2024

Jewish Women's Reproductive Health Traditions from the Perspective of Midwives in the United States

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JEWISH WOMEN'S REPRODUCTIVE HEALTH TRADITIONS FROM THE PERSPECTIVE OF MIDWIVES IN THE UNITED STATES

by

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A thesis submitted in partial fulfillment of the requirements
for the Honors Undergraduate Thesis program in Anthropology
in the College of Science
and in the Burnett Honors College
at the University of Central Florida
Orlando, Florida

Spring Term

2024

Thesis Chair: Dr. Joanna Mishtal

ABSTRACT

This research study examines Jewish women's traditions from the perspective of midwives, in the United States (US), particularly midwives in Florida and New York, based on their work caring for women of childbearing age in the Hasidic Ashkenazi and Sephardic Orthodox communities. The reproductive traditions examined in this research may be practiced differently depending on a woman's degree of religiosity and the rabbinic authorities in their communities. The primary data I collected in this study are based on ethnographic methods, including participant-observation with midwives, and semi-structured interviews with midwives and rebbetzins. The secondary data draws on my analysis of the professional context for the practice of midwifery in the US, and Talmudic texts and rabbinical rulings related to family planning, reproduction, and sexuality education. This study shows how midwives are central to these traditions and facilitate not only the family planning and childbearing experiences, but also the religious practices that go with reproductive healthcare. This research also demonstrates how midwives who take care of Jewish women negotiate on behalf of their patients with the local rabbis to provide care that is patient-centered and clinically recommended on the one hand but is culturally appropriate on the other hand. My research study builds on and contributes to anthropological scholarship about Jewish women and reproductive healthcare, and considers whether, and how, the reproductive health practices of the Hasidic women are surviving in a changing world.

ACKNOWLEDGMENTS

First and foremost, I would like to thank Dr. Joanna Mishtal for so many things. Thank you so much for your initial excitement about my thesis when I asked you to be my thesis advisor, then your encouragement from the very beginning when I was trying to figure out what to research to the very last edit of the thesis. Thank you for your support through these crazy two years of putting the whole thesis together. Thank you so much for everything you have done and all your help.

Next, I would like to thank my committee members, Dr. Ben Kasstan and Dr. Beatriz Reyes-Foster, for their support through the whole process. Thank you so much for your advice, suggestions, and insights. I truly appreciate my amazing committee members, and all the time and work they have put in.

Thank you to my parents and family. Thank you to my mother; thank you for being my rock through it all. Thank you for your support, and constantly lifting words. Thank you for not giving up on pushing me when it became very tough, thank you for seeing my possibilities and my potential when I can't. Thank you for much more than I can say and for being the coolest mother ever. Thank you to my father, who is my biggest supporter in every single aspect of my life. Thank you for believing in me to my very core. Thank you for not only being my dad but one of my closest friends in the world. I could not have written a single word without the love from both my mother and father. Thank you to my sisters, brothers, friends, and grandparents who had to listen constantly to my endless talking about my thesis, about the different research I was doing, and how awesome I think every aspect was.

Lastly thank you to my research participants. Thank you for your incredible stories and giving me the opportunity to listen to them. Thank you to all the Hasidic women who let me into their community and were so filled with encouragement for my thesis.

GLOSSARY

Word	Definition	Pronunciation
Hasidic	A section of extremely religious Jewish people that was founded in the 17th century. From the Hebrew word חסיד translating to pious,	Ha- SID-ic
Halacha	Translated from Hebrew directly it means "the way" in more a colloquial sense the word is used as Jewish law	Ha-la-CHA (the cha is a sound made from the back of the throat)
Minhag	Custom varying for each section of Judaism and from family to family. They are typically passed down from generation to generation.	MIN- hag
Tznuit/ Tznuis	Modesty: in dressing, actions, behaviors, and thoughts.	Tznee-YOOT
Niddah	Translated to separated. A *halacha* practiced by married women. Each month when menstruation starts a husband-and-wife sperate physically. After she is finished bleeding the women wait another seven days and then she must immerse herself in a ritual bath and say a blessing. After this, she and her husband are enthusiastically encouraged to reconnect.	NEE-duh
Kosher	Foods, surfaces, and equipment that satisfy Jewish dietary laws and regulations	KOH-sher
Sabbath/ Shabbat	The day of rest, celebrated on the 7th day of every week, Saturday. On this day, no technology or creation is	Sa-ba-th SHAH-biss

	allowed, such as writing or cooking.	
Mitzvah	A commandment or a good deed	Meetz-VAH
Heter	When a rabbi gives an exception to a law	HEH-ter
Patchke	Refers to an action or item that is messy of fussy	POTSH-kee
Pikuach nefesh	Translates to saving a life, essentially any Jewish law can be broken to save a life	Pee-KOO-ach NEH-fesh
Daven	To pray	DAH-ven
Tehillim	Psalms	Te-hill-im
Segulot	Superstitious item or ritual	Seh-GOO-lot
Mazel Tov	Congratulations	MAH-zil TAHV
Chuppah	A canopy that Jewish people stand under during their wedding	CHUU-pah
Bubbe meises	Jewish old wives tales	BUH-buh MYE-sis
Keinehora	Translates to no evil eye, it is said after good news is spoken to ward off evil	KAY-nah HOR-a
Shlichut	A spiritual mission or task	Shlee-KHOOT
Erev	Evening	EH-rev
Rebbetzin	A title given to a woman who is married to a rabbi	REH-bih-tzin
Talmud	Main text regarding Jewish laws and traditions	TAHL-mud

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CHAPTER ONE:

INTRODUCTION

Reproductive traditions are central to securing Jewish continuity in times of adversity and in a growing array of reproductive healthcare, including assisted reproductive technologies. In Judaism there are remarkable and complex reproductive health traditions and rituals, many practiced into the present (Zeller 2016, 916). This research study examines Hasidic[1] Jewish women's traditions from the perspective of reproductive healthcare providers, particularly midwives, in Florida and New York, based on their work with women of childbearing age in the Hasidic Ashkenazi and Sephardic Orthodox communities. Specifically, I had two research questions:

RQ1: Based on the experiences of midwives and other healthcare providers working with the Hasidic Ashkenazi women in the US states of Florida and New York, what are the patients' cultural and religious reproductive traditions that must be navigated?

RQ2: How are these traditions and needs accommodated (or not) in the biomedical setting in each state, and what are the challenges, if any, in facilitating these traditions?

I answer these questions by exploring the relationship between Jewish cultural practices and how they fit into biomedicine when women seek reproductive healthcare. This study focuses on the most observant and stringent branches of Judaism, which is a minority patient population

[1] Hasidism is a Jewish Orthodox movement that began in the 17th Century by Israel ben Eliezer who was a Ukrainian Rabbi also known as the Ba'al Shem Tov. Hasidism differs from other Orthodox Judaism through their interpretation of the *Mishnah* or Jewish oral laws (Rosman 1996, 1-13). The use of the term "ultra-Orthodox" that is often used in the popular vernacular has been criticized by scholars arguing that it misleads to suggest a gradient in religiosity, whereas the difference between these groups is based on cosmology, and not the degree of devoutness (Kasstan 2019, 14).

in the US medical system. As medical anthropologist Ben Kasstan argues (2019, 100), "health and medicine are one of the few remaining sites where Haredi[2] and non-Jewish people have to confront *each other*,"[3] making it necessary to negotiate between biomedicine and Jewish traditions. Maternity care is therefore a borderland where Jewish minorities and medical systems negotiate authority over birth. My project also considers whether, and how, the reproductive health practices of Hasidic women are surviving in a changing world.

Individual Jewish women's reproductive traditions may have many permutations shaped by cultural, religious, and ethnic views. Hasidic Jews may also use secular logics in their healthcare choices (Kasstan 2021) or avail of biotechnologies to achieve religious and community goals (Ginsburg and Rapp 2020). Midwives and doulas are central to the negotiations between biomedicine and these traditions, as they often help facilitate the birthing process and the religious practices that go with it. As Bayla Berkowitz explains, "By understanding the religious and spiritual needs and preferences of a patient, the midwife is better able to provide optimal, culturally competent care" (2008, 62). Midwives have a long-standing history in Judaism, one that goes back to biblical times; Jewish midwives and doulas are still used and often preferred in the Orthodox community. Midwives in the US medical system used to play a vital role in reproductive health care, but their role has been marginalized with the increased medicalization of reproduction (Davis-Floyd, Pigg and Cosminsky 2001; El Kotni 2022; Jordan 1997; Reyes-Foster 2022, 5). The focus on the Hasidic women in this study, as compared to a broader category of Jewish Orthodox women, is based on the fact that the latter category is quite

[2] Haredi is a umbrella term for the more religious sections of Judasim, there are different sub-sections which fall under it, such as Hasidism
[3] Emphasis in the original.

heterogenous, and thus centering on Hasidic reproductive practices offers a way to narrow the focus to on specific group within a vast community.

BACKGROUND AND LITERATURE REVIEW

The anthropological scholarship on reproduction shows the "process of reproduction also produced the possibility for the transformation of societies and cultures" and that biology, culture, society, and religious institutions are intertwined and are linked to political, demographic, and feminist struggles around reproductive health and rights (Andaya, and Konti 2022, 216; Mishtal 2012, 2015). Ethnographic research conducted in many parts of the globe show that "women themselves rarely define their health problems in the same ways that the biomedical community defines them" (Inhorn 2006, 350). In addition, definitions the biomedical community assigns to individuals can lead to harmful generalizations (Kaba, Sooriakumaran 2007). Generalizations can then surround minority groups, such as Hasidic women, and can lead to preconceived notions that do not capture or fail to capture the diversity or accuracy of their cultural practices (e.g., Waterhouse 1994). However, as anthropologists Carole H. Browner and Carolyn F. Sargent note (2022, 95), "in every society, some women have sought to influence the circumstances of their pregnancies, and in some, reproductive rights may be combined into laws that enable women to more effectively act in their own reproductive interests."

Having the ability for a woman to choose what she does while in labor, gives her the ability to control some of the process of labor. Childbirth is a very precarious time with many unpredictable elements. As a result of this ambiguity, women may experience a wide range of emotions such as "risk, fear, and danger" (Anderson 2006,3). These emotions are not unique to labor and delivery but are part of everyday existence (Boholm 2003; Anderson 2006). Although all people can experience the fear of uncertainty and the risks associated with it, the experiences

of risks are culturally dependent (Boholm 2003), thus, various cultures have unique ways to combat the uncertainty, and some of these methods are specific to childbirth.

Reproduction and Judaism

Childbirth rituals in different societies are also shaped by religious beliefs (Andaya and Konti 2022, 216-217). In Orthodox Judaism childbirth is regarded as a rite of passage for women, a mark of maturity for womanhood, and raising a family as their divine "mission" (*shlichut*) (Ivry, Teman 2022, 388). Although, Judaism makes it clear that "[I]t is a woman's right but not her obligation to have children," with evidence going back to the 18th Century when a notable Jewish scholar Rabbi Sofer has been credited[4] with saying "a woman... need not build the world by destroying herself" (Feldman, 1992, 31; Jakobovits,1983). While Hasidic women are not obligated, childbearing is nevertheless important in this observant, religious community.

Scholarship documents extensive set of reproductive health practices in the Jewish Orthodox community, which has implications for how to care for these patients. Sociologist Susan Starr Sered (1993, 101) observed in her research in Jerusalem that women "reported having performed close to two hundred different religious and secular rituals during pregnancy, birth, and the immediate post-partum period." Many Orthodox customs require a provider familiar with such practices. Based on interview data in the community it shows when a healthcare provider's culture differs from their patient's culture, challenges may ensue, as "many

[4] A source for the direct quote could not be found.

cultures, health care and illness are perceived very differently from the conventional biomedical view" (Bodo and Gibson 1999, 683). Providers' awareness of the community's views on the significance of labor, the sacredness of bearing children, and the cultural importance surrounding these experiences is of the utmost importance in caring for these patients (Callister, Semenic, and Foster 1999; Corrine et al 1992; O'Brien 1999; Walton 1996). Therefore "culturally specific" reproductive care is needed in the Hasidic Jewish healthcare provision as having a provider with a similar background as the patient makes for a more inclusive and patient-centered healthcare experience (Kasstan 2019, 107).

Midwifery Practice: Professional Context

Midwives and doulas are some of the main reproductive health care providers to Hasidic women. Since this project focuses on midwives, it is valuable to review the midwifery training and guidelines in the US. Midwifery work in the US typically begins with family planning care and prenatal care and ends approximately six weeks post-partum (Healthline and Kelbach 2016,1). According to the United States Model Midwifery Legislation and Regulation: Development of a Consensus Document (Kennedy et al 2018) in the US, the midwifery practice is "not federally regulate[d]" as a result there are four types of midwives: certified nurse-midwives (CNM), certified midwives (CM), certified professional midwives (CPM), and licensed midwife (LM)/ direct entry midwives (DEM) (652-653). Each midwife type requires various levels of training, and because of this variety of training not all types of midwives are permitted to work in all 50 states (653). (The midwives who participated in this Research were primarily CNMs, and one was a CM. I elaborate on this in my methods chapter.)

Training to become a CNM begins with a bachelor's in nursing as well as completion of a nursing midwifery program accredited through Accreditation Commission for Midwifery Education (ACME) (American College of Nurse-Midwives 2024) The prospective midwife then completes their clinical education (American Midwifery Certification Board [AMCB] 2024). Although it is not federally required to be accredited with the AMCB to practice in the US, most states do not allow a midwife to practice without certification. In fact, to use the CNM or CM designation a midwife must be certified through the AMCB (AMCB 2024). To work as a CM in the US, a prospective midwife needs to receive a degree from a university or college and take certain science classes. They then must graduate from an accredited education program certified by the ACME as well as complete their clinical practice (AMCB 2024). A CM is only permitted to work in 11 states; New York is one of them, which is where I did my fieldwork with the CM.

Midwifery and Judaism

A considerable part of midwifery is supporting women through childbirth; this is an ancient custom that has roots in biblical times when the first reproductive providers to support laboring women were midwives. Internal medicine doctor at Tel Aviv University, Yechiel Michael Barilian, wrote extensively on the topic of midwifery in Judaism. In old Hebrew, there were two words for midwives, “Haya (life) and Hachamah (wise)” owing to their ability to incorporate spirituality and brisk assessments of life threating situations (Barilian 156). Midwives were the epitome of trust in the Jewish communities since the biblical times. Barilian documents that the communities had so much faith in midwives that few rabbinical ruling scholarships exists on the regulations of midwives’ physical labor, which is significant because

in Judaism there is a "huge corpus of responsa literature, which typically covers all aspect of private and public life" (156). This conveys the magnitude of trust that the rabbis had for the midwives and their judgments when it came to reproductive health aspects.

In Judaism, there is a belief that a midwife is a "messenger for" G-d's[5] "holy work" (Kasstan 2019, 146). Midwives have a significant role, because their Jewish-Hasidic patients are expected to follow specific reproductive practices that are shaped by rabbinical guidelines known as *halacha* as well as their familial and personal customs known as *minhag*. Living life according to *halacha* is Hasidic people's way of striving to live a righteous life. Many of these actions and laws they live by are thousands of years old, therefore following *halacha* and *minhag* is imperative while receiving all medical care from doctors, midwives, and other providers within the biomedical setting (Feldman 1992).

Maternity traditions I proposed to examine in this research study may be practiced differently depending on a woman's Jewish heritage. For example, regarding celebrating pregnancy, Ashkenazi women believe one should not speak about pregnancy until it is impossible to hide it. Sephardic women believe in celebrating the pregnancy through *kortadura de fashadura* (Ladino) a ceremony which takes place at five months of pregnancy, which translates to "the cutting of the swaddling clothes," and may be performed by a midwife (Klein 1998, 70). Therefore, effective midwives and doulas caring for Jewish women would be expected to understand these practices and beliefs and may need to help negotiate them on behalf of the women in the biomedical context.

[5] Jewish law states that one should never write the full word G-d because G-d's name may never be erased as this can be disrespectful or an attempt to erase G-d from one's life (Shurpin 2017).

Building on Anthropological Scholarship

While this study builds on the extensive scholarship about childbearing and midwives discussed above (Jordan 1997; Taragin-Zeller, 2021; Kasstan 2019; Feldman 1992) research in particular builds on anthropological scholarship about Jewish women and reproductive healthcare. A foundational text for this project is the ethnography about the politics of reproduction as experienced by Haredi Jews in Manchester, United Kingdom, by anthropologist Ben Kasstan, as they negotiate healthcare. Kasstan explores the reasoning for the dissimilation of the Haredi people from the secular world, describing the many events that have left the community shaken from years of adversity inflicted by outside peoples, as well as the need to stay within one's own community to avoid outside influences that can change the Haredi way of life. Kasstan explores their challenging relationship with the healthcare system. Kasstan notes that by labeling the Haredi's as outsiders or "hard to reach" the healthcare system is distancing themselves from that community (2019, 98). The construction of this thought shows the importance for healthcare professionals to recognize and understand the ways in which Haredi people interact with the healthcare system, and the way the healthcare system constructs and interacts with outside marginalized groups such as the Haredis. Kasstan argues that the healthcare system needs to evolve around the people who use it, showing how healthcare professionals need to be familiar with outside cultures to treat different people in a more effective and equitable manner (2019).

