

CONCLUSION

ANTONYMIC IMMUNITIES

Taking Jewish Manchester as a stepping stone I have critically engaged with the construction of a Haredi population that sits evasively at the 'hard to reach' margins of the state. There, Haredi Jews are portrayed as responding to preventive health interventions with poor 'compliance' or indeed outright resistance to state authority in some cases. In challenging the view that Haredi Jews are 'non-compliant' with areas of NHS provision, *Making Bodies Kosher* presents an image of how responses to maternity care and infant health interventions should instead be understood. What has emerged over the course of this book is a situation where 'antonymic immunities' are exercised between the Haredim and the state, marked by a failure of each to reach the other's expectations and responsibilities concerning health and bodily protection (Chapters Two, Three and Four). An antonym denotes a state of opposition and applied to the case at hand it illustrates how a body is fully understood when placed in relation to another, rather than being viewed in isolation. Antonymic immunities articulate how contests over a Jewish body – which is itself the margin between the Haredim and the state – rest on opposing conceptualisations of protecting collective life. The antonymic pursuits of 'immunity' undertaken by the Haredim and the state respectively are only fully understood when placed side-by-side.

Preserving Collective Life

The historical and contemporary trajectories of this book articulate how health and bodily care reflect an enduring pressure on the Jews of Manchester to assimilate, integrate or insulate. Émigré Jews during the nineteenth and early twentieth centuries were cast as a threat to the body of the nation, undermining it from within, and were targeted as a foreign antigen in need of cultural prophylaxis or ‘anglicisation’ (Introduction and Chapter One). In many ways this historical narrative is contiguous with the present experience of Haredi Jews who sit in the gaze of the public health authority as a ‘community’ that must be reached in order to secure the protection of all. In each of these cases, a contest arises in attempting to preserve the life of the social body and that of the nation. My focus on maternity and infant care captures how anxieties around bodily protection intensify in health borderlands, particularly when interventions are seen to disrupt social reproduction or the processes through which bodies are made kosher.

Haredi Jews constitute a rapidly growing yet composite minority who are amalgamated and categorised as an ‘ultra-Orthodox Jewish community’ in public health discourse. Public health authorities typically attribute the low uptake of available health services to ‘cultural factors’ or religious ‘beliefs’ (see Parker and Harper 2005). The construction and targeting of ‘hard to reach’ groups for intervention is symptomatic of a discourse of blame, but is actually unhelpful and counter-productive to understanding their health needs (Chapter Two).

Pious Jews in Manchester do not fully trust state healthcare services to care for Jewish bodies in line with their cosmology and expectations to preserve life and bodily integrity, in ways that parallel the experiences of émigré Jews in the Jewish Quarter. The former Manchester Victoria Memorial Jewish Hospital and the current role of Haredi paramedic brigades, *askonim*, and maternity carers reveals how the relation between a Jewish minority and the state is more complicated than is otherwise presented.

Whereas forms of self-insulation have previously been framed as dissimulation (Scott 2009), the Haredi context is best described as a pursuit of *immunity* in ways that are antonymic to the biomedical construction of the term. Immunitary reactions to what are perceived as virulent changes in the outside world over recent decades take the form of a protective and fortified settlement, or

'zone of cultural refusal',¹ that manifests in the development of culturally-specific and professional health and bodily care services. The intention is to reduce the need for Haredi Jews to encounter the state and the broader population as much as possible, thus fortifying group autonomy.

The 'hard to reach' label is a superficial reference to the Haredi aspiration for self-protection that is intended to preserve individual and collective life. The preference for self-protection exemplifies how Haredi Jews station themselves at the margins of society just as much as they are marginalised by the mainstream – they cast themselves aside whilst they are simultaneously positioned as outcasts. Pursuits of autonomy and self-protection enable religious authorities to negotiate areas of healthcare that have the potential to disrupt social reproduction, yet this intervention also has the potential to come at the expense of individuals. The stringency with which self-protection is pursued as an immunitary strategy (Chapter Two) can come to present a danger to the Haredi social body from within, in what can be read as autoimmune reactions (cf. Esposito 2015).

