara. 1995. *The Gypsy and the State: The Ethnic Cleansing of British* Society. Bristol: SAUS Publications.

Philby, Charlotte. 2011. “Who’d be a Midwife?” *The Independent*, November 26. Accessed September 17, 2016. http://www.independent.co.uk/life-style/health-and-families/features/whod-be-a-midwife-6267307.html.

Pickstone, John V. 1985. *Medicine and Industrial Society: A History of Hospital Development in Manchester and its Region, 1752–1946*. Manchester: Manchester University Press.

Pigg, Stacy Leigh. 1995. “Acronyms and Effacement: Traditional Medical Practitioners (TMP) in International Health Development.” *Social Science and Medicine* 41 (1): 47–68.

Poltorak, Mike, Melissa Leach, James Fairhead, and Jackie Cassell. 2005. "'MMR Talk' and Vaccination Choices: An Ethnographic Study in Brighton." *Social Science & Medicine* 61: 709–719.

Pontificia Academia Pro Vita [Pontifical Academy for Life]. 2005. "Moral Reflections on Vaccines Prepared from Cells derived from Aborted Human Foetuses." *Pontifical Academy for Life*, June 9. Accessed February 12, 2016. http://www.immunize.org/concerns/vaticandocument.htm.

Public Health England. No date a. "About us." UK Government. Accessed June 19, 2016. https://www.gov.uk/government/organisations/public-health-england/about.

——. No date b. "Public Health England Equality Analysis." UK Government. Accessed May 30, 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200317/Public_Health_England_equality_analysis.pdf.

——. No date c. "Public Health Outcomes Framework: Salford. UK Government." Accessed July 14, 2016. http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000049/pat/102/par/E08000006/ati/101/are/E08000006.

——. 2013a. "The Children's Flu Vaccination Programme: The Nasal Flu Vaccine Fluenz and Porcine Gelatine." UK Government. Accessed May 31, 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386842/2902998_PHE_FluPorcine_QAforParents_FINAL_CT.pdf.

——. 2013b. "Polio Vaccine Reminder for Travellers to Israel, the West Bank and Gaza." UK Government, September 19. Accessed February 21, 2016. https://www.gov.uk/government/news/polio-vaccine-reminder-for-travellers-to-israel-the-west-bank-and-gaza.

——. 2013c. “Chapter Eight: Vaccine Safety and the Management of Adverse Events following Immunisation.” UK Government. Accessed February 15, 2016. https://www.gov.uk/government/publications/vaccine-safety-and-adverse-events-following-immunisation-the-green-book-chapter-8.

——. 2015. “MMR (measles, mumps, rubella) vaccine: Advice for Pregnant Women.” UK Government. Accessed October 2, 2016. https://www.gov.uk/government/publications/vaccine-in-pregnancy-advice-for-pregnant-women/mmr-measles-mumps-rubella-vaccine-advice-for-pregnant-women

Purdy, Sarah, Kevin P. Jones, Margaret Sherratt, and Paul V. Fallon. 2000. “Demographic Characteristics and Primary Health Care Utilization Patterns of Strictly Orthodox Jewish and non-Jewish Patients.” *Family Practice* 17 (3): 233–235.

Raphael, Dana. 1969. “Uncle Rhesus, Auntie Pachyderm, and Mom: All Sorts and Kinds of Mothering.” *Perspectives in Biology and Medicine* 12 (2): 290–297.

Rapp, Rayna. 1998. “Refusing Prenatal Diagnosis: The Meanings of Bioscience in a Multicultural World.” *Science, Technology, & Human Values* 23 (1): 45–70.

——. 1999. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. New York: Routledge.

Rashid, Mumtaz, and Rabia S. Rashid. 2004. “Higher Order Repeat Caeserean Sections: How Safe are Five or More?” *BJOG: An International Journal of Obstetrics and Gynaecology* 111 (10): 1090–1094.