My research also builds on the ethnographic work of anthropologist Lea Taragin-Zeller who examines rabbinical sources as evidence of different Jewish practices and analyzes laws that lay the groundwork for why certain reproductive traditions are followed. Furthermore, Taragin-

Zeller explores how Jewish people navigate their lives while under the direction of rabbinic authorities and how these authorities can change with different aspects of life (2021), which is directly relevant to this study as Hasidic women and families are subject to rabbinical ruling and decisions.

The Study's Focus

This study sought to examine midwives' experiences caring for Hasidic women in two states: New York and Florida. I expected that the extent and nature of these negotiations would be different in different states in the US, such as Florida and New York, based on differences in the size and composition of the Jewish populations and the healthcare system. The Jewish population of New York has the highest amount of Jewish people in the United States, at 1.77 million people, and Florida's Jewish population is the third highest in the United States with 657, 095 people (World Population Review 2023, 1). Around six percent of those Jews are Hasidic, with this number increasing every year (Jewish Virtual Library 2018, 1; Maltz 2022, 1-2). The Hasidic population follow their own specific rules and regulations when it comes to healthcare, including perinatal care. As a result of this healthcare professionals need to anticipate that they may "encounter deeply held spiritual beliefs, a complex code of religious observance, a delicate balance between patient autonomy and rabbinic authority" (Betancourt et. al 2003; Gabbay, McCarthy, and Fins 2017, 546). Moreover, as physician Perle Feldman notes "Rabbinic consultant is not trying to control the medical course of action but to help the physician fit what is medically necessary within a Halachic interpretation of what is morally right" (1992; 33). Literature review on the health of Jewish women (Simhi et al 2019) shows that the Haredi,

Hasidic, and other minority groups are typically subsumed in research within the larger category of Jewish women, therefore my focus in this study on the Hasidic population will be valuable in highlighting their experiences.

Limited but significant scholarship exists about the need to accommodate this patient population in New York (Gabbay and Fins 2019; Gabbay, McCarthy and Fins 2017), but no social science or public health publications can be found to document this issue in Florida. Since the Jewish Orthodox population in Florida is growing (Jewish Population by State 2024), the question of how to accommodate Hasidic women's perinatal needs in healthcare settings is increasingly significant. Ergo, my research was focused on the perspective of Florida and New York reproductive workers, emphasizing midwives. The intention of centering midwives in this research is owed to the fact that midwives are of such importance in Judaism, as discussed above, but I wish to accentuate this further by noting that excavated tombstones from the medieval ages had only three professions inscribed on them: rabbis, men and women who lead prayer, and midwives (Baumarten 2019, 716). This inscription shows how important midwives were to the Jewish community, and how high their judgements were regarded.

The scholarship for New York shows that the issue of accommodations has been raised (Gabbay and Fins 2019), and this project's midwives' experiences in New York revealed how these religious accommodations are being implemented. Florida, with its growing Jewish population, is likely already facing the issue of religious accommodations but a literature review showed no publications in this area, therefore Florida midwives may be working at the forefront of these challenges.

CHAPTER TWO:

METHODOLOGY

This ethnographic study's purpose was to ascertain how midwives caring for women from minority backgrounds, specifically working in a Hasidic community, maneuver the culturally specific needs of this population with respect to reproductive healthcare. This project's aim included an examination of the extent to which cultural competency, sensitivity and humility is achieved in a healthcare setting. To accomplish this, I had two research questions:

RQ1: Based on the experiences of midwives and other healthcare providers working with the Hasidic Ashkenazi women in the US states of Florida and New York, what are the patients' cultural and religious reproductive traditions that must be navigated?

RQ2: How are these traditions and needs accommodated (or not) in the biomedical setting in each state, and what are the challenges, if any, in facilitating these traditions?

To answer the questions for this research project I used primary and secondary data collection. Primary data collection included participant observation and semi-structured interviews. Secondary data collection included document analysis. Preliminary fieldwork for this study began in February 2023, with the majority of the research taking place from March 2023 until January 2024.

Recruitment Strategy

I recruited the research participants for this study by capitalizing on my existing professional connections in the world of midwifery and the orthodox Jewish communities in

Florida and New York. I conducted recruitment in two phases: (a) I used purposive sampling and contacted the midwives I knew personally to invite them to participate in this study (Bernard 2006, 189-191), and (b) I used snowball sampling by asking research participants and also those who declined to participate for further referrals (Bernard 2006, 192-194). From the referrals of other midwives, I also contacted midwives that I did not know. Furthermore, I reached out to people in my Jewish community via text messages and in person asking for referrals to midwives that they knew. I contacted the rebbetzins[6] using their contact information available in the Jewish community. I used texts and/or telephone, as appropriate, to reach potential participants to invite them to the study.

Sample

My proposed sample included:

- 6 midwives in Florida working with Hasidic patients
- 6 midwives in New York working with Hasidic patients
- 2 observant Jewish OBGYNs, one in Florida and one in New York working with Hasidic patients
- 2 rabbis in the US or other rabbinical experts working with the rabbi, including rabbi's assistant

My sample inclusion criteria specified that midwives should be certified nurse midwives who had to be female as required in the Hasidic community, over the age 18, English speakers,

[6] A title given to a women who is married to a rabbi

who have worked in the Hasidic community for more than two years. They were not limited to those working in hospitals but also included those working in the private practice setting. The criteria for the sample for the rebbetzins included that they had to be Orthodox and/or Hasidic rebbetzins over the age of 18, English speakers, who have been a rebbetzin for more than five years. In the original proposed sample, I listed rabbis or other rabbinical experts, and rebbetzins fulfill this criterium as experts because many of them have extensively studied a broad range of topics and many rebbetzins are educators. They are also typically trusted members of the community about sensitive topics such as health and reproduction. As a result, and also for reasons of greater accessibility, I chose to prioritize interviewing rebbetzins above rabbis.

Recruitment of health care providers for this study proved to be challenging, therefore my final sample included:

- 2 midwives in Florida working with Hasidic patients
- 4 midwives in New York working with Hasidic patients
- 2 rebbetzins working in Hasidic community

Despite significant recruitment efforts over the course of seven months I was unable to recruit any OBGYNs working in the Hasidic community. It was also challenging to recruit midwives. However, my interviews were extremely rich and in-depth, leading to a great amount of data gathered and saturated findings within each interview (i.e., the depth of meanings of codes) and comparatively across interviews whereby interviewees offered similar explanations (Guest, Bunce, and Johnson 2006; Saunders et al 2018). The depth of the interview data, I believe, lessens the impact of smaller than intended sample size.

Semi-structured Interviews

A semi-structured interview is a suitable methodological approach for collecting primary data in this study as it allows the interviewer to focus on the participant they are interviewing while also giving the interviewer the ability to analyze crucial data as it is revealed *in vivo* and follow up with probes as appropriate to pursue further depth of meanings or examples (Adeoye-Olatunde and Olenik 2021; Firebaugh 2008). Semi-structured interviews were therefore essential to my findings. Two of the interviews I conducted were in the participants' homes, five via the online video service Zoom, and one over the phone. To facilitate these interviews, I created two separate interview guides, one for the rebbetzins and another for the midwives (see Appendix D).

The rebbetzins/rabbis interview guide consisted of 22 questions and 41 probes. However, as this was a semi-structured interview, in addition to my questions and probes the participants would naturally bring up additional relevant topics and angles themselves during the interview process. When moments arose, I could ask questions not previously established in the interview guide. The first interview was one hour and six minutes and the second interview was 50 minutes. The rebbetzins interviews focused on background knowledge with three main points, what makes Hasidic people different than other sections of Judaism, what laws there are during reproduction, and where are the laws originating from. The interviews focused on the rabbinical view on how Orthodox Jewish reproductive health traditions and biomedicine intersect, and the main challenges (if any) that they believe Orthodox women encounter in this area.

The midwives/healthcare provider interview guide included 16 questions and 19 probes. Although with providers I was collecting data with fewer questions than the rebbetzins' guide, the midwives' interviews were generally over an hour long. The midwives spoke in-depth

regarding experiences they have had and different stories of caring for Hasidic patients as these arose during the conversation. The shortest midwife interview was 21 minutes and the longest was one hour and 56 minutes. The midwives' interviews focused primarily on the different customs they saw their patients practicing and what their role as midwives was in relation to those customs, and what their experience was working with women from minority backgrounds (Kasstan 2019). Before interviews began, I conducted an informed consent process and secured verbal consent from each interviewee. All participants gave verbal consent to be recorded. When interviews were concluded, I transcribed the audio through Microsoft Word. I de-identified all interview transcripts, and I assigned a pseudonym to every participant. All data is securely stored on my UCF OneDrive.

Participant-Observation

Participant observation is an ethnographic research method that allows researchers to engage with a population or community through participation and/or observation to understand the context in which the midwife and patient interaction takes place (DeWalt and DeWalt 2011). For my participant observation, I shadowed multiple midwives in their own practices. Shadowing included observing prenatal checkups, post-natal examinations (typically involving blood pressure checks and ultrasound screenings), births, and informal conversations with healthcare workers and patients that benefited my understanding of their reproductive customs, and traditions. Participant observation included celebratory events such as a wedding. My participant-observations focused on observing how the midwives interacted with their patients, and how Hasidic women practiced their customs inside a private practice setting and outside the

private sphere in a public hospital. Any shadowing done included an explanation of my research to any patients present and securing the patient's consent for my presence. As a pre-medical student, I have prior experience shadowing healthcare providers which was helpful in allowing me to feel comfortable in the clinical setting, and simultaneously be respectful and mindful of all other people around me during participant observation fieldwork.

Overall, my participant-observation focused on observing the clinic operations and understanding the processes, rather than observing individual people. This provided valuable contextual information in my study. When I interacted with individuals at the midwives' practices (their clients or staff), I ensured that they were aware that I am a researcher and informed them about my research. If individuals did not want to be observed, they were not included in fieldnotes. There were a few instances where patients declined to be observed. These patients were not penalized for refusing my presence during their appointments.

Primary Data Analysis

I conducted a systematic analysis of the participant observation fieldnotes and interview transcripts. The transcripts were analyzed using a thematic coding approach through which I coded the text of each transcript to assign codes and then to identify major and minor themes and subthemes in the narrative data (Crang and Cook 2007,81-83). A theme is a common explanation expressed by multiple participants and contains multiple codes, and a subtheme is a common explanation within the larger themes. I analyzed my participant-observation fieldnotes to look for themes, subthemes, and examples of events, and then triangulated them with the interview data,

looking for an overlap and differences in findings. The analyses in Chapters 3, 4, 5, and 6 combine participant-observation and interview data and document analysis.

Document Analysis

I collected secondary data by conducting relevant document analysis, including religious texts, midwifery guidelines, information from websites, and other documents that may contribute insights about the intersection of Jewish women's reproductive health traditions and biomedicine. This analysis included the Talmudic texts and rabbinical rulings and interpretations relevant to my topic, guidelines and statements generated by the International Confederation of Midwives, Global Standards for Midwifery Education, Regulation, and Association (Kennedy et al 2018), the American College of Obstetricians and Gynecologists, and the North American Registry of Midwives, among other organizations. I also analyzed midwifery and nursing guidelines in Florida and New York to identify differences between these two states.

Reflexivity: Challenges and Positionality

I encountered a few challenges during my time collecting data because of my positionality as an insider/outsider researcher which implies potential for personal biases (Sherif 2001). When I began my participant observation, I needed to be highly aware of and try to remove my preconceived notions about Hasidic people. As someone who identifies as Jewish (but not Hasidic), I had previously interacted with different Hasidic groups throughout my life, and I had both positive and negative experiences. As a result, I had believed to have an

understanding that was pre-established before my data collection even began. I had to consciously remove this bias derived from my previous encounters from the forefront of my mind, reconstitute myself as an ethnographic researcher and rid myself of any ethnocentrism I may have had. I accomplished this by removing my personal feelings from the situation, distanced myself from what I believed, and decided to approach the experience as an outsider.

I was able to successfully achieve this, as I learned much about this community that I had previously believed I had already known. I have a better understanding of who these groups of people are, I was able to observe and interact with them from the inside instead of being an outside observer. Being inside allowed me to gain a deeper level of appreciation for the information I learned, and why this group of people excluded themselves from the outside world.

Another challenge I experienced was recruiting midwives. I originally held the notion that I would easily be able to reach my sample size. However, this turned out to be a challenge that I did not anticipate. I contacted many different midwives, most of them either did not respond or originally responded but did not follow up when I contacted them further. I was able to find a few midwives through snowball sampling, but I was later told when I asked one of the midwives if she knew anyone further that I could contact, that news about my project had made it around the community. She informed me that the majority of the midwives are in contact with each other, and they had heard there was a student trying to interview midwives that worked with the Hasidic community, and they all knew that I was seeking to interview midwives. She notified me that she would ask again to see if anyone was willing.

Overall, I believe being a Jewish woman helped me gain access to individuals and places I would not have been able to otherwise. I had previous cultural and religious knowledge that helped me understand words, phrases, and situations better than an outsider researcher would

have. I was also able to connect with participants in the clinic and community better than an outsider as we had shared history in some regard. Being an insider also granted me access to a better cultural understanding, and I believe I could put participants at better ease. Although there were challenges that I faced due to previous history and preconceived notions, I believe that being an insider was an advantage over a disadvantage.

Ethics Documentation

This study was approved by the UCF Institutional Review Board (see Appendix A). I also completed the Collaborative Institutional Training Initiative (CITI) Certification in "Social and Behavioral Responsible Conduct of Human Subject Research Curriculum" module (see Appendix B).

CHAPTER THREE:

MIDWIVES' ROLE IN FACILITATING THE LAWS OF LABOR

In this chapter, I will discuss the first three findings revealed during my interviews with midwives and my participant observation. The chapter will begin with the discussion of labor and the different Jewish laws that are relevant to it. In Judaism, there are laws that pertain to almost all aspects of life (Taragin-Zeller 2021), from conception and do not end in death. I will discuss the laws regarding contraception before conception, how blood affects a woman's spiritual status, and what one should wear while giving birth. My findings show how midwives can help facilitate these laws that their patients follow, and how culturally competent, sensitive, and appropriate care can make childbirth more positive for women, which in turn creates a better overall laboring experience.

Key Jewish Laws

When approaching the topic of religious birth my data reveals there are a number of critically important laws and traditions that need to be practiced before, during, and after giving birth in the cultural and religious context of Hasidic women's reproduction. These practices originate from laws created 5784 years ago, according to the Hebrew calendar, and are known as *halachas*. *Halacha* has two definitions: the more widely used meaning is interpreted as "Jewish Law" (Merriam-Webster 2024), the more direct Hebrew to English translation is, "the way" that one walks (Britannica 2024). The literal translation can be thought as more of what Judaism is about, not just a set of laws that one practices every day, but instead akin to a lifestyle.

There are two types of *halacha*. The first type, mitzvot[7] d'oraita, means a mitzvah from the Torah, which is a commandment that was given to the Jewish people by G-d. The Torah is the sacred text of the Jewish people and contains 613 laws (Ross 2008). The second type of *halacha*, mitzvot d' rabbanan, is a mitzvah given by the rabbis. According to Devarim, " עַל־פִּי הַתּוֹרָה אֲשֶׁר יוֹרוּךָ וְעַל־הַמִּשְׁפָּט אֲשֶׁר־יֹאמְרוּ לְךָ תַּעֲשֶׂה לֹא תָסוּר מִן־הַדָּבָר אֲשֶׁר־יַגִּידוּ לְךָ יָמִין וּשְׂמֹאל" (Deuteronomy 17:11), a quote from the Torah, the rabbis have the ability to make laws. The text directly translates to "According to the law they instruct you and according to the judgments they say to you, you shall do; you shall not divert from the word they tell you, either right or left" (Chabad.org 2019). The rabbis' ability to make laws is one of the reasons Judaism has several divergent sections. Since rabbis have the authority to create different laws, the various sections are also governed by them differently. These differences also pertain to reproductive practices. Thus, it was essential for my research data collection and analysis to understand that different sections of Judaism live and practice Judaism according to the rabbis they follow.