Protecting the Social Body

Rabbinical authorities and doulas directly intervene in the state provision and delivery of health and bodily care often because of the mistrust with which the NHS is viewed in terms of its ability to meet, or understand, Haredi needs. The Haredi cultures of health that I encountered in Manchester are best described as a preference for managing and mediating its relation to the biomedical authority, rather than evading it altogether. Negotiation thereby becomes a conscious and necessary strategy for Haredi authorities to police the body, which can be conceived as a vulnerable and porous margin with the external world – thus compromising the social *immunity* of the group. Health and bodily care are therefore vital areas of intervention and protection because they represent (and will probably continue to be) two of the remaining points in which the British state and Haredi authorities engage with each other (see Chapters Two, Three and Four).

The culture in which NHS maternity and child health interventions are constructed can contravene interpretations of *halachic* law propagated by local ('lay') Haredi Jews or religious authorities. The concern with preserving (collective) life forms the heart of the Haredi preoccupations and the 'non-compliance' that they field to rebut biomedical interventions that are perceived to be unnecessary.

Studies have articulated how the loss of control over childbirth in marginalised minorities is reflected in the loss of political and collective autonomy (for example Kaufert and O'Neil 1990 on 'the co-optation and control' of Inuit birth by the Canadian state). However, the interventions made by *frum* doulas in Manchester arguably offer an increased sense of protection and *immunity* against incursions into the Haredi social body.

Haredi populations, both in the UK and internationally, are growing exponentially by virtue of larger family sizes. However, there is little debate about how to appropriately meet the maternity care needs of Haredi Jewish families. While hospitals are generally viewed as the safest place for Jewish women to labour, some religious authorities perceive Haredi mothers as being at undue risk as a result of changes in the political and economic organisation of healthcare – especially pertaining to midwifery practice. Pious doulas offer a primarily caring role in childbirth whereas the prerogative of NHS midwives is seen to be one of safeguarding labouring women.

Some Haredi doulas can intervene in clinical encounters to ensure that as few caesarean sections as possible are performed because this obstetric surgery is feared to reduce the number of births a woman can have, and thus presents a threat to the perpetuation of the group (Chapter Three). These Haredi maternity carers can be understood as an 'immunitary reaction' to manage the intrusion of mainstream interventions in a borderland, and enable these external forms of health and bodily care to comply with the Judaic cosmology.

Birth spacing technologies (BSTs) are a routine area of primary care that can contravene the Haredi and Biblical aspiration to 'be fruitful and multiply' and perpetuate the social body. Individuals can experience barriers to accessing BSTs when consulting particular *frum* healthcare professionals, who are reported to collude with rabbinical authorities on the matter of access (Chapter Two). In other cases rabbinical authorities and *frum* maternity carers counsel Haredi couples to approach these services with caution and sensitivity (Chapter Three). Rather than an outright ban on (female) BSTs, as is the case for men, the increasing access to 'the pill' might instead indicate a relative degree of flexibility among women who, in public (health) discourse, are otherwise viewed as being an 'ultra-Orthodox community'. Public health discourse, as Fassin (2001) has argued, amplifies the tendency of culture to constitute differences and thereby overshadows possible similarities.

The prominent role that religious authorities and doulas perform in Manchester illustrates how maternity and infant care is a carefully

navigated area, rather than being a site of outright ‘non-compliance’ or resistance, and thus offers a backdrop against which to critically engage with local responses to childhood vaccinations. Childhood vaccinations are a lauded public health technique to arrest the transmission of infectious diseases, but they are as much a socio-political intervention as they are biomedical. What is often regarded as an issue of poor ‘compliance’ often does not allow for the anxieties that persist after past failings to restore public confidence in controversial vaccination campaigns – such as the MMR.

Vaccinations then form part of a broader culture of biomedical hegemony that is viewed with varying degrees of mistrust. Opposition to vaccinations among Haredi parents are often rooted in safety anxieties that have been informed by experiences of ‘adverse reactions’ or a fear of bodily contamination and damage, which resonates with a broader and historical issue of public concern (and resistance) in England (Chapter Four). Most *frum* parents I met regard vaccinations as an important area of child health, but individual vaccines are nonetheless accepted selectively. The intervention of *frum* doulas in state maternity services, as well as the vaccination anxieties held by families in Jewish Manchester, should therefore be understood in the context of Haredi Jews being a minority group in the UK.

