Chapter 3

Maternity Matters

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

> The king of Egypt spoke to the Hebrew midwives, one of whom was named Shifrah and the other Puah, saying, "when you deliver the Hebrew women, look at the birthstool: if it is a boy, kill him; if it is a girl, let her live."
> The midwives, fearing God, did not do as the king of Egypt had told them; they let the boys live.
> So the king of Egypt summoned the midwives and said to them, "why have you done this thing, letting the boys live?" The midwives said to Pharaoh, "Because the Hebrew women are not like the Egyptian women: they are vigorous. Before the midwife can come to them, they have given birth".
> And God dealt well with the midwives; and the people multiplied and increased greatly. ([*Tanakh*] *Shemot*/Exodus 1:15–20)

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

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

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

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

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

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

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

Doulas and Midwives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

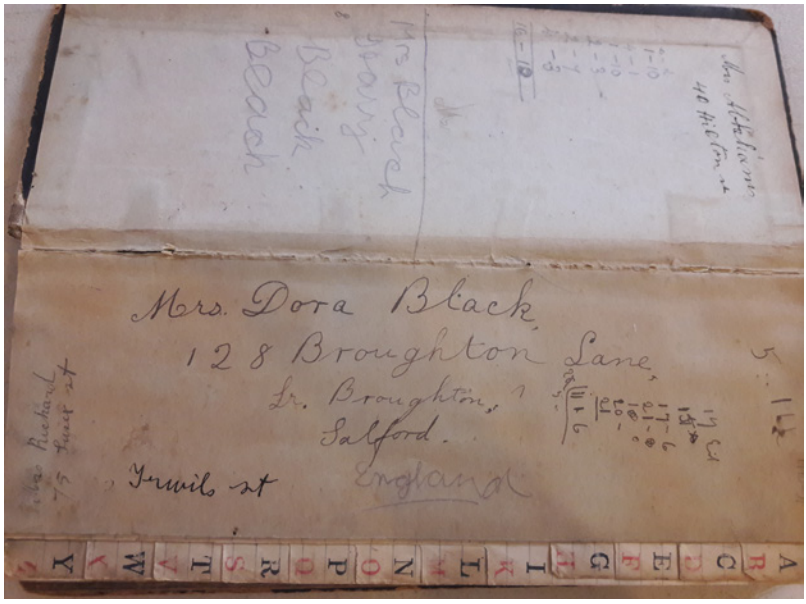

FIGURE 3.1 Dora Black's maternity book. Photograph by the author. © Manchester Jewish Museum, MANJM 1990-51. Published with permission.