Reid, Alice. 2011. “Birth Attendants and Midwifery practice in Early Twentieth-Century Derbyshire.” *Social History of Medicine Advance Access*. Accessed

September 12, 2015.
http://shm.oxfordjournals.org/content/early/2011/10/23/shm.hkr138.full.pdf.

Renne, Elisha. 2006. “Perspectives on Polio and Immunization in Northern Nigeria.” *Social Science & Medicine* 63: 1857–1869.

——. 2009. “Anthropological and Public Health Perspectives on the Global Eradication Initiative in Northern Nigeria. In *Anthropology and Public Health: Bridging Differences in Culture and Society,* edited by Robert A. Hahn, and Marcia C. Inhorn, 512–538. Oxford: Oxford University Press.

Reverby, Susan M. 2011. “‘Normal Exposure’ and Inoculation Syphilis: A PHS “Tuskegee” Doctor in Guatemala, 1946–1948.” *The Journal of Policy History* 23 (1): 6–28.

Rivlin, Ray. 2011. *Jewish Ireland: A Social History*. Dublin: The History Press.

Rohilla, Minakshi, Neelam Aggarwal, Purnima Singh, and Vanita Jain. 2015. “Evisceration as Fetal Destructive Operation: An Art Revisited.” *Archives of Gynecology and Obstetrics* 291 (3): 701–703.

Rollins, Tom. 2016. “The Disappearing Migration Routes that brought Aleppo’s Jews to Manchester.” *Middle East Eye*, 24 May. Accessed June 1, 2016. http://www.middleeasteye.net/news/disappearing-migration-routes-brought-aleppos-jews-manchester-1199438840.

Root, Robin, and C.H. Browner. 2001. “Practices of the Pregnant Self: Compliance and Resistance to Prenatal Norms.” *Culture, Medicine, and Psychiatry* 25: 195–223.

Royal College of Midwives (RCM). No date. “Want to be a Midwife?” Accessed August 30, 2016. https://www.rcm.org.uk/learning-and-career/becoming-a-midwife.

——. 2014. “Postnatal Care Planning.” Accessed October 21, 2016. https://www.rcm.org.uk/sites/default/files/Pressure%20Points%20-%20Postnatal%20Care%20Planning%20-%20Web%20Copy.pdf.

Royal College of Paediatrics and Child Health (RCPH). 2015. “BPSU: Congenital Rubella.” Accessed February 23, 2016. http://www.rcpch.ac.uk/bpsu-congenital-rubella.

Rubinstein, William D., Michael A., Jolles, and Hilary L. Rubinstein. 2011. *The Palgrave Dictionary of Anglo-Jewish History*. Basingstoke, UK: Palgrave Macmillan.

Ryan, Caroline. 200. “Jewish Health Service offers Local Care.” *BBC News*, 19 January. Accessed December 1, 2015. http://news.bbc.co.uk/1/hi/health/2666123.stm.

Saint John’s Ambulance. No date. “Our Heritage and Museum.” Accessed June 14, 2016. https://www.sja.org.uk/sja/what-we-do/our-heritage-and-museum.aspx.

Sargent, Carolyn Fishel. 1989. *Maternity, Medicine, and Power: Reproductive Decisions in Urban Benin*. Berkeley: University of California Press.

——. 2006. “Reproductive Strategies and Islamic Discourse: Malian Migrants Negotiate Everyday Life in Paris, France.” Medical Anthropology Quarterly 20 (1): 31–50.

Sargent, Carolyn, and Lauren Gulbas. 2011. “Situating Birth in the Anthropology of Reproduction.” In *A Companion to Medical Anthropology,* edited by Merrill Singer and Pamela I. Erickson, 289–303. Chichester, UK: Wiley-Blackwell. My Ilibrary.

Sargent, Carolyn, and Nancy Stark. 1987. “Surgical Birth: Interpretations of Cesarean Delivery among Private Hospital Patients and Nursing Staff.” *Social Science & Medicine* 25 (12) 1269–1276.

Sarradon-Eck, Aline, Cyril Farnarier, and Takeo David Hymans. 2014. “Caring on the Margins of the Healthcare System.” *Anthropology & Medicine* 21 (2): 251–263.

