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

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

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

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

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

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

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

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

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

'The NHS Don't Understand Us'

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

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

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

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

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

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

Historical Medical Cultures

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

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

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

Conversion and Assimilation as a Christian Medical 'Mission'

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

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

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

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

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

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

The Manchester Victoria Memorial Jewish Hospital

Local health and medical facilities were not always accessible or appropriate for 'foreign' Jews, with 'religious scruples' and language barriers occurring as far back as 1868.[38] In the eyes of the anglicised Jews, however, a dedicated hospital would appear as an act of Jewish exclusivity that ran in contrast to their strategy of pressuring 'foreign' Jews to assimilate into the social body and integrate into the body of the nation, particularly during a period of profound anti-alien and specifically anti-Jewish sentiments. The Jewish Board of Guardians had instead led attempts to push for the establishment of a kosher kitchen or Jewish ward at the Manchester Royal Infirmary as a counter-proposal to a 'Jewish hospital ghetto' (Heggie 2005; Williams 1989).[39] Local hospitals were no doubt irked by these requests for a Jewish ward, and one institution claimed it would be 'likely to interfere with the effective management of the hospital' (Dobkin 2004: 50). Hospital compromises around culturally-specific care mark a major difference between the social histories of Jewish Manchester and London; the London Hospital made these special facilities available to Jewish patients (in exchange for generous financial support), and had the Manchester Royal Infirmary taken a similar approach to patient care by agreeing to a Jewish ward the MVMJH may never have opened (Black 1990). Thus the historical health encounters of Jews in East London were not a norm that can be projected in the 'provinces'.

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

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

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

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

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

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

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

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

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

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

> The hospital was built for a Jewish atmosphere. It is managed by Jews, and the food is in accordance with Jewish law. But the law – of which, I believe, this gentleman is an ardent student – tells us that we must treat 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.[51]

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

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

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

Gehah: Bridging Distances in Health

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

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

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

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

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

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

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

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

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

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

Contesting Gehah Volunteers

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

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

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

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

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

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

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

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

Public Health Surveillance as an 'Art of Government'

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

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

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

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

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

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

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

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

Manchester Jewish Ladies Visiting Association

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

Notes

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

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

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

Hampshire and Simpson 2015; Inhorn 2015; Inhorn and Tremayne 2012; Kahn 2000, 2006).

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

at Lancashire County Council as well as clerk to the Asylum Board, to address this.

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

England n.d. c.), falling short of the national average of 79.5 and 83.2 respectively (over the same period).

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

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

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J229: Marjorie Smith. Date of interview: 22 December 1976, by R. Livshin.
J273: Louis Rich. Date of interview: 7 November 1979 and 17 July 1980, by R. Burman and J. Emanuel.

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M182/3/1–4: Manchester Jewish Board of Guardians for the Relief of the Jewish Poor M182/5/2: Manchester Jewish Ladies Visiting Association
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