As a result, the role of the rabbi cannot be underestimated, as they can hold significant power and exert major influence in their congregations and beyond. Rabbi Menachem Mendel Schneerson is an example of this influence. Rabbi Schneerson was not only extremely influential to many different sections of Judaism, but to non-Jewish people as well (Ferry 2019). Most rabbis are less well known and mainly oversee their own congregation. This makes for variation among Jewish laws, which impact reproductive practices. Overall, however, the Torah is the final word in everything that guides the observant Jewish daily life, and thus rabbis cannot make changes to the mitzvot d'oraita. I interviewed one of my research participants, rebbetzin

[7]Mitzvot is the plural for mitzvah. Mitzvah has two meanings, the first one is laws and the second is a good deed.

Batsheva, on this important topic. A rebbetzin is a title given to a woman who is married to a rabbi[8]. Typically, they are very knowledgeable about a variety of Jewish topics, especially reproductive health and practices. Many rebbetzins teach *kallah*, bridal, classes to Jewish women who are getting married. Batsheva is a Hasidic rebbetzin, however she does not live in a Hasidic community. Instead, she lives in a less Jewish area and her job is to find Jewish people who are looking to explore different aspects of religious Judaism. This makes Batsheva educated in a wide range of topics and easier to comprehend as she usually teaches a less religious population. These characteristics made for an ideal interviewee. As I interviewed her, we spoke about *halacha*, and rabbis, rebbetzin Batsheva said:

> Everything the way the Torah works and when rabbis rule, even today, it's all based on previous rulings. That leads you all the way back to the Torah. At the end of the day, everything ends up back at a verse of the Torah.

The Torah is crucial to the observant Jewish people, and it is believed that any question can be answered by the Torah, and every ruling by a rabbi leads back to it. While the Torah is the final authority, it can be challenging for many people to follow it. As Batsheva explains,

> ...you know our premise is that Torah is the absolute undeniable truth. Then who am I to go against the Torah. I have feelings. I'm subjective. I'm a person who can be swayed from here to there. The Torah is, the Torah knows us better than we know ourselves. The Torah is the blueprint of the world. It's the manual for the optimal life. So, you know if this is the manual, when I want to use it differently (…) [You] take the risk of ruining your machine... And if I do things, everything I do is based on my instinct, because I feel like it or [it] doesn't feel right to me, then I'm going to do things differently every time, depends on how I feel. But if I know that there's an absolute truth, then, no matter how I feel, I'm still going to do [things] with absolute truth.

Batsheva's explanation highlights the reasoning behind the nature of the practice of Judaism by the Hasidic people. Every morning when a Hasidic person wakes up, they consciously continue

[8] In the Hasidic and modern Orthodox communities only men are allowed to be rabbis, whereas this is not the case in Reform Jewish communities.

the path to follow laws that were written thousands of years ago. As Batsheva and I discussed, Hasidic people believe the Torah is the undeniable truth. Truth cannot be swayed, truth does not change because emotions get involved, it simply is, and it does not change. These laws can appear difficult to follow but they are part of the fabric of Judaism and that fabric is what makes Judaism into more than simply a religion but a culture as well, Scholars have been debating the complexities of Jewish identities (Gitelman 2009), showing that the Jewish people may identify in a number of ways, including based on religion, culture, or ethnicity rooted in common cultural traditions, or some combination of these elements. There are also nuanced and important diversities within the pious communities of the Haredim and Orthodox groups (Kasstan 2019, 14-15).[9] For the Hasidic communities relevant to my study, the religious laws are foundational and guide reproductive and sexual practices from contraception to birth – a complicated terrain that is navigated with the assistance of midwives.

The Kosher Way to Plan a Family and the Role of the Midwives' Assistance

The information I gathered in my interviews and participant observation fieldwork demonstrate that midwives were working within the laws of Judaism to best assist their patients in finding a birth control they could use and still follow *halacha*. There are many uses for birth

[9] Additionally, people who identify as Jewish in the U.S. may have no religion and be secular, including atheist or agnostic. According to the Pew Research Center, "a quarter of U.S. Jewish adults (27%) do not identify with the Jewish religion: They consider themselves to be Jewish ethnically, culturally or by family background and have a Jewish parent or were raised Jewish, but they answer a question about their current religion by describing themselves as atheist, agnostic or "nothing in particular" rather than as Jewish" (Pew Research Center 2021). However, secular Jews and modern Orthodox Jews may not be considered "authentically" Jewish by the Haredim (Kasstan 2019, 14).

control pills that offer benefits other than the prevention of pregnancy, including the reduction of menstrual pain, excessive bleeding, acne, menstrual-related migraines etc. (Jones 2011). Typically, however, in the Hasidic community it is prescribed for family planning so a woman can take a break from being pregnant until she is ready to conceive again. Anthropologist Ben Kasstan based on his ethnographic research with the Haredi community in Great Britain which focused on reproductive health, argues that birth control may be more accurately thought of as birth spacing technologies because it is not prescribed to unmarried women, and it is used to regulate the spacing of children so Hasidic women can continue to have sex without the worry of pregnancy. My data too revealed that healthcare providers, in my research midwives, are assigning birth control to only married women. However, while Kasstan found that IUDs "are presented as being unsuitable for ***frum*** Jewish women" (182), my data on the contrary revealed that IUDs are prescribed as the second most common method after the oral contraception pill. The differing for my findings can be attributed to geographical and rabbinical differences. Kasstan's research was done in England and mine was conducted in Florida and New York.

In addition, birth spacing technologies are typically given to women with allowance from their rabbis. The sanction from a rabbi typically comes from the *halachas* regarding birth control (182). These laws originate from a story in the Talmud, the book of Jewish law (Votaw 1894). The story of Judith is accepted by many in the Jewish faith, including Hasidic people, and gives women the option to use birth control. The story is described by folklorist Michele Klein as follows:

> ...a woman named Judith had suffered so much in childbirth that she never wanted to become pregnant again. She was surely not the first woman to feel that way, nor by any means the last, but she was determined. She disguised herself well and went to consult her husband, Rabbi Hiyya. She asked him only one question, whether women are

> commanded to propagate the race, and received the negative answer she had hoped for. The rabbi stated that the duty was strictly a man's. Judith went home and drank a sterilizing portion to avoid future conception. When the sage discovered what his wife had done, he was greatly upset. Nevertheless, her action set a precedent for women to use an oral contraceptive... (Klein 1998, 42)

Although Klein explained that women are allowed to use oral contraceptives, there are other options for birth control as well, however not all forms of birth control are permitted, except in the scenario of the mother's health being in danger (Weisberg and Kern 2009). The general principle dictates that the type of birth control that can be used needs to be the women's responsibility physically. The forms of contraception that can be used include the oral contraceptive pill, "implants, injections, rings, and patches... diaphragms and spermicides, IUDs" (Weisberg and Kern 2009). Men are not allowed to engage in birth control. For example, men may not use condoms so to prevent the destruction of the "seed," however, there is an exception if the male partner has a disease that can be harmful to the woman's health, and it can be transmitted through sperm or contact during sexual intercourse (Weisberg and Kern 2009; Jacobovits 1980). Such diseases may include, for example, human herpes virus, Zika, HIV, Ebola, and many others (Salam and Horby 2017). The birth control methods that are not allowed include, the pull-out method (also known as withdrawal or coitus interruptus), condoms, spermicide, abstinence, and a vasectomy (Handelsman 2022; Jacobovits 1980). These prohibitions originate from the Mishna Torah, written by Rabbi Moshe ben Maimon, Maimonides, that combines *halacha* and philosophy and formulates new laws about how to live (Britannica 2013). It declares that the wasting or destroying of seed is not allowed, meaning that

it cannot be thrown away or deposited somewhere that is not inside the vagina (Issurei Biah 1180 CE; Kasstan 2019; Schauder 1996).[10]

I discussed the *halachas* of birth control with another rebbetzin, rebbetzin Chaya. Chaya works as the rebbetzin for one of the biggest congregations in Florida, and counsels' congregants from many different sections of Judaism. As a result of this role, she needs to know the laws across sections. Although she is not Hasidic herself, she is very informed about their rules and customs, which made her a particularly valuable research participant. Chaya is also an educator, and teaches several classes, including a *kallah* class, which covers the topic of birth control (Kasstan 2019, 179). During our interview, Chaya explained the rules around birth control as follows:

> Any birth control that's like on the woman. So that would be pill, IUD [Intrauterine Device], the NuvaRing, the diaphragm, which [the diaphragm] we don't really use so much anymore. A hysterectomy if it's needed, you know. Medically, those are all you know, those are all OK. It's the birth controls that are on a man that Judaism does not allow, so condoms cannot be used; a man cannot have spermicide on him. Basically, his sperm is supposed to be able to exit the man's body into the woman, we believe that things happen the way that it should.

It is important to acknowledge that as seen above there are exceptions to the condom rule, and exceptions to a lot of laws in Judaism, however abstinence is not one of them. I could not find any instance where abstinence is allowed in Judaism, except during *niddah* which will be

[10] This also means that Hasidic couples would not consider the advances in male contraception relevant to their lives, as these new technologies, currently in clinical trials, rely on the male partner's daily responsibility of applying a contraceptive gel designed to impede the sperm's function (Louwagie et al 2023). Thus, while anthropologists and gender scholars have noted women's disproportionate burden of the responsibility for contraceptive efforts (e.g., Dudgeon and Inhorn 2004, Kimport 2017), these arguments may have less relevance from the Hasidic cultural perspective.

discussed later, and in fact a couple is advised that it would better to divorce than have a sexless marriage (Jacobovits 1980; Schauder 1996).[11]

As birth control is allowed and often used, it is an important part of a midwife's job to prescribe birth control, however it is equally important for the midwives to understand these rules to best assist their patients. Ava, one of the midwives I interviewed, has been working as a midwife for almost 25 years. Although she is a religious Jewish woman, her clientele were not originally Jewish, however her practice today is made up of about 99 percent Hasidic or religious orthodox women. Ava explained that she prescribes a lot of birth control, including IUDs, pills, and diaphragms. She spoke about how it is harder to get permission from a rabbi for her Hasidic patients to get diaphragms. This is an example of the variability in rabbinic authority, as a different midwife that works in the same community does not have this issue. Ava speculated that the other midwife, who can prescribe an abundance of diaphragms, must get a *heter* to be allowed to provide so many diaphragms to her patients.

> Diaphragms are harder to get a *heter* for than the pill or the IUD. Because it's a barrier system. And Sarah by the way, is very into diaphragms now, and I don't know how she gets any of these ladies to get *heter* to for it. My patients don't seem to and none of them want to use diaphragms because they're *patchke* and they must clean them and whatever. And so, I don't. I mean you must like when it comes to birth control. She likes it because she feels like these people have control over their fertility.

A patient's rabbi has an influence on what birth control their midwife can offer for them to use. Ava refers to a *heter,* this is an allowance given by someone's rabbi. There is a process to get a *heter* which begins with a person asking their rabbi whether they are permitted to do

[11] In contrast, in Catholicism, periodic abstinence during marriage is the only Church-sanctioned pregnancy prevention method, and any "artificial" method of preventing procreation, including condoms, is forbidden by the doctrine (Mishtal and Dennefer 2010; Vatican 2010). (https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20101221_luce-del-mondo_en.html).

something, and if they are, then the rabbi will grant them permission to do it. This can be done when someone is unsure about a situation or when they are unable to follow a rule within the laws of Judaism. It is not mandatory for a woman to get a *heter* from their rabbi regarding birth control, but it is often done in Hasidic communities because they believe that the rabbi can guide them in demanding situations. Often rabbis will consult experts such as midwives to best guide them in questionable situations, an aspect of my study that I will discuss in-depth in the upcoming chapters.

Ava may not prescribe as many diaphragms possibly because her patients are not receiving a *heter* for them. However, there can be another aspect to this, and it is the patient's choice. Ava says her patients are less likely to ask for a diaphragm because "they're *patchke*" - a Yiddish word with different interpretations based on circumstance or individual use, but in general it can mean messy, dirty, fussy, or not doing something efficiently. In Ava's case, it can be any of these translations. The diaphragm can be complicated to use at first and may require a "learning curve" (Bukusi 2010, 7). It can also be messy on insertion and removal (Frezieres et al 2011). As a result of either one or both reasons could be why Ava prescribes less diaphragms than other midwives.

Contraception is a vital part of family planning, but there are other aspects to it as well, such as abortion. Abortion will be discussed in greater detail in the following chapter, but it is important to briefly mention it here. Abortion is allowed in Judaism, although it is typically dependent on individual circumstances, and there are many factors that contribute to a Hasidic woman receiving an abortion, such as the fetus having a terminal disease (Teman, Ivry, & Bernhardt 2010, 70). If this is the case, a woman will seek guidance from her rabbi, and the rabbi

will consult many different religious sources and decide the best approach (Kasstan 2019: 190). As there are many considerations when it comes to abortion, it is important for a midwife to understand that it is most likely not just the Hasidic woman's decision alone.

If the midwives were unfamiliar with the *halachas* surrounding birth control they could not help their patients to the same degree, therefore it is imperative for the midwives to simultaneously understand their patients' needs and the *halachas*, so they can best assist them in various circumstances.

Individualizing care to a minority groups' specific needs, such as the Hasidic culture, and providing culturally specific care has been shown to increase the likelihood that these communities will seek healthcare when they need it (Kasstan 2019; Napier et al. 2014; Summerskill and Horton 2015; World Health Organization 2015). Kasstan shows how although this group is a minority, they are not a "hard to reach" community. By labeling Hasidic communities as difficult to engage with a false notion is created surrounding the group. When it is more likely that Hasidic communities are not hard to reach, but instead are a private community due to trying to safeguard their way of life (251). It is crucial to consider why this minority group prefers to be on the outside of society. Kasstan again argues that a factor of them being outsiders is a result of past injustices that have been done to them (98). Another contributor is the idea itself that they are "difficult to engage" with, creating a falsehood that further excludes them from society at large. Both elements have influenced Hasidic communities to be reserved. Therefore, having a culturally competent healthcare provider is not only a desire but it is a necessity, as the biomedical sphere is one of the only places where Hasidic people are forced to interact with individuals outside their community, and as a consequence, culturally-

appropriate skills and knowledge for a minority group, such as Hasidim, should be a requirement for healthcare professionals (100). This is not to say that clinicians need to understand the *halacha* behind birth control as that would be very difficult, but they need to understand the basics of what is permitted and what is not. Understanding these women's needs creates a bond not only between the midwife and the women patients, but also between the midwife and the rabbi of their communities, which can be helpful when navigating medical decisions in this culturally specific setting. Thus, the midwife's pre-established relationship with the rabbi helps guide her patients to a safe outcome.

In addition to the considerations of the *halachic* laws, midwives take the patient's safety as the utmost priority in all situations. However, patient comfort is also very important. To help make patients as comfortable as possible in a clinical encounter, it is necessary to understand patients' unique needs surrounding the clothing that Hasidic women wear as they dress more conservatively by following the laws of *tznuis*.

Modesty Laws while Giving Birth

My interviews and participant observation revealed that midwives' understanding how Hasidic women present themselves and dress can make for a more compassionate environment in clinical encounters, in particular during stressful situations like labor and delivery.

Hasidic women dress *tznuisly*. *Tznuis* is translated as modesty which in Judaism has two main components: how one dresses and how one acts. Being *tznuis* incorporates how one carries

themselves, and how they associate with other people (Booth et al. n.d.) My findings will focus on the first part of *tznuis*, dressing modestly.

While numerous interpretations exist for every ruling in Judaism including with regards to *tznuis*, overall, there is a consensus around parts of the body that should be covered, however, a consensus is lacking on how much of said body part should be covered. Indeed, Hasidism and the orthodox community disagree on the laws regarding t*znuis* requirements. Each section of Judaism has their own rabbis that interpret what they believe the ruling should be. For example, this is evident with the ruling regarding covering the upper arm. Authorities agree the upper arm should be covered, but some say the upper arm stops before the elbow while others say the elbow is included in the upper arm (Novick 2023). In the case of Hasidism, the more cautious approach is followed: if there is a question on whether the elbow should be covered, it will be covered. Another debate concerns the length of one's skirt or dress with a disagreement on the interpretation of the word in relation to the body. The Gemara[12] analyses in the Talmud state that *shok*, which translates to "nakedness," needs to be covered, and while Orthodox Jewish people agree with this, they do not agree on where the *shok* ends (Student 2011). Some authorities say that *shok* is between the waist and the knees, meaning garments that are considered bottoms can end there, but others translate it to be from the knee to the ankle (Student 2011). Being on the more cautious side, Hasidic women wear stockings underneath their dresses and skirts.