Scanlon, Thomas J. 2002. “MMR Vaccine Uptake may be lower than Reported because of Manipulation of Target Groups.” *British Medical Journal* 324: 733.

Scheper-Hughes, Nancy, and Margaret Lock. 1987. “The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology.” *Medical Anthropology Quarterly* 1 (1): 6–41.

Schmied, Virgina, and Deborah Lupton. 2001. “Blurring the boundaries: Breastfeeding and maternal subjectivity.” *Sociology of Health and Illness*, 23 (2): 234–250.

Scott, James C. 1985. *Weapons of the Weak: Everyday Forms of Peasant Resistance*. New Haven, CT: Yale University Press.

——. 2009. *The Art of not Being Governed: An Anarchist History of Upland Southeast Asia*. New Haven, CT: Yale University Press.

Seeman, Don. 2010. *One People, One Blood: Ethiopian-Israelis and the Return to Judaism*. New Brunswick, NJ: Rutgers University Press.

Seidelman, Rhona D. 2012. “Conflicts of Quarantine: The Case of Jewish Immigration to the Jewish State.” *American Journal of Public Health* 102 (2): 243–252.

Semenic, Sonia E., Lynn Clark Callister, and Perle Feldman. 2004. “Giving Birth: The Voices of Orthodox Jewish Women Living in Canada.” *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 33 (1): 80–87.

Sered, Susan Starr. 1992. *Women as Ritual Experts: The Religious Lives of Elderly Jewish Women in Jerusalem*. Oxford: Oxford University Press.

Shah, Saeed. 2011. “CIA Organised Fake Vaccination Drive to get Osama bin Laden’s Family DNA. *The Guardian*, July 11. Accessed October 26, 2016. https://www.theguardian.com/world/2011/jul/11/cia-fake-vaccinations-osama-bin-ladens-dna

Shaked, Michal, and Yoram Bilu. 2006. “Grappling with Affliction: Autism in the Jewish Ultraorthodox Community in Israel.” *Culture, Medicine, and Psychiatry* 30: 1–27.

Shand, Alex. 2005. “Rejoinder: In Defence of Medical Anthropology.” *Anthropology & Medicine* 12 (2): 105–113.

Shaw, Susan J. 2005. “The Politics of Recognition in Culturally Appropriate Care.” *Medical Anthropology Quarterly* 19 (3): 290–309.

Sheinman, Anna. 2013. “Fluenz Flu Vaccine Containing Pork Product is Kosher.” *The Jewish Chronicle*, October 10. Accessed May 31, 2016. http://www.thejc.com/news/uk-news/112249/fluenz-flu-vaccine-containing-pork-product-kosher.

Shildrick, Margrit. 2002. *Embodying the Monster: Encounters with the Vulnerable Self*. London: SAGE Publications Ltd.

Shorter, Edward. 1997. *Women's Bodies: A Social History of Women's Encounter with Health, Ill-Health, and Medicine*. New Brunswick, NJ: Transaction Publishers.

Simhi, Meital, Yana Shraga, and Orly Sarid. 2013. "Vaccination of Infants and Health Beliefs of ultra-Orthodox Mothers." *Journal of Vaccines and Vaccination* 5 (1): 1–6.

Simm, Andrew, and Pradeep Ramoutar. 2005. "Caesarean Section: Techniques and Complications." *Current Obstetrics and Gynaecology* 15: 80–86.

Simpson, Bob. 2006. "'You don't do Fieldwork, Fieldwork does you': Between Subjectivation and Objectivation in Anthropological Fieldwork." In *The Sage Handbook of Fieldwork,* edited by Dick Hobbs and Richard Wright, 126–139. London: Sage.

Singer, Merrill, and Hans Baer. 2009. *Killer Commodities: Public Health and the Corporate Production of Harm*. Lanham, MD: Altamira Press.

