

## INTRODUCTION

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

—Avot d’Rav Natan

Mrs Abrams is highly prized in Manchester for supporting local women to birth according to the heightened standards of bodily governance that define them as Haredi Jews – a minority that is commonly regarded as ‘ultra-Orthodox’ and ‘hard to reach’ in the UK, claims which are critiqued in this book. She’s frequently told by women ‘you don’t understand how nice it is to have a Jewish midwife who understands you’, which is reflected in the warm smiles and greetings she receives while we sit in the neighbourhood’s busy café. Mrs Abrams makes herself constantly available for local birthing women, but the value of her role extends to more serious issues that can involve contestations around the interpretations of bodily care upheld by practitioners of authoritative knowledge<sup>1</sup> in biomedicine and Haredi Judaism:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Health at the ‘Hard to Reach’ Margins

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **The Social Construction of Protection**

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Who Are the Haredim?

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

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

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

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

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

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

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

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

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

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

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



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



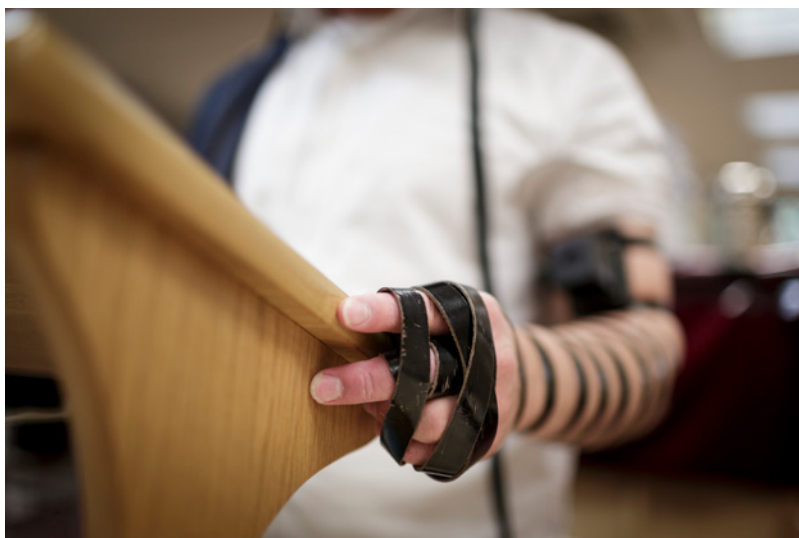


FIGURE 0.2 *Tefillin* (phylacteries), Jewish Manchester. Photograph by Thomas S.G. Farnetti. © Wellcome Collection. Published with permission.

## The Jews and Haredim of Manchester

The United Kingdom has the second largest Jewish population in Europe (after France), currently numbering approximately 271,250.<sup>47</sup> The vast majority of Jews live in England, and almost all Haredim live in the settlements of North London, North Manchester (Northwest England), or Gateshead (North East England). Manchester is home to the UK's second largest Jewish and Haredi settlement after London,<sup>48</sup> and sits in a region of historical and contemporary significance.

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

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

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

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

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

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

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

### *(In)Security and Antisemitism*

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

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

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

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



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

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

## **A Recent History of Jewish Immigration to England**

The UK became a significant destination for Ashkenazi Jewish immigration from Eastern and Central Europe during the years 1880–1914.<sup>55</sup> This period saw an exodus of up to three million Jews from the European continent, approximately 150,000–250,000 of whom settled in the UK (Dee 2012; Tananbaum 2004, 2015). Up to 30,000 of these émigré Jews had arrived in the already existing Jewish settlement in Manchester by 1914 – a time marked by growing resistance to ‘alien’ and Jewish immigration in the local area and country as a whole (National Archives n.d.).<sup>56</sup>

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

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

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

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

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

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

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

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

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

## **Researching Historically-Situated Jewish Worlds**

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

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

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

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

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



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

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

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

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

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

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

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

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

### *(Re)Presentation*

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

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

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

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

## **Outline of the Chapters**

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

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

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

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

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

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

## Notes

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

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

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

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



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

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

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

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

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

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