To understand how Hasidic women give birth it is imperative to understand what they are wearing while doing so. In the Hasidic community a typical outfit consists of a long dress or skirt that should reach to around the middle of the shin or longer, a shirt that touches and covers the

[12] Gemara is a component of the Talmud.

collar bone, a shirt with sleeves that go beyond the elbows, and for married women a scarf known as a *tichel* or a wig known as a *sheital* that covers the hair (Novick 2023). It can be difficult to be modest while giving birth since a healthcare professional needs to have access to a women's vagina to help with delivering a baby. I asked rebbetzin Batsheva about this predicament: *tznuis* while giving birth, is that feasible?

> I mean, you can't officially, officially, officially, you know you want to be as modest as you can. I mean, when you're giving birth, you can't be modest. *You're not giving birth under a blanket* (the midwife's emphasis), and I'm saying, but that's why, if there's only women around there's less of an issue.

When I asked the midwives about *tznuis* while giving birth I expected them to say that it was not possible to truly accomplish, but my interviews revealed that even in birth the midwives' patients wanted to keep within the laws of *tznuis*. I discussed *tznuis* with the midwife Scarlet. Scarlet is currently retired, but she had a wealth of experience working with Hasidic patients most of her life in both Florida and New York. Scarlet identifies as modern orthodox[13] and when she was starting to practice midwifery in New York she was excited to work with Hasidic women, as she grew up around them and was interested to learn more about them. Scarlet described her experience regarding her patient's desire to be *tznuis*, "They were always very careful to keep their hair covered at all times. For the most part they wore *tichels,* sometimes they would come in with a *sheital* or wig and then they would change to a *tichel* during the birth, or later on."

Most of the midwives spoke about how the women tried to stay as covered up as possible throughout the entire labor and delivery because of not knowing who might walk through the door while amid labor. It was important for them to not feel exposed to people they did not

[13] Modern Orthodox Judaism refers to communities which are committed to maintaining their religious practices and heritage, but also integrate into modern American society.

know. Hasidic women's desire to be *tznuis* is an integral part of the labor process that Ava, when she opened her own birthing center, purchased special kimono robes, "...the Hasdish ladies, so we have these robes that we give them which they don't have to wear, but they're not like hospital gowns. They're like real kimono robes. So, they're totally *tznuis*, you know, but they open up like this [gesturing to opening the robe in front] they go below the elbows."

When discussing *tznuis* with Ava, she spoke about accommodating Hasidic women. She is not Hasidic herself, but she stressed that it is important for her patients to feel comfortable in the place they are giving birth. I also asked her if the women she works with typically keep their hair covered as well, specifically when giving birth in water, as Ava told me many of her patients deliver in water. She explained, "They were usually wearing a *snood* and they bring a few *snoods* that are extra that can get wet, you know, then change it, and it makes me think I should add it to some of the stuff we keep in there. You know, we should keep some extras around."

This interaction was meaningful because even while not working and just conversing with me, she was thinking about the women she works with and how she can better assist them. She previously went through a huge process to make sure the delivery suites were kosher by making sure to have the highest level of kosher food[14], and by designing the birthing suites with their needs in mind. Specifically, the midwives had contractors put in walls not normally found in a birth suite. Specifically, the midwives had contractors put in walls not normally found in a birth suite. These walls were made so the women who wanted to practice being *tznuis* but also wanted to be in the shower while giving birth could do so because the walls are made of frosted glass, giving the midwives the ability to make sure the women are safe but also the women can

[14] There are different levels of kosher certification. Each certification organization has different rabbis, as a result there are organizations that are much stricter than others. Hasidic kosher organizations hold to the highest level.

be fully naked without being seen. Ava's unique accommodations in her birthing center would not typically be seen in secular centers and were made to the specifications for the most religious of her patients. I observed that during our interview she remembered another aspect that could help her patients, and she wrote it down while we were speaking so she could look into it the next day – this is an example of what scholars describe as cultural humility in healthcare provision, wherein the provider is able to self-evaluate the care they provide (Tervalon and Murray-García 1998). I also thought it was powerful to be so invested in other people's care that something that might appear minor, like a hair covering, matters so much. Ava recognized her power here and can accommodate these women's cultural and religious needs.

I too had the privilege of seeing the religious practice of *tznuis* in person during my participant observation. As part of my fieldwork, I volunteered as a Hasidic women's doula in a hospital in New York. My work as a doula began the night before. At around four in the morning the midwife I was accompanying, Sarah, called me and told me her patient was in labor and we needed to go to her home. The woman Rachel Leah planned to give birth in the hospital, but she did not think her contractions where close enough together to go yet, so she called Sarah. Sarah had explained to Rachel Leah that I was a doula in training, and she asked if it was agreeable if I accompanied her. Rachel Leah agreed, so Sarah and I drove to her home. When we arrived, her husband opened the door and welcomed us inside. Sarah introduced me as a student doula and told her I could help her with pain relief during her labor. Rachel Leah thanked me for being there as she was pacing the room. She then immediately told us she did not believe her contractions were close enough together but was in a lot of pain. Rachel Leah's husband informed us that since we were here with Rachel Leah, he was going to go to the *mikvah*. I believe Sarah was already expecting this as she was unphased and told him he could go. Sarah

then asked Rachel Leah if she wanted her to examine how many centimeters dilated, she was. Rachel Leah agreed, and Sarah checked. Rachel Leah was around three centimeters, not enough to go to the hospital. She then asked Sarah if she was in *niddah*[15], Rachel Leah did not think so but wanted to ask Sarah to make sure. Sarah informed her she was not in *niddah*, there was no blood, and her mucus plug was still intact. Rachel Leah was happy to hear this. A brief time later her husband arrived back home. Sarah told both that it would be best if Rachel Leah could sleep until she was farther along. Rachel Leah was a little nervous about this and was unsure if she would be able to sleep. Sarah assured her that she and I would be right outside the room if anything was to progress. Sarah and I then proceeded to sit on the couch trying to rest. At around six in the morning, Rachel Leah came back outside her room and asked Sarah if she could check to see if she had dilated more. She had not. Sarah told her she should try and get more sleep and that she and I would be going now but would immediately return if she were to progress. Sarah felt comfortable leaving as Rachel Leah was not yet in active labor. Active labor begins at 6 centimeters of dilation (Mayo Clinic 2022). This is around the time when healthcare facilities advise going to a hospital (Mayo Clinic 2022).

We returned to Sarah's home, and I went back to sleep. At around 8:30 in the morning, I was awoken by Sarah and was told she had called me a taxi that would take me to a hospital as Rachel Leah had progressed and was already admitted. She could not come as she was no longer on duty, but another midwife was on call. I arrived at the hospital nervous as I had never interacted with Rachel Leah by myself, and I was only a student doula. Before I was granted

[15] Translated to separated. A halacha practiced by married women. Each month when menstruation starts a husband-and-wife sperate physically. After she is finished bleeding the women wait another seven days and then she must immerse herself in a ritual bath and say a blessing. After this, she and her husband are enthusiastically encouraged to reconnect.

access I went through security and they asked my purpose, I told them I was a student doula and I was there to help Rachel Leah, they wished me luck.

I walked into Rachel Leah's room, and she was surprised to see me. She told me she was excited to have a doula as she had never had one before. I told her I was excited to be part of her birthing experience. She asked me what I could do to help her with her contractions, and I told her about several types of massages, breathing techniques, and counter pressures I had learned. During one of her contractions, I asked if I could apply counter pressure and she agreed. The counter pressure I applied involved me applying one hand on each of her hips and asserting pressure. She sighed in relief and told me how much better she felt when I did that. This form of counter pressure can help with back labor.[16]

Rachel Leah began her labor in a dress that covered her from her collar bone to her toes, including wearing full stockings. Eventually she took her stockings off when her mucus plug came out, which is "a thick piece of mucus that blocks the opening of your cervix during pregnancy" (Cleveland Clinic 2021). Before labor, the plug must come out, which is an especially important point in time because many rabbinical scholars believe that this is when *niddah* begins, a *halacha* that will be discussed later in this chapter. Now Rachel Leah took off her stockings completely, however some women choose to wear thigh high stockings keeping their legs covered during labor. Eventually, Rachel Leah's labor stalled, and the contractions

[16] Back labor "refers to the intense lower back pain that many women have during labor and delivery" (ACOG 2020).

became very painful; she was in pain but with no progress. In the end, however, she could not handle the contractions and chose to receive an epidural.[17]

Choosing an epidural anesthesia can be complicated for women who are *tznuis*, as many hospitals have a policy that requires patients to wear a hospital gown (Cedars Sinai 2024). These gowns are open in the back for easy access to the epidural injection site. I thought this was going to be an issue because Rachel Leah would not be able to follow *halacha*, however I was wrong. When Rachel Leah decided she wanted an epidural, before she could utter a word the nurse told her "Don't worry, I am going to get you an extra gown with sleeves." I thought this was a very beautiful moment, the nurse knew what this woman required and before she even had to request it the nurse anticipated her patients' needs to make her as comfortable as possible. When the nurse brought Rachel Leah the extra gown, I noticed it was not a patient gown but rather one of the gowns the doctor wears. The doctor's gown is unique because it comes with a high collar and long sleeves, making it ideal for a patient that wants to be *tznuis*. When the nurse came back with the clothing, she and I started to carefully change Rachel Leah into the mandatory gown, but to do it we needed to lift her own dress off her body. During this complicated maneuver, her *tichel* almost came lose, but she asked us to stop midway so she could adjust it before we could see her hair.

Later when writing my field notes, I thought about this interaction because I was struck by how very important it was for Rachel Leah to keep her hair covered, a part of the body that Judaism sees as very private, but she had no issues when the nurse and I where undressing her, or even when the time came to push, during which the nurse and I saw the most intimate part of a

[17] An epidural is a procedure that involves "the most common type of anesthetic used for pain relief during labor" (ASA 2024).

person. The dichotomy of that moment spoke to me greatly, between someone's head hair, which is visible every day around the world and a body part that most people would not think twice about seeing, and someone's vagina which is almost universally covered while in public. This speaks to what the rebbetzin Chaya discussed: Rachel Leah tried to be as modest as she could within the limited options she had. She knew that we would need to assist with delivering her baby and she could not be *tznuis* in that regard, but she took control of the situation where she could and made sure her hair was covered, practicing the *halacha* of *tznuis* in the best way she could manage.

I was privileged to witness the interaction between Rachel Leah taking control of her religious needs, but also the nurse understanding what Rachel Leah needed in that moment and providing all she could to assist her patient. It was a powerful moment to see cultural competency and cultural sensitivity in action in a healthcare setting (Kleinman and Benson 2006, Scrimshaw and Lane 2018). Rachel Leah was able to practice being tznuis and she was also able to practice other *halacha*. The *halacha* of *niddah*.

Blood and Spiritual Status

My findings revealed that a major influence on reproductive practices in Judaism is the *halacha* of *niddah*. *Niddah* was the most spoken about subject in all my interviews, it was the topic every midwife spoke extensively about, and the rebbetzins told me about the laws of it. Before I explain exactly what *niddah* is, or what the midwives had to say, it is extremely important to note that the word *niddah* is often translated incorrectly into "impure," and so often in fact this inaccurate translation is often used in the literature I reviewed for this thesis.

Throughout my life whenever someone spoke of *niddah*, be it teachers, mothers, friends, and many rabbis, they used the word "impure." I was unaware of the actual translation until I began the journey of researching it for this thesis. In Kasstan's research he engages with the word *niddah*, also explaining its direct translation as "separated" (150). He further states that the word does not mean impure, but when a woman is in *niddah* she is in the spiritual status of being impure. The belief by many that a woman is impure during this time can be offensive, and a great many women disagree with this notion (Nahary and Hartman 2020: 438).

According to Rabbi Miriam Berkowitz's analysis of *niddah* (2006) and approved by the Committee on Jewish Law and Standards, the direct translation of *niddah* is, "separated or put aside." *Niddah* is a mitzvah that a woman begins practicing after she gets married. *Niddah* means that a married woman and her husband may not physically touch during a specific period of time. Three forms of *niddah* exist which differ only in length of the separation: (1) the first time a woman engages in intercourse, for Hasidic women, typically on the night of marriage, (2) during menstruation and for seven days afterwards, and (3) during some aspects of pregnancy (Feldman 1992).

Specifically, a woman enters the state of *niddah* for seven days after she begins bleedings from her uterus, during which she and her husband may not touch, at all (Noble et. Al 2009). This includes sexual intercourse, sleeping in the same bed, or even passing objects to each other such, for example, during meals or other everyday activities (Weisberg and Kern 2009). After seven days have passed with no bleeding, the woman must then immerse herself that night into a

ritual bath, known as a *mikvah* (Circurel 2000).[18] To enter a *mikvah* a women must take off everything that is not a part of her body, this includes, makeup, jewelry, nail polish, and piercings. She must then wash herself completely from head to toe, including brushing her teeth, and cleaning underneath the nails. When she is ready, she will put on a robe and call for a *mikvah* attendant, who will lead her to the *mikvah.* A *mikvah* attendant is a woman who observes the dipping process to make sure the woman is fully underneath the water (Rosenbach, Salamon, and Levine 2021). The attendant turns around facing the wall, as to give the woman privacy as the woman submerges. When the woman is underwater, she checks to make sure every last hair is submerged. If the woman is submerged correctly, the attendant can leave and the woman can have time by herself to reflect, or talk to G-d, or whatever she needs to do. It is a holy and deeply reflective time for Jewish women. The importance of this ritual as crucial in the mitzvah of *niddah* is reflected in the fact that *mikvahs* were allowed to remain open during the COVID-19 pandemic they were considered an essential service by the United States and Israeli governments (Green 2020). It is practiced by so many religious women that if it were to close all these women would not be able to touch their husbands.

From an emic perspective of the Jewish laws, the *halacha* of *niddah* is done for both the woman's sake and for the sake of marriage. It is not just about not touching physically, there is an emotional aspect to it as well, "It encourages human beings to infuse a potentially animalistic drive with personality, moderation, restraint, respect, and holiness" (Berkowitz 2006:1). There is

[18] There are numerous *mikvahs* (ritual baths) around the world and one can be located using the Worldwide Mikvah Directory (https://www.mikvah.org/directory/directory.asp?show_country=FL&temp=2) or other websites or word of mouth information. Men typically use the *mikvah* before Shabbas, and certain other holidays, as well as their wedding day. Women use the *mikvah* before their wedding day, and monthly at the end of *niddah*. There are approximately five *mikvahs* in Monsey, NY, where I conducted part of my fieldwork, and two *mikvahs* in Orlando, FL. See for example: https://www.chabadorlando.org/templates/articlecco_cdo/aid/265346/jewish/Mikvah.htm

a belief in Judaism that the soul consists of many parts, one of those being the animalistic drive. Rabbi Israel Lipkin Salanter describes the animal part of the soul as the drive that makes people go after whatever they want without any thought or ethical considerations (Claussen 2011, 208). By practicing *niddah*, a couple can tame that piece of the soul through reflection on their wants and the consideration of other people's emotions, not just one's own. *Niddah* strengthens the relationship between the husband and wife, G-d and the couple, and G-d and an individual person (Berkowitz 2006). Some people believe that it can be hard to stay in a relationship with the same person for many years, as it can become predictable. I spoke to different teachers throughout my life that talked about losing a spark or excitement, but rebbetzin Batsheva said *niddah* is

> To learn to appreciate the wife and not to take her for granted. Keeping the laws of *niddah* really helps to keep the excitement in the marriage because there's always a renewal. You know when you pull back, you appreciate more what you have. So, if they're, you know, if you just have something, you take it for granted. You don't appreciate. So that's one thing. We do it because Hashem [G-d] said so that's the best thing for us... So, it really it, it forces them [husbands] to also look at their wives as people, not just as objects, it really helps develop communication skills because you must use your communication, you know your verbal communication and not just physical. Keeping to these laws really changes the nature of the relationship.

As Batsheva argues, the mitzvah of *niddah* is about taking a relationship beyond the physical aspects of it. It is about learning how to become a better communicator. This does not just mean with their spouse; these communication skills can be used in other ways, and with other people. Batsheva's explanation also implies that *niddah* teaches patience. Sometimes people want something immediately, and if it is always given without a second thought, it can become mundane. By having an actual break where people cannot come together, there is a realization about how much more special that physical desire is. Indeed, rebbetzin Batsheva's claim is validated by research studies which find that the longer a heterosexual couple is together, the less

physical intimacy and sexual satisfaction they have (e.g., Schmiedeberg and Schröder 2014, Sims and Meana 2010). Since the length of a relationship and the act of physical intimacy and desire are inversely related, having a physical break may help bring more intimacy into long term relationships.

Intimacy goes beyond sex. When couples are unable to pass things between one another, it forces awareness to little parts of life that may not be appreciated. The brush of a hand when one person passes an object to the other. It develops the mind's awareness about doing actual tasks, instead of handing something off without even thinking about it. Now the mind is conscious of the act, it breaks from the norm as now a person must pick the object up, place it down on the table and so on; by performing a different action it causes the mind to be more present and to acknowledge the moment, instead of doing things without thought. However, practicing *niddah* can appear to be easier than it is to do, especially when it comes to labor and birth.