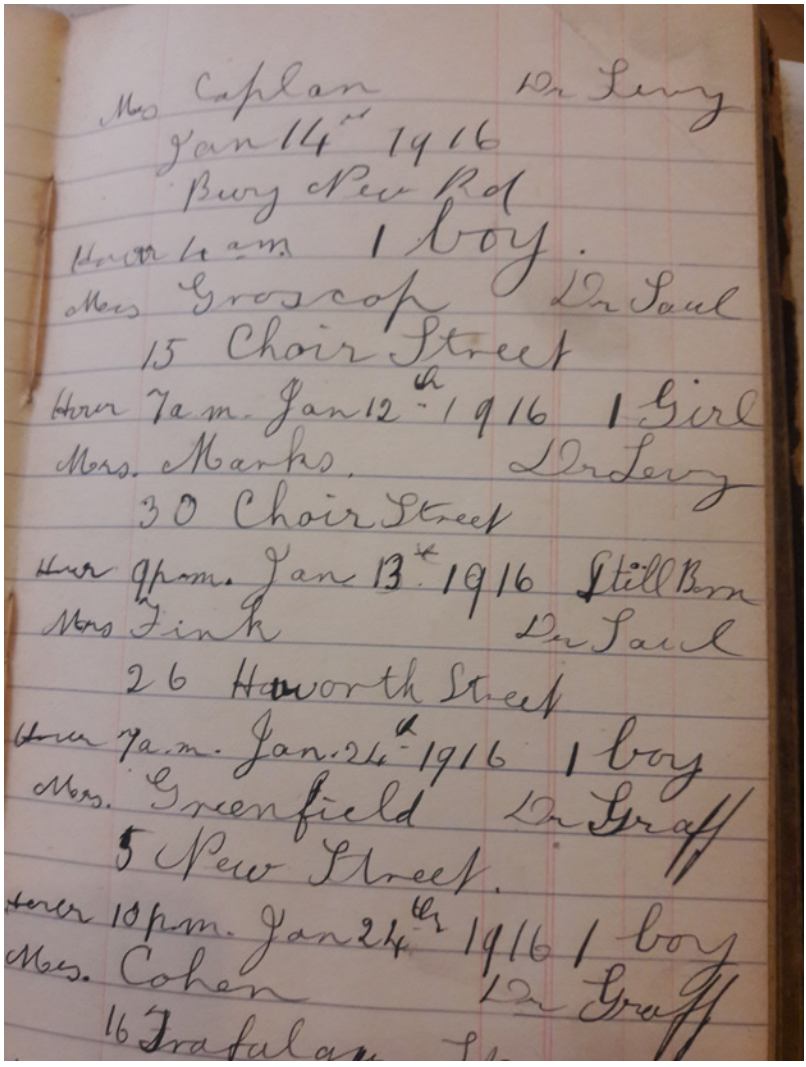

FIGURE 3.2 Dora Black's maternity book. Photograph by the author. © Manchester Jewish Museum, MANJM 1990-51. Published with permission.

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

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

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

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

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

Pregnancy

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

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

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

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

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

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

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

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

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

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

Antenatal Screening

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

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

> Carefully how they may react to a test result, which may *chas vesholom* [God forbid], detect a defect or disability in a baby for which there may be no therapeutic remedy … Termination of pregnancy may be offered at such a time [by healthcare professionals], and this is generally not an option for an Orthodox Jewish family.
>
> It is important to consider the *consequences* of ante-natal screening before embarking on such tests, and a mother may wish to discuss these issues with her husband, Rabbi, or GP, before reaching a decision. *It should be noted that parents have the right to refuse antenatal screening tests, if they so wish*. (Emphasis added)

