

Chapter 2

CULTURE, FAITH AND HEALTH

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

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

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

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

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



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

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

Framing the ‘Hard to Reach’ Margins of the State

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

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

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

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

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

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

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

The Expectations of the ‘Other’

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

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

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

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

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

Helping and Healing in Primary Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Culturally-Specific Care, Collective Autonomy and Individual Choices

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

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

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

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

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

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

Kosher-ing Healthcare

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

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

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

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

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

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

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

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

Visible and Invisible Vulnerabilities

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

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

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

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

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

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

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

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

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

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

'The NHS Don't Understand Us'

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

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

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

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

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

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

Historical Medical Cultures

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

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

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

Conversion and Assimilation as a Christian Medical ‘Mission’

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

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

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

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

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

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

The Manchester Victoria Memorial Jewish Hospital

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

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

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

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



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

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

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

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

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

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

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

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

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

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



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

Gehah: Bridging Distances in Health

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

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

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

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

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

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

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

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

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

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

Contesting Gehah Volunteers

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

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

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

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

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

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

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

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

Public Health Surveillance as an 'Art of Government'

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

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

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

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

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

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

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

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

Manchester Jewish Ladies Visiting Association

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

Notes

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

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

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

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

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

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

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

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