My research revealed conflicting perspectives about when *niddah* starts during labor, however both rebbetzins agreed that a woman enters *niddah* when her mucus plug comes out. Rebbetzin Chaya described it "You know, the baby's going to come out and everything changes at that point. She's in the same kind of situation as a woman who's menstruating for the same type of thing with uterine bleeding, and it's just the contractions that everything concerning active labor, which makes her what's called *niddah* which is a spiritual status, it's not like a physical status."

When a woman enters *niddah* during labor, this is where things can get complicated because the same laws apply as above. The couple can no longer be physical. Having a midwife

or provider who is aware of *niddah*, and understands its rules, can make for a more prepared birthing experience and, the provider can better support the women physically. Rebbetzin Chaya was fortunate enough to have a provider that was a religious Jewish woman who understood what Chaya needed, and helped her with practicing the laws correctly, "When I used to have my babies, my doctor would say, OK, give one last hug. Your doctor is about to break your water, the Pitocin will kick in and you'll have a heavy contraction. So, give me one last hug. She was, you know, she was a religious woman and knew what was to come."

It is beautiful that Chaya was able to work with a religious healthcare provider (or one who understands religious requirements) for her labors, but not all women have that option. By midwives understanding some of the rules they can mentally prepare their patients, warning them about one last touch for the next few weeks or even months. The midwives I interviewed for this study had significant knowledge on the subject even though many of them do not practice these *halachas* themselves. I asked Ava about her experience regarding her patients entering the spiritual status of *niddah*,

> There is no one answer. There are people who are very strict and say as soon as the water breaks, which could be at the end or as soon as there's some red bloody mucus, and others might say, well, water breaking is later. Some say when she [the pregnant woman] can't walk anymore, you know, one little bit of blood. And some, like I said, some people just see a little bit of blood in mucus and consider that that's it. And they would prefer you not tell them if you see bloody mucus. But the truth is the bloody mucus is coming from the cervix, [it] is not really coming from inside the uterus. It's a plug and it's really more like the cervix and the cervix dilates... In terms of, it's just so, *but everybody has different opinions. It's not one opinion. [*emphasis mine]

As Ava notes, some women prefer to not be told if they have a little bit of blood. This may be because they want to be able to physically engage with their husbands as much as they can before they must stop touching for weeks or even months. These women are making the choice

to not know, because although they follow the *halacha* it is still hard to do so, and they do not want the physical support from their husbands to stop until the last moment.

This act of not telling a woman if she has blood coming from her vagina was not unique to Ava; I discussed this question with another midwife who said that after an internal examination she will turn the glove inside out before her patients can see if there was blood on it. That way the patient does not need to know if they had blood or not, and the midwife does not know either, so she does not feel morally obligated to tell the woman if there was blood. She could not see the glove and the patient could not see it, so the woman goes home and continues to touch her husband without worry.

The attitude that embraces not knowing if there is blood does not just apply to birth and gynecological procedures but is typical. When I was speaking to Batsheva, I asked her about a rumor I heard regarding Hasidic women wearing specific colored underwear.

> It is good to wear black after the *mikvah*. It is good to wear black until like not in the *niddah* times. So, if there's any spotting you don't have to see it. Because if there's any bleeding, like just random bleeding it could just be a spot that is nothing. Then you see the spot in your underwear and it's like "Oh my gosh!" But if you're not even suspecting that anything's going to happen, then just wear all dark underwear, and then you don't have a problem.

Batsheva's quote shows that Hasidic women want to remain physically close with their husbands. They want to be able to follow *halacha* but also be able to engage with casual touch and physical intimacy. They understand the importance of following the laws, but they also understand that sometimes things occur in the body, and we do not know why, and if a little drop of blood happens for no reason it is better to not know. They are not dismissing the laws by wearing black underwear but instead are accounting on plausible deniability. The rebbetzin and I discussed this, and she even said a great wedding gift for the bride is "14 black [underwear], and

7 white." A woman not wanting to know about uterine bleeding appears to be a pretty common occurrence.

"...but everyone has different opinions. It's not one opinion."

My research found that the Hasidic community takes a more cautious approach when there is ambiguity among laws. As Ava explains, if one believes that *niddah* starts from the moment the water breaks then that could be much farther down the line and could occur even during the pushing phase. Thus, every expert has their own opinion on when *niddah* begins, which makes it particularly complicated for healthcare providers because it is important for secular and religious midwives to be aware of each of their patient's specific cultural practices. Or if the midwives are Jewish, to be aware that different sections of Judaism follow the laws differently. Having a culturally competent and sensitive midwife often does rectify the very real, and very hard challenges that go with practicing *niddah* correctly.

One of the women that I spoke to during my participant observation fieldwork shared with me the story of her stillbirth. She gave birth to her stillborn baby in the beginning of her third trimester of gestation. As she went into premature labor she had a mucus plug, and water breaking, and contractions – all the qualifiers that put a woman into the status of *niddah*. She recounted that "...it was a very, very tough, tough time and it wasn't easy that during that time I couldn't like even to get a hug from my husband." It is in a moment like this that it becomes extremely difficult to not seek physical comfort from a spouse or partner. There is the mindset in this cultural context that someone's needs still have to stay within the laws of *niddah,* and the

woman spoke about the way someone needs to think to have the strength to go on with *niddah* in tough times,

> This might be an annoying answer to you. But part of religion is a little bit blind faith, you know, it's a little bit G-d has a reason for this. We don't always understand. We're you know its finite beings. We don't understand the makings of the world and why G-d gave us certain laws or certain things [that] would be good for us as we don't see as good or pleasurable, you know, or enjoyable, or that so choose for ourselves, but part of religion is kind of going along. So, you know there are two options here. You say forget the whole thing, which I would try not to do. Or you know when you say this is what's happening in my life right now and I must go along with it and you know the hub [husband] will wait.

As this woman said, the strength is about faith: these women chose to practice *niddah*, because they believe that it is what G-d has told them is the right thing for them. They not only believe that they should practice *niddah*, but they are also physically capable of doing it because there are midwives that help them fulfil this requirement through culturally specific care. A provider who is not just informed about the laws but knows how to best assist her patients is necessary, because the patient might need a provider to take a more active role than they normally would for their secular patients who do not have the same needs (Kasstan 2019, 150-151).

It is important to note that there is nothing more important than life in Judaism. *Pikuach nefesh* translates to saving a soul, this is a precedent that any rule in Judaism can be broken to save a life, including a major and important one like *niddah* (Kasstan 2019, 96). As Ava explained, there are times in labor where the situation can get dangerous, everyone needs to start moving faster to save mom or baby's life. She shared with me an experience about one of those times,

> We need her to get out of the tub, if the person is in the tub just gave birth and there's too much bleeding, we need to get her out and we're taking the baby and we're trying to and we're trying to get them out and some of these men will be like, no, I'll move her cause they know *halachally* of course, she needs to be moved out of the tub. And who's the

> strongest? He is right? So, they grabbed and moved around the tub. I can't believe it, but that's the whole thing is if you need, if we need them, they have to do it. You know? *It's like not a question.* [emphasis mine]

Having a culturally informed midwife in this situation makes for a quicker response to an emergency. Hypothetically, if there is a healthcare provider who is unaware of the practices surrounding *niddah* or Judaism, but they have had Hasidic patients so they know the process to some degree that the husband will not touch his wife. But if the provider does not know about *pikuach nefesh*, this could mean that in an emergency situation such as a mom needing to be lifted out of a tub, they may waste important time calling for someone other than the husband that can help lift the woman, instead of knowing that her husband will already be there grabbing her out of the water before the provider can even make the call. Therefore, having a certain depth of knowledge about ritual practices makes not only a more efficient healthcare setting but can even lead to safer outcomes.

In this chapter I focused on the rules and regulations of reproduction in the Hasidic cultural and religious context, from the beginning of conception with birth control, to the end with the product of conception, labor. I will conclude this chapter with a quote from the midwife Chloe. Chloe has worked with different cultures and communities all over the United States and the world. She has been practicing midwifery for almost 40 years and has been teaching natural and gentle birth for around that same time as well. Chloe's experience with so many different cultures and religions I believe gives her a unique viewpoint and helps to summarizes why there are so many laws surrounding birth in Judaism: "The laws were put there to elevate women's status because we cocreate with G-d... they were doing what only G-d could do." In the next chapter, I will focus not on laws but on *customs*, what people are choosing to do not because they have to but because they want to.

CHAPTER FOUR:

THERE IS POWER IN WORDS

My data show that midwives believe the power of prayer has miraculous capabilities, and they recounted how they witnessed the power of prayer when caring for their patients because their patients were comfortable enough to ask them to pray with them or to be in the room while they prayed. This was a possibility for these Hasidic women because they knew their midwives had an understanding about their patients.

Prayer can be performed in many formal ways, such as being in a shul,[19] church, or mosque. There is unstructured prayer, asking G-d or the universe for something, just a person and their belief in and communication with a higher power. In Judaism, both types of praying are important. Rebbetzin Batsheva explained that men are obligated to pray three times a day in a structured setting and women are obligated to pray in a way they see fit: it can be structured, or it can be just talking to G-d, there are no specific guidelines for them, "Women are obligated to daven, it doesn't say specifically which time of day, but to say something."

Kasstan in his ethnographic study with Haredi Jews in Manchester showed that in addition to praying three times a day, men are obligated to pray for good birth outcomes: "Reciting tefillot and davening for the wellbeing of the fetus and a 'smooth' birth is viewed as an essential act of pregnancy and labour for both frum men and women" (Kasstan 2019, 155).[13] The midwives in my study also spoke about how men are supposed to say certain *tehillim*,[14] psalms, while their wife is in labor. Scarlet noted the husbands have to say a few different prayers, "There are special prayers that are supposed to be said by the husbands and then they would also

[19] Shul is a Yiddish word for synagogue.

say *tehillim*." Chloe expanded on this and explained that it is "his job to recite 10 different psalms." Men are not the only people that are praying in the labor suite; many women also chose to pray to G-d during labor, although it is not necessarily done formally with a book of *tehillim* or a prayer book. Chloe shared a story from one of her experiences with a patient that not only exposed this midwife to her tradition of praying while in labor, but also taught her a meaningful lesson,

> Somebody can come out with a string of expletives in the middle of psalm 27, you know? There is music going on, scripture being read, and somebody is davening. Human nature is human nature. We can make birth gentler and kinder. In a religious community or a non-religious community. And what I've learned the most is just to respect, to respect somebody's core principles, to respect someone's ideals.

In Chloe's experience, her patient was not using a prayer book, but she was saying a prayer that she was familiar with, and it comforted her in her time of need. What Chloe's experience really shows is the power of understanding and respect. Chloe does not need to believe in the same religion as her patient; all she is required to do is have respect for her patient. Chloe understood her patients' wishes in her time of need and did her best to accommodate them. Chloe's Hasidic patients inspired her to use the skills she learned from them with her non-Jewish patients as well, who would sometimes ask her to pray with them, "When I'm asked to perform a blessing, and I've done it for hundreds of women, I always quote scripture, I always invoke the presence." These women seek comfort from her in their time of need and she helps comfort them in a way she has learned from her other patients.

Furthermore, Chloe goes beyond prayer; she has participated in baby showers and celebrations. At these parties she brings a tradition that she learned in Israel,

> And one of the practices comes from Israel, and that is to tie a red string. And what I'll do is I'll take a spool of thread and we'll tie it around. We'll loop it around the mother and

> then go to the next person and loop it and then go to the next person and loop it, go to the next person, loop it and then everybody's connected. The people who are there are required then to be godmothers of not only the baby, but of this woman. So they're required to pray for her.

Chloe's exposure to her Hasidic patients shaped the way she practiced midwifery with other patients because her Hasidic patients required a midwife who understood their life and was willing to help them in ways that midwives are not necessarily taught in their school training. It is important for healthcare providers to not only "tolerate" other cultures, but to embrace and learn from these differences with humility, and ideally work either in a given community or with them in their own practices.

Understanding other cultures' needs may not only influence the way a healthcare provider helps their other patients, but it can also help deliver a more favorable outcome for patients, as recounted by one of the midwives, Luna. Luna practiced midwifery for over 35 years in New York, and 20 of those years she worked with Hasidic women. Although not Hasidic herself, many of her family members are. However, she did not seek to work with the Hasidic community; they sought Luna out. Luna was working outside of a big Hasidic town in New York. Her patients started to come to her because she was not working with many Hasidic patients, and they wanted the anonymity of working with a provider who did not treat anyone they knew. Eventually Luna's patients became majority Hasidic, and she moved her practice into town to be closer to her patients. She recalled to me one of her experiences that demonstrated the power of prayer working with the Hasidic community,

> I had a patient she wasn't delivering. She was in labor for 30 hours. She progressed slowly, and then she sorts of stopped. I was suspicious that this baby wasn't going to come through. It was not going to fit. And I offered them a C-section at one point, and they said no. And I said, fair enough. I'm willing to wait. I have, you know, some concerns and I said I'm going to get another opinion. I called in another midwife. I said, "What do you think?" She examines. She pulls me and goes: This lady's not going to

> deliver. This is a midwife that I trust had, you know, just as many or maybe even more years of experience than I had. I'm like, that's kind of what I thought. And then I called in one of my backup docs who happened to come by, and I said, can you check this patient for me? It was a couple hours later now because I wouldn't be constantly messing with this poor lady. And I said, what do you think? And she examines her, she comes out and she says to me there's no way this baby's coming out vaginally. And I said, but [she] just wants the gift of time. And she [the doctor] said, "I don't care, if the fetus is happy and healthy, in there she can have as much time as she wants. And I said precisely, I feel the same way.
>
> Eventually, something's going to happen. The fetus is going to declare him or herself. And say, the heartbeat is going to go down and then it's going to be an emergency. And I explained all that to them. That never happened. The fetus behaved. And he [the patient's husband] said to me, he was on the phone like for an hour, and he comes back into the room, and he says: We need some time alone.
>
> OK, I'm not going to be watching you, just the baby's monitor, OK? I said let me put an automatic blood pressure cuff on. I said, is it OK if I'm on the other side of the curtain? And he said that's fine. So, for a few minutes I stood on the other side of the curtain. And I got to say, he was close enough to her to almost touch her and he davened over her like this for half an hour. Shouting at her davening. And she was talking back every so often, you know whatever she was saying. And he said to me, "We need another hour. I've talked to several ravs [rabbis]. I've talked to my mother-in-law, and my mother, and I'm davening, and I've done everything I can. And if all that I'm doing with this, doesn't work then we're going to consent to a c-section." I said, fair enough. Your fetus is very well behaved. Your wife is very sweet. You're very much in love with her. I've been praying she progresses as well.
>
> So, I asked one of the nurses to come in because I didn't want to break the bad news to them. With me being alone, I wanted somebody there. I check her. And she's ready to deliver! So, you know, people can say oh, such a coincidence. I don't know. I just know what I saw, and I know what I felt, and I know what the other two very experienced providers felt. We were all shocked. *And after that, nobody could convince me that that prayer didn't do something* (emphasis added).

Luna's experience with this Hasidic patient shows why it is imperative to have health care providers that are knowledgeable and understanding. There are healthcare providers that would not have let Luna's patient wait all day for labor to progress on her own. Many providers insist that if labor does not progress by a certain time, the patient should be induced (Simonds 2002). There are providers who would not have left the mother and father to pray for hours to try and change the outcome, instead they would have likely been pressured into different interventions to

force progress in their labor, and if those techniques fail, eventually patients will be pushed to have a c-section (Reyes-Foster 2022, Simonds 2002). This would not have been an ideal outcome, as Chloe explained, Hasidic women try to avoid c-sections when they can, “The caesarean birth rate is so low in the Orthodox community because of the thought that once you have one caesarean you have to keep repeating it, and with every repeat caesarean you double the chances that that women is going to die.” Many studies have been done that substantiate Chloe’s reasoning. Women are more likely to experience life threating complications with each subsequent cesarean (Niino 2011; Nisenblat 2006; Zwergel and von Kaisenberg 2019). As a result of this danger Hasidic women try to avoid cesarean sections, as typically they want to have a large family (Kasstan 2019, 166).

My finding regarding prayer in the delivery room shows why it is crucial for healthcare workers, regardless of their own religiosity, to understand their patients and work with them to best suit their needs. My data show that cultural competency and humility can influence patients' lives in a real and important way. Having a culturally competent provider gives the patient the ability to practice how they see fit, including delaying an unnecessary surgery that can limit someone's ability to have more children in later years. Having an understanding provider that a patient trusts makes for an overall better patient experience (Moryossef and Or Chen 2021). My data also show that the midwives’ role is not just about respecting praying in the delivery room, but about helping advocate for the patients' wants and needs.