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

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

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

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

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

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

The Politics of Parturition

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

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

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

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

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

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

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

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

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

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

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

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

Alleviating Pain and Fear

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

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

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

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

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

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

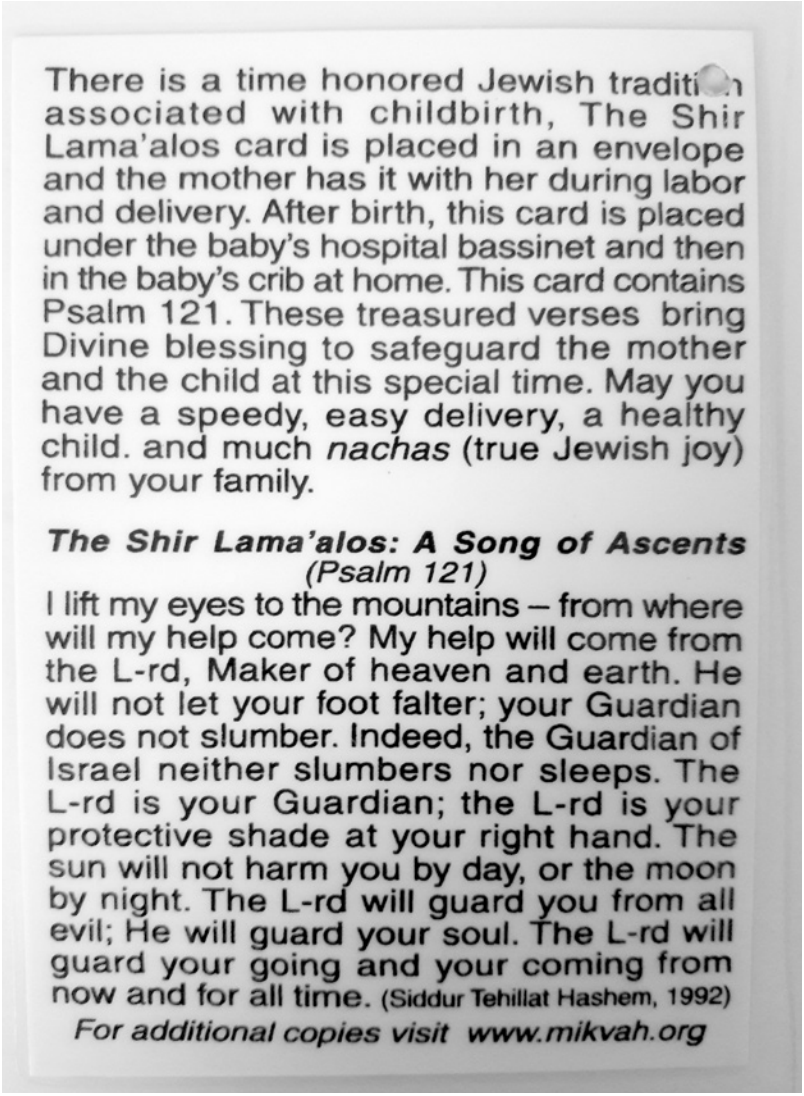

FIGURE 3.3 Card containing the verses of *Shir Lama'alot* (Song of Ascents) that are given to birthing women. Card collected by the author during fieldwork. © The Taharas Hamishpacha Organization/Mikvah.org. Reprinted with permission.

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

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

Caesarean Section

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Overstepping the Mark

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

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

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

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

Postnatal and Infant Care

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

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

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

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

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

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

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

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

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

Maternal Convalescence

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Through revisiting past maternity cultures in Jewish Manchester, it becomes clear that birth, as Van Hollen has discussed in its broader socio-political context, can be analysed 'as an arena within which culture is produced, reproduced and resisted' (1994: 501). Jewish Manchester developed culturally-specific maternity care provisions to buffer mothers against the city's insalubrious, urban and industrial conditions in an era that predated the NHS and welfare state, when standards of maternal and infant care services were formative but subject to increasing political attention. The surveillance and assimilatory mandates of particular organisations aside, maternity cultures in the former Jewish Quarter (especially around breastfeeding) were thought to influence the lower rates of infant mortality observed in the area[73] – reflecting the experience of émigré Jews in the East End of London.[74]

Breastfeeding and Modesty

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Birth Spacing Technologies (BSTs)

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

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

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

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

> Mrs Tikvah: I am happy to say that in the younger, even in the Haredim, they want to take contraception after one child. I'm shocked, not shocked in disgusted at them, I'm shocked and pleased to see they do take and it's not inbred in them – that culture – anymore to not take contraception … I really strongly believe that we are a weaker generation.
>
> BK: Weaker?
>
> Mrs Tikvah: Women don't cope as well; you see something like fasting on *Tisha B'Av*,[80] yeah? Everybody used to have to do it but there are so many leniencies, even for *Yom Kippur*. I've heard the rabbis say that [pregnant] women can drink a certain amount if they really feel they have to, whereas ten years ago you would never have heard of that. You'd fast and that's it. So this generation is getting weaker, laws are changing.
>
> Mrs Saunders: And the rabbis are understanding that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

Notes

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

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

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

frequently asked questions put to *rabbonim* – not questions that are put to doulas. This material was produced under the authority of Haredi rabbis in London.

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

    > 'With the definition of all pregnancies as potentially pathological, ante-natal care obtained its final mandate, a mandate written by the medical profession in alliance with the population-controlling interests of the state, and one giving an unprecedented degree of licence over the bodies and approved life-styles of women'.