Smith, Alex, Judy Shakespeare, and Anna Dixon. 2010. "The Role of GPs in Maternity Care: What does the Future Hold?" *The King's Fund: Ideas that Change Health Care*. Accessed January 17, 2016. http://www.kingsfund.org.uk/sites/files/kf/Maternity.pdf.

Sobo, Elisa J. 2015. "Social Cultivation of Vaccine Refusal and Delay among Waldorf (Steiner) School Parents." *Medical Anthropology Quarterly* 29 (3): 381–399.

——. 2016. "Theorizing (Vaccine) Refusal: Through the Looking Glass." *Cultural Anthropology* 31 (3): 342–350.

Sourasky, M. 1928. “The Alleged High Fertility of Jews.” *British Medical Journal* 2 (469): 469.

Spitzer, Joseph. 2002. *A Guide to the Orthodox Jewish way of Life for Healthcare Professionals*. Department of General Practice and Primary Care, St Bartholomew’s and the Royal London School of Medicine and Dentistry and the East London and the City Health Authority.

Stadler, Nurit. 2006. “Terror, Corpse Symbolism and Taboo Violation: The 'Haredi Disaster Victim Identification Team in Israel’ (ZAKA).” *The Journal of the Royal Anthropological Institute* 12 (4): 837–858.

——. 2007. “Ethnography of Exclusion: Initiating a Dialogue with Fundamentalist Men.” *Nashim: A Journal of Jewish Women’s Studies and Gender Issues* 14 (1): 185–208.

——. 2009. *Yeshiva Fundamentalism: Piety, Gender, and Resistance in the ultra-Orthodox World*. New York: New York University Press.

——. 2013. “Infiltrating Fundamentalist Institutions.” In *Qualitative Research: A Reader in Philosophy, Core Concepts, and Practice*, edited by Barbara Dennis, Lucinda Carspecken, and Phil F. Carspecken, 342–357. New York: Peter Lang.

Stadler, Nurit, Eyal Ben-Ari, Einat Mesterman. 2005. “Terror, Aid, and Organization: The Haredi Disaster Victim Identification teams (ZAKA) in Israel.” *Anthropological Quarterly* 78 (3): 619–651.

Staetsky, L. Daniel, and Jonathan Boyd. 2015. “Strictly Orthodox Rising: What the Demography tells us about the Future of the Community.” *Institute for Jewish Policy Research.*

Stanford-ISERDD Study Collective. 2016. “Maternal Mortality, Technological Innovations, and Therapeutic Strategies.” In *Living and Dying in the Contemporary World: A Compendium,* edited by Veena Das and Clara Han, 47–66. Berkeley: University of California Press.

Steffens, I., R. Martin, and P.L. Lopalco. 2010. “Spotlight on Measles 2010: Measles Elimination in Europe, a New Commitment to meet the Goal by 2015.” *Eurosurveillance* 15 (50). Accessed February 21, 2016. http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=19749.

Stein, Eric. 2009. “‘Sanitary Makeshifts’ and the Perpetuation of Health Stratification in Indonesia.” In *Anthropology and Public Health: Bridging Differences in Culture and Society,* edited by Robert. A. Hahn and Marcia .C. Inhorn, 541–565. Oxford: Oxford University Press.

Stein-Zamir, C., G. Zentner, N. Abramson, H. Shoob, Y. Aboudy, L. Shulman, and E. Mendelson. 2008. “Measles Outbreaks Affecting Children in Jewish ultra-Orthodox Communities in Israel.” *Epidemiological Infections* 136: 207–214.

Stewart-Freedman, B., and N. Kovalsky. 2007. “An ongoing Outbreak of Measles Linked to the United Kingdom in an ultra-Orthodox Jewish community in Israel.” *Eurosurveillance* 38 (20). Accessed February 21, 2016. http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=3270.

Stöckl, Andrea. 2010. “Public Discourses and Policymaking: The HPV Vaccination from the European Perspective.” In *Three Shots at Prevention: The HPV Vaccine and the Politics of Medicine’s Simple Solutions,* edited by Keith Wailoo, Julie Livingston, Steven Epstein, and Robert Aronowitz, 255–269. Baltimore: The John Hopkins University Press.