State healthcare is the site where an individual’s body can be entangled between the Judaic and biomedical cosmologies, having the potential for grave consequences for the Haredi social body as a whole. Thus sophisticated and impressive ‘immunitary responses’ emerge as strategies of protection on the part of *frum* women and religious authorities. They direct their gaze towards healthcare, and more specifically, the body, because it constitutes the boundary between what is positioned as internal and external to the group – or social constructions of ‘purity’ and ‘danger’ (cf. Douglas 2002; Esposito 2015).

Immunising the Body of the Nation

The Haredi quest for *immunity* and protection, from what it positions as belonging to the outside world, is often antonymic to that which is put forward by the biomedical and public health authorities. Public health is a political intervention, under the semblance of ‘welfare’, that targets the body of the nation in order to preserve collective life (cf. Esposito 2015: 137). Biomedicine and public health form a culture in which the body of the nation is reproduced, and construct ideals of citizenly obligations that it expects to be performed through bodily compliance.

Reproduction is not only a biological experience of a woman's life but also the basis of nationalism and its perpetuation, and is thus an eminently political domain concerning collective life (cf. Ginsburg and Rapp 1991; Kanaanah 2002). For this reason, "the politics of reproduction" cannot and should not be extracted from the examination of politics in general' (Ginsburg and Rapp 1991: 331). Obstetric and maternity care is paramount to not only reproducing the body of the nation but also the *way* in which it is reproduced, and is thus a significant target of medicalisation and intervention (cf. Oakley 1984). Areas of biomedicine are intended to maintain a degree of biological immunity from untoward threats posed by populations as well as contagions – which consequently result in obstetric interventions (such as antenatal screening) and vaccinations schedules, as explained in Chapters Three and Four. From this perspective, vaccination coverage is presented as necessary for the protection of all, with 'non-compliance' posing a threat to the health and defence of the body of the nation.

Making Bodies Kosher explores the encounters between these antonymic immunities and protections, particularly in the context of maternity care and child health. The Haredi Jews of Manchester are an example of how particular and subversive responses from minority groups are provoked by biomedical interventions that are perceived to contest the cosmological governance of Jewish bodies. Being 'hard to reach' is therefore not an attempt to evade the state altogether. Instead the Haredi minority arguably attempts to evade a 'subject status' (cf. Scott 2009). Their quest for self-protection and *immunity* from the obligations bestowed on the social body make them 'graded citizens' (cf. Esposito 2015; McCargo 2011), causing socio-politically constructed expectations of bodily citizenship to be negotiated. Yet margins are a demarcation of both territories and bodies (Das and Poole 2004), and the maternity and infant care is emblematic of bodies forming a contested terrain of intervention and consequent 'immunitary reactions'.

Biomedicine is exemplary of state attempts to not only control subjects into being governable but to preserve the lifeblood of the body of the nation, which necessitates an exercise of techniques and technologies of power at both the level of the individual and the population (cf. Foucault 2006; Esposito 2015). I have analysed the strategies used by a religious minority group to intervene in the state's use of the biomedical and public health authorities to incorporate the Jewish social body into that of the nation.

Last Words: *Sof davar*

The pressure for Jewish émigrés to integrate and assimilate in Manchester during the nineteenth and early twentieth centuries resembles the struggles I have observed during the years 2013–2019. The implications of maternity care and infant health for social reproduction can result in contestations over the body, the guardianship of which is sought by competing authorities in ways that persist over time. The struggles investigated in this book are not confined to the by-gone ‘*Yiddisher Hospital*’ that was conceived by émigré Jews who settled in Manchester. They continue to be at play in the current interventions imparted by rabbinical authorities and organised Haredi services, which all attempt to fulfil the *halachic* imperative of preserving life (*pikuach nefesh*) – the life of an individual, but also the social body.

Just a short walk from where the *Yiddisher Hospital* used to sit is a *Hatzolah* brigade providing free emergency care to cyclists by the roadside, as was the case for me when I moved to Jewish Manchester in 2014 (Chapter Two). The *frum* doulas can be found nearby birthing the Jewish social body in the twenty-first century, just like the ‘unregistered’ émigré midwives and the *Hameyaldot Ha’ivriot* before them. These Haredi maternity carers are all busy performing ‘God’s holy work’ amidst NHS hospitals situated at the frontier area of a Jewish settlement and the state – where the politics of parturition and bodily protection are performed.

Note

1. Term borrowed from Scott (2009: 20).

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