39. It should be noted that termination of pregnancies among Haredi women in Israel is not unheard of, with *rabbonim* granting dispensations (or exerting pressure to take dispensation for an abortion) in certain circumstances (Ivry 2009; Ivry, Teman and Frumkin 2011). Examples discussed by Ivry and colleagues include a foetus' being diagnosed with a fatal disease (e.g. Tay Sachs or a heart defect), or if the physical or emotional health of a woman would be affected by carrying a pregnancy. The sensitivity of abortion among Haredi Jews meant

that, in some cases, medical professionals would refer *frum* women to a particular rabbi who was considered 'likely to allow pregnancy termination' (Ivry, Teman, and Frumkin 2011: 1,532). Whilst rabbinical authorities might agree that abortion is permissible when the mother's life is in danger, interpretations of what 'danger' actually constitutes are far from uniform (see Ivry 2015: IV). Rabbinical authorities interpret the body of religious texts that inform the Jewish cosmology in relation to an individual's circumstance, and it is this interpretation that formulates a *psak* (ruling of *halachic* law, see Chapters Two and Four).

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

Lothian and Grauer (2012) have argued how the historical shift from 'home to hospital' has contributed to women's lack of knowledge of birth and their fear. She describes how 'telling birth stories not only provides important information about birth but can help women to be more responsive to that information' (Lothian and Grauer 2012: 126).

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

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

Children' in 1929. There is no definitive record of when the United Sisters Maternity Society was first instituted.

67. According to records from 1925, non-Jewish women were referred to the Jewish service by various 'Child Welfare Centres' in Manchester. The Manchester School for Mothers made a donation of £10 towards the care of non-Jewish women.
68. GB127.C15/3: 1922.
69. GB127.C15/3: 1920.
70. GB127.C15/3: 1922.
71. C15/3: 1923. The aim of the convalescent home for mothers was to 'restore them to health'.
72. Williams (1976: 155) notes that the 'United Sisters Charitable and Benevolent Society' was formed in 1847 to relieve poor (married) women 'during their confinement in childbed and sickness'. This was a small-scale charity that does not seem to compare with maternity provisions in London's East End.
73. See Dulberg (1909) who claims rates of infant mortality in 1907 were lower in the émigré Jewish area of Cheetham compared with neighbouring areas in Manchester.
74. Marks (1994) also notes that Jewish family diets (rich in Vitamins D and A) would have contributed to lower infant mortality rates compared with the region.
75. This is likely a reference to the WHO (n.d.) which attempts to encourage mothers to nurse exclusively for six months.
76. The term often used was *Rov*, denoting a personal relationship with a rabbi or even a learned man who offers spiritual mentorship (also *rav*).
77. Also *Chatan*.
78. *Negel vasser* (vernacular), for morning washing of hands.
79. See Feldman (1974) and Feldman (1992) for a detailed discussion on the *halachah* surrounding birth control.
80. Ninth day in the Hebrew month *Av*: A twenty five hour fast that commemorates the ancient destruction of the first and second temples, and in some circles the fast as well as more recent calamities such as the *Shoah*.
81. The broader body of anthropological work illustrates how contraception and family planning form a contested biopolitical 'intervention' for ethno-religious minority groups who are negotiating their presence as migrants in Europe. Émigré women can encounter notions of reproductive rights in Europe that cause established Islamic teachings to be negotiated, yet state contraceptive agendas are also viewed in the broader context of racism and hostility towards minorities, with some women viewing birth control as an institutionalised attempt to restrain their growing demographic (Sargent 2006). As the broader anthropological discourse attests, the bodies of – usually of female, non-white, and poor – citizens are targeted as 'vessels of population

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

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

Archival Records, Manchester Jewish Museum (MANJM)

1990-51: Dora Black's baby book.

Archives & Local History, Manchester (GB127)

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