~~*Congratulations,*~~ *Words Not to Say and Other Superstitions in Judaism*

A finding that arose from my interviews, after discussing prayer, was how reproductive decisions can be influenced by Jewish superstition. When I asked rebbetzin Batsheva about superstition she did not agree with that term, "I feel like superstition has like a negative connotation. There are things that our people are careful about and are a lot more vigilant about." Specifically, in this rebbetzin's section of Hasidism they believe that while they are pregnant everything, they look at influences their baby, "women that are pregnant are very careful not to look at anything that's impure. So, you're a lot more careful in what you look at, for example, non-kosher animals, so were very careful to not go to the zoo when you're pregnant because there's a lot of non-kosher animals."[20] Although the rebbetzin prefers a different term, many of the midwives said they witnessed a few acts that they labeled as superstitious.

Another midwife, Jessie, elaborated on superstition during the interview. Jessie has been practicing midwifery for over two years. Around 50 percent of her patients are Hasidic and 50 percent secular. She is a Jewish midwife although not Hasidic herself. Her Judaism helped navigate her towards learning midwifery; she felt as though she could help women give birth even though she struggled with having children herself. She chose midwifery because she said she had a belief that perhaps G-d wanted her to deliver babies instead of birthing them. Although Jessie did not seek out to work with Hasidic women, her practice is remarkably close to an area where a lot of Hasidic families live, and as a result she has many Hasidic patients. When we

[20] Non-kosher animals include pigs, rabbits, squirrels, bears, dogs, cats, camels, horses, and other animals. See: https://www.chabad.org/library/article_cdo/aid/133726/jewish/Which-Animals-Are-Kosher.htm#:~:text=Examples%20of%20kosher%20animals%20include,%2C%20cats%2C%20camels%20and%20horses.

broached the topic of superstition, she mentioned *segulot,* which is a form of protection. A *segulot* can be a physical item such as a prayer book or it can be a ritual that an individual performs. In Jessie's experience, she had patients who would wear necklaces with red rubies to prevent miscarriage.

She was not the only midwife who had patients bring with them or wear some item of protection. Many of the midwives brought a *safer,* prayer book, with them, not to read from but to put under either their pillows while in labor or to put under the babies after they were born. Scarlet witnessed patients bring red strings to tie around the baby's wrist after they were born,

> Scarlet: As soon as the baby was born, they would put what's called a red *bendel*, which is basically a red string on the baby or in the baby's crib. They would put something under the mattress to protect the baby.
>
> Haley: Protect the baby from what?
>
> Scarlet: From evil spirits.

Observing patients bring in tokens of protection or participate in certain religious rituals, which requires an understanding healthcare provider. These midwives were conscious of these women's beliefs and made it a safe environment for them to practice what they believed they needed to do to keep their babies safe. A safe environment is crucial to a safe delivery: when a woman feels comfortable and secure this can help produce oxytocin, the chemical that contracts the uterus and is also believed to be a pain reliever (Uvnas Moberg 2003; Westbury 2015, 1).

My findings show that it is not only important for midwives to make a safe and calming environment for their patients, but it is important for them to be aware of certain words and phrases that are used. One of the midwives, Ava, described how people are not supposed to wish pregnant women *mazel tov,* congratulations, until after they have delivered the placenta, "Really, you're not supposed to say m*azel tov* when the baby's born until after the placenta comes.

Because things are still not done, the birth is not done. There's still another stage you know, and like there's a lot of, you know, safety concerns until the placenta comes out. So really not supposed to say *mazel tov*." This tradition comes from the idea that people are not supposed to congratulate someone on something that has not happened yet (Kasstan 2019, 156-157). In Judaism there is an understanding that pregnancy can bring extreme happiness, but there is also an understanding that pregnancy can bring sadness (Falk, Judson, and Rapp 2004). To avoid wishing a congratulations on something that might become sad later Jewish people will say *Bsha-ah tovah* which translates to "in a good hour" (Falk, Judson, and Rapp 2004, 2). The phrase is supposed to imply that the things that will happen, will happen when they are meant to.

I was fortunate enough to see a comparable situation during my participant observation fieldwork. When I shadowed a midwife in a midwifery clinic in New York for four days, numerous women came in for care, from never pregnant to women in menopause with many children, and every stage in between. One of the midwives that worked in the clinic, Sarah, was a Hasidic midwife, although before Sarah became a midwife, she was a community doula. She was inspired by her own births, which were very calm, and decided that she wanted to help other women have gentle births as well. Eventually, she wanted more responsibility involving the delivery and chose to go into the field of midwifery. From starting her work as a doula and later a practicing midwife, she has always worked with most Hasidic patients. When I was doing my fieldwork in the clinic, I noticed that Sarah would add a phrase after she asked how many live kids a women had, and would say *keinehora,* no evil eye (Yiddish Book Center 2015). It is said after a happy thing such as someone living a long life, or how many live children a person has, it is meant to ward off the evil eye, so that a person can keep living a long life, or that someone's children all stay alive and live long and healthy lives (Bunin Benor 2007).

Sarah was not obligated to say this, it is not a law in Judaism that someone must utter the phrase after good news, but she did it anyway because, as she said, she knew that it made her patients feel safer. I witnessed this interaction many times. Sarah would ask for the number of children, the women would say the number, and then Sarah responded with *keinehora.* I could see the women visually relax after she said the word, and it became apparent that hearing it made the women feel better. Observing the situation as a researcher and outsider, there did not appear to be anything particularly scary about the situation, and the question about the number of live births is routine and asked all women patients in an women's healthcare office, it is important information for a provider to know. But seeing the physical relief expressed by these women upon hearing Sarah's reply was enlightening and expanded my understanding of how perceived safety or danger might be experienced. It became clear to me that Sarah made the office feel like a safer place for these women.

Keinehora is a word in the Yiddish language, and it is important for providers to familiarize themselves with relevant words and phrases that are used in the communities they work with. Language constantly changes as society changes, and part of language is code switching. When people take the time to learn about other people's culture, they help shape a more inclusive environment. Arguably, Sarah was using code switching by changing her speech to match her patients to better relate or connect with them (McCluney et al. 2019). This speech technique is common in everyday lives as people do it to bond with another person or to better fit into a group (McCluney et al. 2019). The use of *keinehora* by the midwives exemplifies code-switching since they understood that certain phrases like congratulations or questions may make their patients feel unsafe, or uncomfortable and to better put them at ease they used phrases and words that their patients knew and were familiar with. Furthermore, they did not need to

continue their education to learn how to code switch, they acquired this skill by working with the patients in their communities. Code switching is an attainable goal for other healthcare professionals to do for their patients as well as part of culturally specific care, it is not a skill that must be taught; it is a concept that a provider needs to make a conscious effort to recognize the words and phrases that are said around them. This approach can better connect and assist their patients in their physical and emotional needs.

Jewish Folklore and Legends

Another part of Jewish superstition is *bubbe meises*, old wives tales. In my participant observation and talking with Jewish people in the communities there were a few old wives tales that continuously came into conversation; the most mentioned one was regarding how a boy or girl was conceived. There is a belief that when a husband and wife are having sex, if the husband has an orgasm first, then the baby will be a girl, and if the wife orgasms first then the baby will be a boy. This idea comes from the belief that the sex of the baby was decided in the exact moment of conception, and one should not pray for either a girl or boy because it has already been decided by G-d in that moment. There is a belief in Judaism that one should not pray to have something changed if it has already been decided, such as the baby's sex (Falk, Judson, and Rapp 2004).

Many of the findings I have discussed in this chapter are not laws or *halacha*, instead they are *minhags* or traditions. Women are not obligated to pray during labor instead they chose to. It is not forbidden to say congratulations to a pregnant woman, it is just not done because these are ideas and traditions that many Jewish people have been taught from generation to

generation and these become practices people choose to practice themselves. An example of one of the *minhags* in Judaism came up during my interview with Chloe. She recounts how she helped facilitate it,

> Let me tell you about something from the Babylonian Talmud, about childbirth practice. The father is supposed to take the placenta and bury it. If it's a boy, plant a cedar, and if it's a girl plant a cypress, and tend to the tree throughout their childhood. And when they become betrothed, the father is charged with cutting down the tree and making two poles for the *chupa* So, the father of the bride makes two poles, and the father of the groom makes two poles. Babylonian Talmud, 300 BCE. So, I've had quite a few Jewish couples that have followed that, and I've kept their placentas in the freezer until they bought a house.

The *minhag* Chloe helped facilitate is not a law, it is a story that comes from the Talmud regarding what a husband and wife should use when they build the canopy-like structure (*chupa*) that their children will stand under when they get married. Chloe learned about this story and helped her patients achieve their dream of fulfilling this *minhag*. Her patients trusted her not only with their cultural traditions, but they asked her to help them achieve them by storing their child's placenta. This is a serious request from a healthcare provider. It is uncommon for a patient to ask this of their midwives, and many would not feel as comfortable as Chloe to accommodate the patient this way. What Chloe did went beyond cultural competency. Chloe chooses to further her involvement with her patients by participating in this *minhag.* Being understanding and helping one's patients need not extend this far, making this example especially moving.

Having compassion for patient's culture, even if the patient believes in practices the midwives do not understand, is an achievable task. Something as simple as learning how to code switch to help put patients at ease, not wishing someone congratulations because they know it will make them feel ill at ease, does not seem as though it is unattainable. Letting patients have moments to themselves so husband and wife can pray together and hopefully achieve a favorable

outcome is not a difficult request to grant. Furthermore, it is attainable for providers to have more patience for their patients to let them practice their culture in a way that is safe for everyone involved and not rushing procedures or surgeries because things are not moving on a satisfactory timeline. If the patient and baby are safe and healthy it is important for healthcare providers to have cultural patience and cultural understanding; a safe and comfortable environment makes for an overall better birthing experience. In the next chapter, I will focus on the midwives' firsthand experiences working in the Hasidic community, the challenges they have faced, how they navigated situations that were not taught in their training, and the different types of authority relevant in the midwifery practice in the Jewish community.

CHAPTER FIVE:

A MIDWIFE'S WISDOM HAS POSITIVE EFFECTS

My findings reveal that midwives possessing knowledge about how *halacha* and *minhags* are used in a healthcare setting has a positive impact on patient satisfaction. The midwives were knowledgeable about *niddah*, birth control, and prayer. Taking the time to educate themselves beyond the basics of what they learned in school can make patients comfortable, feel seen, and even understood (Moryossef, Or Chen 2021, 41). The evidence for this finding stem from the way the Hasidic people welcomed the midwives into their community. Many of the midwives cultivated trust with their patients, and that trust led to having patients that spanned generations and even produced interactions beyond the healthcare environment. In this chapter I will show how the midwives navigated the *halacha* and *minhag*, discussed above, not only in active birth, but also practicing basic gynecological healthcare inside the Hasidic community, and finally I will discuss how the midwives navigated rabbinic authority.

"All it requires is an education" - Chloe

As I delineated in the previous two chapters, working in the Hasidic community is decidedly different than working with the secular one, not only regarding traditions and practices, but also when it comes to knowledge. The midwife Luna explained the difference between speaking with first time secular patients and speaking with her first time Hasidic patients:

> They're very purposeful and they're very knowledgeable. I used to sit with these secular women at their first visits and you know, go through everything and they had no clue.

> And now it's like, [referring to her Hasidic patients] yeah, yeah, I know that you know. And I know that, you know, their sisters and their mothers, they've just seen it all around.

Hasidic women go to the midwives' practices with already a lot of gynecological information. For most of these women this information does not come from the Internet.[21] Instead, part of that information comes from learning about *niddah* from *kallah* classes, which focuses on menstruation and sex education.

Sex education looks different in the Hasidic world than it does in the secular one. Sex education is not taught to woman until they are engaged to be married. Of course they may speculate around sex, however it is not openly addressed until right before marriage (Taragin-Zeller and Kasstan 2020, 11). This discussion is typically done in a group class, although it can be done one-on-one, and it also may be formal or it can be a very relaxed environment, these factors depend on the rebbetzin or teacher that teaches it. Typically, a *kallah* class will discuss *niddah,* and "there are also an array of topics that may be covered from emotional to psychological and sexual education" (Taragin-Zeller and Kasstan 2020, 112). They also learn from their female family members such as sisters and mothers. Because of the love of having children and pregnancy as a proclamation of faith (Teman, Ivry, and Bernhardt 2010), the Hasidic women want to be prepared and knowledgeable. Mothers or *kallah* teachers often suggest that a bride should see a gynecologist before they are married (Taragin-Zeller and Kasstan 2020, 12), to ask any questions, seek advice, talk about birth control options, and make sure there are no health problems that need to be addressed. Ava found that "They're not

[21] Hasidic communities may not always be permitted to access the Internet for browsing purposes, therefore, seeking self-education about sexuality online, which is a common practice for other populations in the US (Reeves 2019), would not be common for Hasidic women.

necessarily on the Internet, but they know about it [reproduction] already because their babies is what they do. Their life is about their babies and families and all."

Having knowledge and education can work in both directions: the midwives learn about different cultures, such as Hasidism, and the patients learn all about reproduction, family planning, and sexuality. education. Each party taking the time to educate themselves makes for a symbiotic relationship – education goes both ways. This can be seen in little ways like Jackie saying *keinehora* or like Luna taking time to learn about the community, "I would sometimes inject a little Yiddish, or I would understand their community and their personal and family needs."

Healthcare providers are not obligated to learn about the people who live around one's workplace or who are one's majority patients, but it makes for a better overall health experience (McPherson, Headrick, and Moss 2001). In clinical practices with Hasidic patients, knowledge about sources of blood is of particular importance because it may imply that the patient is in *niddah*. Alice's education as a midwife gives her the knowledge to understand this, but by furthering her education to distinguish the exact source and kind of blood she makes for a better healthcare experience, "Sometimes I'll just say to them, listen, I didn't put my fingers inside the cervix. And it's not coming from the inside. You do a pap smear and there's a drop of blood from the brush and then they say, oh my God, I'm in *niddah* so there are times that I have to say to them no, you're not." Alice comforted her patient about not being in *niddah*, which would otherwise mean she could not touch her husband for seven days because of a little drop of blood.

In the Hasidic world, understanding *halacha* can have a major impact on the baby, such as the baby's birthdate, for example. In Judaism, every week there is a 25-hour period known as

Shabbos, where no technology can be used, no writing can be done, no cooking, and nothing should be created or destroyed (Nevins 2019; Sharon 2010). Sometimes a delivery date can be complicated if one needs to work around Shabbos by either giving birth before Shabbos or having the baby after the 25 hours have ended. This may happen to midwives caring for Hasidic women, and indeed it has happened to Ava.

Ava had a patient whose labor was exceedingly long, so they were considering breaking the water, "Because the person is in labor long, I guess it was getting close to that questionable time. We'd wait till that questionable time is over. So that it's more like, you know, let's say I'll wait another 20 minutes so that they know that their baby's birth can be not a Shabbos." A patient may want this delay facilitated for varied reasons, but particularly because no technology is allowed, it makes it difficult for the moms and family to stay in the hospital on Shabbos. Many doors in hospitals are electronic, so they cannot walk around them, and lights may need to be turned on and off, which is not permitted.[22] Also, delivering on Shabbos can be difficult because not everyone has a family that can stay at home if the couple has other kids. In these cases, the father must stay at home while the wife labors alone. There are different reasons for not wanting a baby to be born on Shabbos. Having a midwife who understands the complications that come with being a Hasidic Jewish person, and by establishing a connection they can help their women patients in an already stressful situation (Moryossef and Or Chen 2021).

[22] A religious person may work through an electric door after a secular person has walked through it beforehand. They also may not turn on lights, however if a secular person has turned it on this is permittable. However, a secular person must do this for themselves, a religious person is forbidden to ask for someone else to break Shabbos.

It is also important for midwives to know about *pikuach nefesh* because, as I discussed in Chapter 3[23], any Jewish law can be broken to save a life. In Judaism, labor is considered life threating, so this law applies here as well. If a woman goes into labor on a holiday or Shabbos, she is allowed to do anything she needs to for her and her baby to be safe. This includes more than just emergency situations.

During my fieldwork in the midwifery office in New York the midwives were discussing a question that one of the patients asked, "Can I call my doula on Shabbos, because having a doula is not necessarily a life and death situation?" The midwives' answer was an astounding yes. The *Shulchan Arukh*, the book of Jewish laws, says that "A woman giving birth is treated as a dangerously ill person and Shabbat is desecrated for everything that she needs" (Karo 1563). This includes calling a midwife, someone else lighting a candle for her, and anything else she needs (Karo 1563). It is especially important for a healthcare provider to know that laws can be broken to save a life and to assist women in labor.