Summerskill, William, and Richard Horton. 2015. “Faith-Based Delivery of Science-Based Care.” *The Lancet* 386 (1005): 1709–1710.

Szurek, Jane. 1997. “Resistance to Technology-Enhanced Childbirth in Tuscany: The Political Economy of Italian Birth.” In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives,* edited by Robbie E. Davis-Floyd and Carolyn F. Sargent, 287–314. Berkeley: University of California Press.

Tananbaum, Susan L. 1993. “Making Good Little English Children: Infant Welfare and Anglicization in London, 1880–1939.” *Immigrants and Minorities* 12: 176–199.

——. 1994. “Biology and Community: The Duality of Jewish Mothering in East London, 1880–1939.” In *Mothering: Ideology, Experience, and Agency*, edited by Evelyn. N. Glenn, Grace Chang, and Linda R. Forcey, 311–332. New York: Routledge.

——. 2004. “Ironing out the Ghetto Bend: Sports, Character and Acculturation among Jewish Immigrants in Britain.” *Journal of Sport History* 31 (1): 53–75.

——. 2015. *Jewish Immigrants in London*, 1880–1939. London: Routledge.

Teman, Elly, Tsipy Ivry, and Barbara A. Bernhardt. 2011. “Pregnancy as a Proclamation of Faith: Ultra-Orthodox Jewish Women Navigating the Uncertainty of Pregnancy and Prenatal Diagnosis.” *American Journal of Medical Genetics Part A* 155: 69–80.

The Economist. 2015. “Shtetls of the Mind: Attention Falls on a Little-Known but Growing Group of Britain’s Jews,” June 13. Accessed May 9, 2016. http://www.economist.com/news/britain/21654102-attention-falls-little-known-growing-group-britains-jews-shtetls-mind.

The Guardian. 2015. “I Loved Being a Midwife but Bullying, Stress and Fear made me Resign,” March 23. Accessed September 17, 2016. https://www.theguardian.com/healthcare-network/views-from-the-nhs-frontline/2015/mar/23/i-loved-being-a-midwife-but-bullying-stress-and-fear-made-me-resign.

The Lancet. 1884. “Report of the Lancet Special Sanitary Commission on the Polish colony of Jew tailors,” 123 (3166): 817–818.

——. 1904. “Manchester Jewish Hospital,” 164 (4237): 1382.

The United Synagogue. No date. “Conversion.” Accessed October 21, 2016. https://www.theus.org.uk/article/conversion-2.

Ticktin, Miriam. 2008. “Where Ethics and Politics Meet: The Violence of Humanitarianism in France.” *American Ethnologist* 33 (1): 33–49.

——. 2011. *Casualties of Care: Immigration and the Politics of Humanitarianism in France*. Berkeley: University of California Press.

Tomkins, Andrew, Jean Duff, Atallah Fitzgibbon, Azza Karam, Edward J. Mills, Keith Munnings, Sally Smith, Shreelata Rao Seshadri, Avraham Steinberg, Robert Vitillo, and Philemon Yugi. 2015. “Faith-based Health Care 2: Controversies in Faith and Health.” *The Lancet*, Vol. 386, No. 10005.

Top, Geert. No date. “From an Outbreak of Measles in some Orthodox Jewish Communities in Antwerp to Specific Actions for Undervaccinated Groups in a new Public Health Goal on Vaccination for Flanders, Belgium.” *Eurosurveillance*. Accessed February 21, 2016. http://ecdc.europa.eu/en/press/events/Documents/Belgium-From-outbreak-

measles-orthodox-Jewish-Communities-to%20specific-actions-undervaccinated-groups.pdf.

Trankell, Ing-Britt, and Jan Ovesen. 2010. *Cambodians and their Doctors: A Medical Anthropology of Colonial and Post-Colonial Cambodia*. Copenhagen: Nias Press.

Tsing, Anna Lowenhaupt. 1993. *In the Realm of the Diamond Queen: Marginality in an out-of-the-way Place*. Princeton, NJ: Princeton University Press.