Part of midwives' learning about the community is learning about not only patients' rituals but their mindset: understanding how patients think and operate. This can be valuable in calming them down when they are scared and/or upset. Ava understood this concept and can help patients that panic about routine things, as some patients continuously come back to the office with inquiries and concerns, even when they understand what is happening are normal occurrences: "I don't lecture them about religion, but I say, do you believe in G-d? You can't go around thinking everything can go wrong all the time. So, there's a balance." Ava understands

[23] This is discussed specifically in Chapter 3 under the subsection "but everyone has different opinions. Its not one opinion" in the section Blood and Spiritual Status.

that majority of her patients have faith in a higher power, she can calm her patients down, when warranted, by having an understanding of that balance, i.e., knowing when her patients need to be connected to a higher power and when they need to rely on her clinical knowledge (Moryossef and Or Chen 2021). Ava need not share a religion with her patient to help, although in this situation she does. She just needs to recognize the middle area between her patient's belief system and her authority which is vital in times of stress.

Although it is beautiful to be able to accommodate patients, sometimes it can be a struggle, or it simply cannot be achieved at all. There are occurrences when midwives treat patients who do not want to use modern technology. Luna has had situations where a patient did not want any testing, including an ultrasound:

> Luna's patient: I won't go through any testing. I'm going to accept what the Lord Hashem is going to provide for me.
>
> Luna: It got to a point where I put my foot down, I said if you want to be part of my practice then understand that we have these tools that Hashem gave us, right, we need in order to tell you or to help you if in case there's an issue or problem, [or] we're unsure about something later on in the pregnancy. If they didn't go along with that, I actually excused them from my practice. There's a comment that an OB/GYN once made to a patient in front of me, which I thought that nails it, she said: "I don't want to find out that you have placenta previa when you come in to deliver your baby, you've already bled out and you and the baby are dead." I know, harsh. But you know what? She's right.

It can be seen as severe for Luna and other midwives to not accept or dismiss patients because they have an all-encompassing belief "that G-d oversees the universe and humans are not in control of their fate" despite the fact that various prenatal testing or imaging may alleviate the uncertainties of pregnancy (Teman, Ivry, Bernhardt 2010, 72). This is a necessary situation where cultural accommodation can become tricky and must be navigated carefully or the

midwife cannot make any cultural accommodations. A question arises here: Is there a limit to how far a medical provider should go to be culturally accommodating? (Padela 2008).

The health and safety of these women and their babies is of the utmost importance. As Luna aptly explained, G-d gave modern humans the technology to see if there is something wrong with the pregnant woman or her developing fetus. This comment shows how the midwife understands what her patient needs in that moment and can provide it because she has gained the knowledge from working in the Hasidic community. Luna acknowledges the fact that her patient believes in a higher power, and she is taking the patients logic and using it in a different way to try and make the patient understand that if G-d did not want people to have the ability to check if something is wrong, then G-d would not have made it. This idea follows the concept in Judaism called *hishtadlut*, which means obligatory effort (Teman, Ivry, and Goren 2016).

Anthropologists Elly Teman, Tsipy Ivry, and Heela Goren explore the concept of applying effort to solve a situation, but also having faith in G-d. Navigating between having enough faith to understand that G-d has an all knowing plan, and also realizing that people are empowered to make an effort when it comes to their life is a fine line (271). A person must acknowledge that G-d has provided, and had made things happen, and to not take credit for G-d's work. However, at the same time, a person must actively make those things happen (271-272). *Hishtadlut* also applies to pregnancy in Judaism. A woman is obligated to seek prenatal care in order for her and her baby to have the safest outcome possible (277). Simultaneously she needs to acknowledge that the outcome is out of her hands, and G-d has an overarching plan for everyone. In these moments with her patients, the midwife tried to be accommodating by using similar logic to make her patient understand, but Luna also understood that if the women did not

listen to her educated position as a healthcare provider, she could not accept the patient for both the patient's and her baby's safety, but also for Lunas professional safety and security as well.

Ava experienced a similar situation where one of her patients rejected having an ultrasound because they did not want to know if there was anything wrong, the patient believed that if a problem was found then nothing could be done to change it. The midwife recounted:

> They feel that if you find out there's something really wrong with your baby, like a cardiac defect. You did the ultrasound, so now Hashem has sealed the fate of that baby. But if you don't do an ultrasound, you don't know if the baby has a cardiac defect and Hashem could change it at any time because hidden miracles happen. And I don't believe that. What can I tell you? I don't. But one of my patients said to me, "I don't want to do an ultrasound because I don't want to look for problems." And I said, "I want to look for problems I don't want them to be there. But I want to look for problems. You know, I want to see that there's no problems. So I can take you [accepting her as a patient]"

These experiences are not unique to Ava and Luna, they can happen to other healthcare providers as well. That is why it is important to have balance in the healthcare sphere.

A part of midwives' learning about *minhags* is understanding the atmosphere in which the *minhags* take place. Many traditions are about spirituality or have spiritual components in them. Spirituality can mean different things to different people; people interpret different situations based on our own firsthand experiences. A provider does not have the same history as their patient, and this matters in many situations. However, there are some moments when people's differences do not matter, they (the provider and the patient) all feel connected in a moment. This moment may be described as some by a sacred presence spirituality, it does not matter what it is labeled. The label is a construct of society, what is significant in this moment is the provider and the patient coming together to provide the best outcomes for all parties involved. This moment can happen in healthcare, and it did happen, it happened to Ava

> Afterwards [labor], when she needed to be stitched, she had some tearing, some suturing had to be done because she had a laceration. There was like no way, she was hysterical every time they tried, we tried and trying to get the anesthesia and and she was screaming hysterically and so all of us together started getting the breathing and calming down. We started singing Jewish songs like *coalhaolam* and everybody singing. And she's singing. And we did the suturing that way and it was just such like a spiritual thing.

Ava recognized this woman's fear and knew they were not going to be able to help her in the way she needed to be helped. She knew she had to change the atmosphere of the room, and she did. Ava gathered the people in the room, and she managed to make it a much calmer environment. In Ava's case she knew Jewish songs that resonated with her patient and was able to use them to settle the women down. This is not necessarily feasible for most midwives; it is difficult to learn songs about other cultures and religions especially when they are in a different language. But the songs were not necessarily what calmed the woman down, it was the presence of spirituality, the woman had a provider that understood what she needed in that moment, and for her it was songs that spoke to her on a deeper level. It was about Ava having an understanding, whether it was songs, scripture, in Chloe's experience, or words of compassion it is important to be aware of what a patient's unique needs.

Having an understanding can help patients in times of stress by relating to them, or discussing information in a way that makes sense to the patient (Padela 2008). Taking the time to learn different words not in one's vocabulary but significant to their patient population or educating oneself about the several types of blood and what each type means to the patient can help a patient population. It makes a difference in women's labor, as Scarlet has seen for her patients, "I think sometimes it's easier for the women who practice rituals and who believe in G-d than those who don't, because I think they believe in a higher power and they believe G-d is watching over them and that he'll make things go smoothly. I did notice that Jewish women in

general tend to have easier births, then some other cultures... they tend to have wonderful, beautiful births." It may be important to note that research data from setting with minimal obstetrical interventions show that women who had previous labor and deliveries had significantly shorter labor in subsequent births than nulliparous women (Tilden et al 2022). This might suggest that Scarlet's observation that Hasidic women have easier births may reflect the fact that these patients are typically multiparous. However, the midwife's observation refers not to the length of time but rather the "smoothness" of the overall birthing experience.

In Judaism there are many rituals that are practiced whether to make labor easier, or to connect with other people, but there can be challenges navigating those rituals. When questions arise during labor, *niddah*, or other halachic situations sometimes there needs to be more than just a midwife, but a rabbi as well. There is a rabbinical authority in many Hasidic communities, and it can be a challenge for healthcare providers to navigate.

Maneuvering through Different Types of Authority in Hasidic Healthcare

My data revealed that healthcare professionals, specifically in my research, midwives, are not the final authority when it pertains to certain medical decisions in the Hasidic community. In many Hasidic populations there is a foremost rabbi, and he is the authority when different medical *halachic* questions arise. To fully comprehend the weight of a rabbi's decision-making capabilities, the concept of authoritative knowledge must be discussed. One of the scholarly leaders in this field is Brigitte Jordan, she was a pioneer in the field of obstetric anthropology and wrote extensively about different types of authority in people's lives. In her article,

"Authoritative Knowledge and Its Construction" (1997) she examines how various authorities "come to carry more weight than others" (56). The unequal power balance can be derived from one authority describing aspects of life in a more satisfactory manner or they are affiliated "with a stronger power base, and usually both" (56).

As she argues, a person is not born with the power to lead others, people must yield some of their own power and give it to that individual. This is an intriguing idea as the person with the authority does not necessarily have to be correct in their information and decision making (58). All that they must do is have a group of people follow what they are saying and that knowledge "counts" (58) and being deemed to be "correct." This ability to influence other people pertains to many aspects of life, including making medical decisions. In this regard, listening to a healthcare provider, who carries their own authority due to being part of the biomedical system and education for example, can come in conflict with a person's authority figure in their life, if both the provider and leader have opposing advice. In moments like this, a person (a patient, for example) must decide whose knowledge they wish to follow, often as a result discrediting the advice that they chose not to follow, thus shifting the balance of power, giving more to one authority and discrediting the other (Browner and Press 1996, 142).

The question of how authoritative knowledge is constructed and understood in healthcare encounters is highly relevant in my study. This can become an issue when an authority figure such as a rabbi in the Hasidic community gives conflicting advice as compared to a midwife's recommendation. This can lead to women being disappointed in their medical care as it can seem that the midwife is providing advice without thinking how it can affect their life (Browner and Press 1996, 150), of if they can even take the medical advice at all. As a result, midwives need

to, and often do, navigate the "clinical observations, theoretical knowledge, intuitive assessment, and spiritual awareness as components of a competent decision-making process" (Davis-Floyd and Davis 1996, 258-259).[24] Midwives need to do this not only because they are in a position of authority when it comes to certain medical decisions, but also there are moments when medical guidance can seem accurate in general but in may not actually be valid for a certain group of people (Kasstan 2019:102).

To be a beneficial healthcare provider, healthcare providers should be able to give correct medical advice, but also tailor their advice in way that complies with a community's way of life (Kasstan 2019, 102). If a population's needs are continuously not met by a medical authority or do not accommodate their community's cosmology, people may lose faith in the biomedical sphere. Thus, providers lose that power and community leaders often gain it. This can lead to women not wanting to follow the medical advice given to them by health professionals (Browner and Press 1996,151), as well as alienating a population because it may feel like scientific knowledge is being thrust upon them continuously without the consideration of their own unique needs. Therefore, this can often lead to "irreconcilable ideas of 'authoritative knowledge'" (Kasstan 2019, 121). There needs to be a careful distribution of power for healthcare professionals and community leaders to accomplish the most satisfactory outcome, especially in a religious community. As my data show this equilibrium can be reached, when midwives and rabbis are willing to work together.

[24] This quote comes from Midwives Alliance of North American 1994, as cited by Davis-Floyd and Davis, however I am unable to locate this original source, hence I have cited Davis-Floyd and Davis.

Rabbinical Interpretations and the Question of Authority

In Judaism each community has their own religious authority, a rabbi. The authoritative knowledge of a rabbi is derived from both his knowledge of the Talmud and his own wisdom and interpretation of the Talmudic laws for the local community. Several areas in reproductive healthcare may require interpretations and thus the rabbi's counsel; abortion care in particular is a useful example with which to illustrate the role of the rabbi's involvement.

Social anthropologist Lea Taragin-Zeller whose scholarship specializes in reproduction and religion explains how depending on the section of Judaism a person practices; a rabbi can interpret the law differently (Taragin-Zeller 2021). In Judaism there are the overall laws that the interpretation is agreed on by Hasidic and Modern Orthodox rabbis, but different Jewish communities may add to pre-existing laws, and some rabbis may understand the law more precisely than others. Furthermore, there are communities that follow the spirit of the law rather than the letter of the law; the former allows for potentially varied interpretations to exist in different communities. As the midwife Jessie observed, "everybody has their own [rabbis]. Everybody has their own." Although there are many rabbis with many unique interpretations, their rulings stem from original rulings made by others, as Taragin-Zeller notes "all groups purportedly adhere to an extensive body of Talmudic and post-Talmudic exegesis" (Taragin-Zeller 2021, 4). This makes for an overall foundation of laws that religious communities follow. It is when rabbis build on this foundation that different explanations occur. Rabbis must study the laws carefully and understand them extensively, so they may give proper answers to a multitude of *halachic* questions that may arise.

Observant Jewish people will often go to their rabbis for advice, as well as questions. When a rabbi makes a decision, it is unique to the person who sought advice with that specific question, thus no two rulings are the same, and the rabbi must consult many texts before answering (Taragin-Zeller 2021). The uniqueness of these rulings is also relevant in reproductive health care. Indeed, the midwife Luna spoke about this when I interviewed her regarding the role of the rabbinic authority as related to reproduction, "Very smart people who examine the situation and look at the individuality of someone's situation." Luna then contrasted how this is unique in Judaism as compared to Catholicism by using the example of abortion,

> In Hasidic and the Jewish law, you know abortion is frowned upon. But I just think that, you know, it's so amazing because, I mean, it's like you compare it [Judaism] to Catholicism and you look at like the Pope, under no circumstances that the scholarly individuals [would] look at a bigger picture [in comparison to rabbis making individual decisions]

As Luna noted, there is an aversion to abortions in Hasidic communities, but this does not mean that they are not allowed.[25] Her description of the analytical and interpretive aspect of Judaism illustrates the ways in which a particular healthcare service such as abortion care can be understood, utilized or not utilized, within the parameters of both the Jewish laws as well as the best interests and choices of the pregnant woman. Barilian[26] triangulates evidence from numerous scholarly Jewish sources, such as the Talmud, which explicitly says, "If a woman has

[25] My discussion here focuses on the religious guidelines around abortion. It may be useful to note that in terms of laws in the Jewish state of Israel, abortion is lawful and state subsidized until the 24th week of gestation (Ministry of Health 2024). On June 27, 2022, the Israeli government further liberalized access to abortion (understood as a response to the US Supreme Court's Dobbs decision to restrict abortion access) by eliminating the need for the woman or pregnant person in Israel to physically appear before a committee to secure abortion care approval, and instead allowing a simpler digitized process only (Rose 2022). In the US, Hasidic women who, after a consultation with the rabbi, decide to seek abortion may or may not be able to access this care locally (depending on the state laws where they reside), and therefore Jewish women's grassroots advocates created the Jewish Fund for Abortion Access to help them travel across borders for care (National Council of Jewish Women 2024).

[26] Introduced in background and literature review, page 6.

difficulty in childbirth, one dismembers the embryo within her, limb by limb, because her life takes precedence over its life. Once its greater part has emerged it may not be touched for, we do not set aside one life for another" (Barilan 2009- 2010, 143). Furthermore, it is a person's obligation to save a women's life when the fetus is threatening it (Barilan 2009-2010).

Although abortion as a right is clearly written in the Talmud, it is still a highly debated topic in many rabbinical courts as there are two major sides to the argument. One side believes that a fetus is a person while in the womb, and the other side believes that the baby has no soul until its head has entered the birth canal. It is beyond the scope of this thesis to cover this extensive topic, but there are a few key points relevant to my research that should be understood. In a different section of the Talmud, it is written "that only born people are considered legal persons" (Barilan 2009-2010, 101). Although this may be evidence for rabbis believing that fetuses have no soul, there are still the rabbis that disagree with this, but Barilan argues "that even when they disapprove of the choice to abort, rabbis have to overcome the lack of precedent in Jewish law obliging women to submit to a difficult pregnancy and labor. Pronouncing such an obligation would amount conceptually to what Jewish law and ethics otherwise agreed as slavery" (Barilan 2009-2010, 104).

As a result of conflicting opinions, Jewish people who live within a more authoritarian section of Judaism have more rigid rules regarding abortion, and typically will ask their rabbi. The rabbi will listen to the situation and then consult with other rabbis and look at previous rulings from a time before him prior to making a decision.

Moreover, many Hasidic communities may have stricter laws regarding other aspects of reproductive health care. While some scholars of religion and law believe that "The great

religious authorities hold the power to issue rulings not only in their specific areas of expertise but in all areas of life" (Brown 2014: 255-256), anthropologist Taragin-Zeller argues the opposite, saying that scholars have overestimated the control that rabbis have over their communities. For my findings I will discuss rabbis who are more centrist. They hold much power, but they do not decide every aspect of Hasidic people's lives.