——. 1994. "From the Margins." *Cultural Anthropology* 9 (3): 279–297.

Tsuda, Takeyuki. 2015. "Is Native Anthropology Really Possible?" *Anthropology Today* 31 (3): 14–17.

Tully, Kristen P., and Helen L. Ball. 2013. "Misrecognition of Need: Women's Experiences of and Explanations for Undergoing Caesarean Delivery." *Social Science & Medicine* 85: 103–111.

Turner, Victor. 2002. "Liminality and Communitas." In *A Reader in the Anthropology of Religion*, edited by Michael Lambek, 358–374. Malden, MA: Blackwell Publishing.

United Kingdom Government (UK Gov). 2015. "Vaccine Damage Payment." Accessed February 10, 2016. https://www.gov.uk/vaccine-damage-payment/overview.

Valins, Oliver. 2000. "Institutionalised Religion: Sacred Texts and Jewish Spatial Practice." *Geoforum* 31 (4): 575–586.

——. 2003. "Stubborn Identities and the Construction of Socio-Spatial Boundaries: Ultra-Orthodox Jews Living in Contemporary Britain." *Transaction of the Institute of British Geographers* 28: 158–175.

Van Esterik, Penny. 2015. “Foreword. What Flows through us: Rethinking Breastfeeding as Product and Process.” In *Ethnographies of Breastfeeding: Cultural Contexts and Confrontations*, edited by Tanya Cassidy and Abdullhai El Tom, XV–XXIII London: Bloomsbury.

Van Hollen, Cecilia. 1994. “Perspectives on the Anthropology of Birth.” *Culture, Medicine, and Psychiatry* 18 (4): 501–512.

——. 2003. *Birth on the Threshold: Childbirth and Modernity in South India*. Berkeley: University of California Press.

Vargas-Cetina, Gabriela. 2013. *Anthropology and the Politics of Representation*. Alabama, AL: The University of Alabama Press.

Vaughan, Laura, and Alan Penn. 2006. “Jewish Immigrant Settlement Patterns in Manchester and Leeds, 1881.” *Urban Studies* 43 (3): 653–671.

Vulkan, Daniel, and David Graham. 2008. “Population Trends among Britain’s Strictly Orthodox Jews.” *Report of the Community Policy Research Group, Board of Deputies of British Jews*. Accessed December 1, 2015. http://www.bod.org.uk/wp-content/uploads/2014/10/StrictlyOrthodox.pdf.

Wakefield, A.J., S.H. Murch, A. Anthony, J. Linnell, D.M. Casson, M. Malik, M. Berelowitz, A.P. Dhillon, M.A. Thomson, P. Harvey, A. Valentine, S.E. Davies, and J.A. Walker-Smith. 1998. [Retracted] “Ileal-Lymphoid-Nodular Hyperplasia, non-Specific Colitis, and Pervasive Development Disorder in Children.” *The Lancet* 351: 637–641.

Watzman, Haim. 1994. Translator’s note to *Educated and Ignorant: Ultraorthodox Jewish Women and their World,* by Tamar El Or, XI. Boulder, CO: Lynne Rienner Publishers, Inc.

Weiss, Meira. 2002. *The Chosen Body: The Politics of the Body in Israeli Society*. Stanford, CA: Stanford University Press.

Whitmarsh, Ian. 2013. "The Ascetic Subject of Compliance: The Turn to Chronic Diseases in Global Health." In *When People Come First: Critical Studies in Global Health,* edited by João Biehl and Adriana Petryna, 302–324. Princeton, NJ: Princeton University Press.

Williams, Bill. 1979. "The Jewish Immigrant in Manchester: The Contribution of Oral History." *Oral History* 7 (1): 43–53.

——. 1985. *The Making of Manchester Jewry, 1740–1875*. Manchester: Manchester University Press.

——. 1989. "'East and West': Class and Culture in Manchester Jewry, 1850-1920." *Studia Rosenthaliana* 23: 88–106.

——. 2011. *Jews and Other Foreigners: Manchester and the Rescue of the Victims of European fascism, 1933-1940*. Manchester: Manchester University Press.

Wilson, Thomas M., and Hastings Donnan. 2006. *The Anthropology of Ireland.* London: Berg Publishers.

Wineberg, Jonny, and Sandi Mann. 2016. "Salford Jewish Community Health Research Report 2015." Accessed May 30, 2016. http://archive.jpr.org.uk/download?id=2721.

Winograd, Zoe. 2013. "Measles Hits Orthodox Community." *The Jewish Chronicle*, July 18. Accessed February 24, 2016. http://www.thejc.com/news/uk-news/109598/measles-hits-orthodox-community.

Winston, Hella. 2005. *Unchosen: The Hidden Lives of Hasidic Rebels*. Boston: Beacon press.

Wise, Yaakov. 2007. "The Establishment of ultra-Orthodoxy in Manchester." *Melilah: Manchester Journal of Jewish Studies* 7:2. Accessed May 9, 2016. http://www.manchesterjewishstudies.org/storage/melilah/2010/2.pdf.

Wolfe, Robert M., and Lisa K. Sharp. 2002. "Anti-Vaccinationists Past and Present." *British Medical Journal* 325: 430–432.

World Health Organization (WHO). No date. "Exclusive breastfeeding." Accessed August 30, 2016. http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/.

——. 2010. "The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per year: Overuse as a Barrier to Universal Coverage. World Health Report. Accessed December 6, 2015. http://www.who.int/healthsystems/topics/financing/healthreport/30C-sectioncosts.pdf.

World Health Organization: Regional Office for Europe. 2013. "A Report on the Epidemiology of Selected Vaccine-Preventable Diseases in the European Region." Accessed May 30, 2016. http://www.euro.who.int/__data/assets/pdf_file/0003/191910/EpiBrief_2_2013_FINAL.pdf.

——. 2016. "Tailoring Immunization Programmes to Reach Underserved Groups — the TIP Approach." Accessed May 30, 2016. http://www.euro.who.int/en/health-topics/communicable-diseases/measles-and-rubella/activities/tailoring-immunization-programmes-to-reach-underserved-groups-the-tip-approach.

Wright, C., D. Stone, and N. Parkinson. 2010. “Undernutrition in British Haredi infants within the Gateshead Millenium Cohort Study.” *Archives of Disease in Childhood* 95 (8): 630–633.

Yaffe, Yosef. 2012. *Ashrei Yoladeto: A Chronological Guide to Pregnancy, Childbirth and the Nursing Mother, Presenting Halachos, Minhagim, and Medical Advice including Segulos and Tefillos*. Brooklyn: printed by author.

Yakobson, Alexander. 2013. “State, National Identity, Ethnicity: Normative and Constitutional Aspects.” In *Nations: The Long History and Deep Roots of Political Ethnicity and Nationalism*, edited by Azar Gat with Alexander Yakobson, 328–379. Cambridge: Cambridge University press.

Haredi printed publications and pamphlets

Chabad Lubavitch. *L’Chaim* issue 855, 23 May 2014.

Haredi pamphlets

‘Maternity issues and halachah.’
‘הלכות המצויים בשעת לידה [halachic laws that concern the hours of giving birth]’ (in Hebrew and English).

Appendix A: ‘Vaccine damage’ scheme

- Diphtheria (Usually administered as the combined DTP-immunisation with Tetanus and Pertussis)
- Haemophilus influenzae type B (HIB)
- Human papillomavirus (HPV)
- Influenza (except for influenza caused by a pandemic influenza virus)
- Measles
- Meningococcal group C (meningitis C)
- Mumps
- Pandemic influenza A (H1N1) 2009 (swine flu) - up to 31 August 2010
- Pertussis (whooping cough)
- Pneumococcal infection
- Poliomyelitis
- Rotavirus
- Rubella (German measles)
- Smallpox (up to 1 August 1971)
- Tetanus
- Tuberculosis (TB)