The rabbis who do wield a lot of power can become difficult to work with in the healthcare field, especially in emergency situations. Luna had an emergency with one of her patients, and it became life threatening quickly, but the couple would not make a decision without consulting their rabbi and the situation continuously worsened,

> I had a patient who delivered a beautiful, healthy baby. It was her first. We have retained placenta [placenta would not fully come out of the uterus]. So I tried to get the placenta out and I couldn't. I tried every which way it was going on about an hour and she started to hemorrhage. The first thing I did was put in two bags of IVs and cross matcher for a blood transfusion, and at the same time have the nurses call my backup physician to come in. And my backup physician came in and examined her and said we need to go to the operating room, and we need to completely relax you [speaking to the patient] and get the rest of the placenta out because you're going to bleed and you're going to get an infection. At this point, she was hemorrhaging. We had four IVs in her, we had blood going, she was going to die. And the husband would not sign the consent because in the consent form, it said that if there's a placenta percreta, you'll have to have a hysterectomy. Which you know, or else she'll bleed to death. They wouldn't sign a consent. And they tried to call their rabbi, but it was Shabbos. They tried faxing the rabbi, no response. So, we had Doctor John. He told them if you don't sign the consent, then we're going to sit here and watch you die. Which was true. And we made the decision to contact a judge. And we called a judge we got permission to do the D&C [dilation and curettage, a procedure to remove the contents of the uterus] on the patient to override her lack of consent because we said we're watching her die, you know. She was at the brink of death. So, we brought her back into the operating room. And John said to me, the first thing I'd like to try is just reach your hand in there grab the placenta because he said, "my hand's a lot bigger." It's general anesthesia. I reach in. I grab for the placenta. I scrape along the inside of the uterine lining. I pulled it all out. We examine the placenta. We think we've got everything. Do a quick ultrasound to look. She completely stopped bleeding. Completely

> stops bleeding. We keep the IVs and the blood going and we run out to tell the husband the good news. He was hysterical, crying, he hugged John, he said he wanted to hug me, but he couldn't.

This frightening situation could have ended very badly. Although Luna was patient to let the couple try and call their rabbi, she was still quick to act when the situation warranted it. This is an example of being culturally competent but also knowing where the boundary is. Luna understood that this couple wanted to consult their rabbi before they made a life altering decision, and she gave them as much time as possible for them to try to accomplish that, but she knew where that life-threatening boundary was and took appropriate action, as Ava said, "We try very hard to be respectful when it's not an emergency, you can go ahead and ask a question [to the rabbi]." This story illustrates the complexities of the midwives' work in navigating their care provision in the Hasidic community. It shows how the power of the rabbinic authority can be a serious obstacle in life-or-death decisions in the healthcare setting, but it also demonstrates the authoritative knowledge and power of the midwife to save the patient's life. But was their decision to involve the judge culturally insensitive? Getting a judge to override the couples' refusal to consent to the D&C risks repercussions from the patient and the wider Hasidic community where the midwife practices.

Not as often, but there are occurrences when rabbis deny permissions or will not give a *heter* and this can make it difficult for healthcare providers to treat their patients effectively and to the best of their abilities. However, there are also situations where a rabbi told congregates to decline the doctor's orders and the outcome was favorable, "Rabbi Menachem Mendel Schneerson (1902–1994), leader of the Chabad-Lubavitch movement and one of the most influential figures in modern Jewish history. He would, according to some accounts, occasionally instruct patients to reject doctors' diagnoses or treatment recommendations, without providing a

full explanation, and his advice would prove correct. Physicians, patients and relatives who witnessed these cases describe, implicitly or explicitly, a sense that something extraordinary, if not supernatural or even miraculous had occurred" (JewishMedia, 2016; Gabbay et al 2017).

There is a website dedicated to telling stories about different Jewish events and people, Jem.tv[27]. One of those stories describes a time when the rebbe told someone that the doctors could be wrong. The encounter begins with a woman writing a letter to the Rebbe asking for advice regarding her father's diagnosis of Multiple Sclerosis (MS). He had been to three doctors, and they all told him the same thing, he had MS. The Rebbe wrote back to check his mezuzah[28] and tefillin.[29] The man did not have either of those items, so he went out a bought them. Six months later the woman goes with her future husband to the Rebbe to ask for a blessing. While in the Rebbe's office her father and the Rebbe start talking about his condition, and the

> Rebbe says, "I know who you are, did you receive my response to your letter?"
> The father: Yes, I put up mezuzah have been putting on tefillin everyday"

The Rebbe and the father spoke extensively about his condition, and how it was affecting him, and three times during that conversation the Rebbe said "I don't think you have MS" at the end of the conversation the Rebbe says to the father "I think you should get a brand new diagnosis and we should hear good news." The father, his daughter, and future son-in-law thanked the

[27] Formally under the name JewishMedia
[28] A mezuzah is a small piece of parchment with a Jewish prayer, the Shema, written on it. They are affixed to all doorways in a Jewish home. They are meant to identify the house as a Jewish home, and to remind the occupants about their history and their relationship with G-d (Chabad.org 2017).
[29] Tefillin can be described as "Phylacteries" roughly meaning a "safeguard, a charm or an amulet" (Lookstein 1961:67). They are two black boxes made of leather that are attached one to the arm and the other to the head. They are worn every day except Saturdays and most holidays. There is parchment inside the boxes detailing the different commandments G-d gave regarding wearing tefillin (Chabad.org 2012).

Rebbe and they left. The father did not want to repeat the MS tests again as they were very invasive. A year and a half later a new test came out and the father goes to get it done. A few days later they receive the results, and he does not have MS. He then went to live 16 more years after this (JewishMedia 2013). Although this is a very specific example and a rare occurrence, it demonstrates that there are cases where rabbinic authority proved to be correct over a doctor's diagnosis.

"I've never had a rav say no"

However, when a rabbi refuses to grant a request, situations become more complicated, and because of this people have thought of ways to get around denials. Ethnographic research shows that Hasidic people in Israel will "shop around until they find a rabbinic opinion that resonates with their personal desires" (Taragin-Zeller 2021,1). There are different severities to "shopping around" ranging from people who outright do not do this and will accept a rabbi's ruling like it is a law, to people who reject the decisions of different rabbis, until they find one that has a satisfactory answer for their situation, accepting only one that meets their predilection (Taragin-Zeller 2021). Ethnographic research in England demonstrates that for Haredi Jews "the *rulings* of religious authorities might be less sought after than their *views*" (emphasis in the original), and even a rabbinical endorsement of a health care service such as vaccinations might have little impact on the utilization of this service if members of the community have an underlying objection to immunizations (Kasstan 2019, 232). In effect, the rabbis might provide authoritative guidance, but congregants might not act on it. A way to accomplish congregant's

own aims that became evident in my study is by not asking the rabbi for "permission" and instead asking for a "blessing" – this makes it possible for midwives to give medical advice that may be denied by a person's rabbi, such as Ava's patients have done, "So what they've learned to do is they tell their husband go to the rabbi, and tell them [the rabbi] 'My wife is having a home birth, I want a *bracha*,' so they'll get a *bracha* because he'll be like, OK, so I'll give her a *bracha* for her home birth, you know, but he won't get permission."

This tactic cannot be used for every situation, and sometimes another authority needs to speak with the rabbi, such as a midwife. All the midwives I spoke to said they have called rabbis and explained situations with regards to birth control, abortion, and/ or other medical decisions. Luna has been fortunate enough to have never been denied, "I've never had a rav[30] say no." Because midwives need to communicate with rabbis, it is important for them to understand what to say beyond the medical facts, how these medical facts work in Judaism, and how both the laws and the midwives have the power to affect their patients' lives.

This is a very high level of cultural competency and sensitivity, the healthcare providers do not need to understand the Talmudic laws perfectly or how exactly the laws work in Hasidic people's lives, but they need to have a basic understanding of how the law will affect the patient's care and how a medical decision needs to be made that the rabbi might disagree with; Ava explained, "They have to talk to their rabbi, they have to understand that if we [midwives] talk to the rabbi, it's going to be a different answer than if they talk to their rabbi because we're going to explain that this is not a joke and they [patients] might not explain it that way." This situation is mutually beneficial: the midwives becoming familiar with reproductive laws makes it

[30] Rav is a shortened word for rabbi.

easier for them to work with the rabbi, when their patients have questions, and this in turn creates a rapport with the rabbi. Over time an understanding with the rabbi develops which subsequently makes it easier for midwives to ask for permissions for their patients because the rabbi trusts the healthcare provider to make the right decisions. In this way, the midwives act as both healthcare providers and cultural/religious brokers in the interest of their patients.

Furthermore, because trust has been established, rabbis will consult with the midwives when it comes to medical questions. Often rabbis need consultations when they are making recommendations or decisions for their congregates. If a person asks the rabbi their question and the rabbi is unable to answer it, the rabbi will then seek a medical authority (Taragin- Zeller 2021, 6). By establishing a collaborative relationship with a healthcare provider, rabbis can now make better and safer decisions. Scarlet, for example, spoke about how she was the consultant midwife for a few rabbis, "The rabbis would actually come to us sometimes with questions because of issues that were going on." She explained that this exchange was not only beneficial to the congregates but also to the midwives, they could better understand their patients, which in turn made them better able to assist them, but also because of the trust built with the rabbi, the rabbi would send patients to them when they had questions he could not or did not know how to answer. This sometimes happened regarding *niddah*: a midwife who knows how to distinguish different types of blood can help when a woman goes to their rabbi with questions regarding whether she is in *niddah* or not. This, understanding the different cultural laws and traditions helped people in their community.

Having a healthcare provider advocate for one's health is extremely important and can make a drastic difference in a person's lives (Li 1998). It is significant that there are midwives

willing to learn more about their patient population and to take action when it is necessary. It can be difficult navigating the different laws or Judaism as well as having to sometimes provide medical care that is constrained by rabbinic authority. These midwives have gained insights from working with the community, whether it is a new appreciation for a different culture or ritual, or just being able embrace the spirituality around them, they enhanced the lives of their patients because these midwives cared enough to explore outside of their own culture, traditions, and training.

CHAPTER SIX:

GOING BEYOND CULTURAL COMPETENCY: THE WAY FORWARD IN THE DIVERSITY IN HEALTHCARE

The data I gathered in this study shows that it is important for clinicians to be culturally competent and that they practice cultural humility. In this chapter, I consider how cultural humility could be achieved in the context of caring for religious minority patients. Cultural humility differs from cultural competency in that cultural humility goes beyond the understanding of a patient and instead makes a provider assess themselves, it creates a symbiotic relationship between the patient and healthcare provider, and it provides the opportunity for healthcare professionals to help advocate for not only their patients but for the communities the patient is from (Tervalon and Murray-García 1998).

This study's findings support the argument that it is critical for providers to start learning about how to be culturally understanding in school. Healthcare professionals should already possess the ability to be sensitive and understanding of patient needs when they start treating patients independently. This is happening in some schools, such as the school where rebbetzin Chaya's daughter is enrolled to become a certified nurse midwife (CNM).

> A fellow student was taking a test and reached out to her because she you know, [being] Orthodox there was a question on a test for nurses:
>
> You're with a patient who is having a baby, and you see that her husband is not holding her hand and is not actively part of the labor birthing experience. It is an Orthodox couple, what do you do?
>
> a. Call the department of abuse because her husband doesn't care about his wife
> b. Take the role of the husband, let him be more of an observer and you hold her hand and help her through labor
> c. You tell him [the husband] absolutely not, you have to help

To have a question like this on an exam is impactful! It exposes the provider, in this case a future CNM, to a situation that they can experience, and more than likely could experience if they are working near a religious Jewish community. By having questions like this on exams the school is providing the opportunity for the midwives to hopefully learn about different customs of other people in the curriculum and have this information included on their examinations before they have even interacted with them. These kinds of curricula give the clinicians the foundation for cultural humility, as this exam question is not necessarily about a specific medical idea but about how oneself would act in this situation. This question forces a healthcare worker to self-evaluate their own feelings in a situation they may not understand, and in this specific case the question was about *niddah*! However, the question could have been about anything, such as *tznuis*.

It may be odd to some providers that a woman would choose to give birth fully covered and, in some cases, wearing stockings. Having examples of different situations that can arise helps a provider re-evaluate themselves, and take a moment to not judge a patient who wants to give birth fully covered, whether in a bed or even in a birthing tub. The findings from midwives' approaches in Hasidic patient care in this study exemplify how a provider can come into a situation with an open mindset. This can happen if medical professionals are exposed to unique situations and diverse types of self-evaluating questions, as seen by Chaya's daughter.

Understanding diverse populations' way of life must begin in medical education (Sorensen et al 2017). Questions on exams regarding different situations is a great first step to achieving this, but medical institutions need to go beyond simple questions. Cultural humility begins with the institution itself, and part of the curriculum should be about teaching cultural sensitivity. My findings support the call of other scholars for increasing the number of educators

that specifically instruct classes about diversity and inclusion in healthcare (Sorensen et al 2017). Central to the diversity education in healthcare curricula is healthcare providers' exposure. It is far less useful to learn new theoretical skills about different cultural sensitivities techniques if a medical professional cannot practice them. There may be a circumstance where a patient is superstitious and they want to, as in Jessie's experience, wear a red ruby necklace to prevent miscarriage, or tie a red string bracelet around a newborn baby to protect it from evil spirits. A culturally sensitive provider would examine what is happening and agree or even help their patients with a superstitious token, or *segulot.* Having cultural competency is understanding that the baby wearing a red string or putting a prayer book underneath the mattress does not harm them and can even help the mother by giving her peace of mind.

Besides formal education, medical personnel need to continuously learn about new ideas. Whether it is a clinical technique or a custom that is done in the community they are working with, it is important for professionals to stay apprised of what is happening around them. An example of this informal yet crucial mentoring education is exemplified in Scarlet's experience:

> Scarlet: If somebody has something wrong and they came to you, let's say she had a bad yeast infection and you check her out, and then you see some blood and you have to determine where that blood is coming from.
>
> Interviewer [Haley]: Is that something you receive training in midwifery school or is that more Jewish training that you received?
>
> Scarlet: There's a Jewish training
>
> Interviewer: Did you do extra schooling for it?
>
> Scarlet: No, it was more like the midwives showed when you first worked there, you learn to discriminate between different types of blood.
>
> Interviewer: Jewish midwives?
>
> Scarlet: One was Jewish, and the other was not.

Structured education is a good start, but it is not an end. Teaching *niddah* in school would not be useful for most healthcare providers to learn as the Jewish population make up approximately 2.4 % of adults in the United States (Pew Research Center 2021). Of those 2.4% only 9% identified as being Orthodox (Pew Research Center 2021). As a result of there being such a small population it would be inefficient and likely impossible to teach a specific practice that is done by a minority group.

Instead, teaching overall about cultural humility would be more valuable; the providers then would bring that knowledge with them to their future place of employment,[31] and from there this knowledge would serve as the foundation to further their education once they begin working in a specific community. Scarlet did exactly that. She went to midwifery school and was formally educated in medicine, and then when she began working in the Hasidic community the other midwifes at the practice taught her how to develop her skills further, including for example how to distinguish different types of blood so she could best assist her Hasidic patients. This is an excellent example of cultural humility: Scarlet understood she needed to know more about the population she was serving and made sure she had the skills to help her patients in the specific way they needed to be helped.

It is important to underscore that a provider's apparent culturally-relevant knowledge might also inadvertently lead to stereotyping patients, therefore a provider must be conscious of their own limits of comprehension of other people's cultures. For example, a provider should not make assumptions when they receive a patient for the first time, and although they may have been taught something about a community it does not mean that such information always applies

[31] [1] The framework of cultural humility has been identified since the early 2000s, and despite general interest in this concept there have been insufficient attempts to incorporate this concept into medical education (Solchanyk 2021).

as there is significant intra-cultural diversity within every community as well. Anthropologists Arthur Kleinman and Peter Benson communicate this idea efficiently when they argue that all medical practices caring for immigrant, refugee, and ethnic-minority populations should have a sign that says, "First do no harm by stereotyping" (2006, 1675). I would also argue that this should include practices that have religious minority patients, as well as patients from other intersectional backgrounds including for example LGBTQ patients. They also argue that "overemphasis on cultural difference can lead to the mistaken idea that if we can only identify the cultural root of the problem, it can be resolved" (1675), and for this reason scholars have also identified structural competency as important (Metzel and Hansen 2014) which calls attention to such matters as access to facilities, health insurance, infrastructure, and other issues that structure unequal access to healthcare.

To combat stereotyping, physicians, and public health scholars Melanie Tervalon and Jann Murray-García suggest "patient-focused interviewing and care" (1998, 120-121). This technique gives the patient the opportunity to tell the healthcare professional what they believe is pertinent. Having an interview or conversation gives the patient the power to describe medical and non-medical occurrences (1998, 121). Tervalon and Murray-García suggest that this style of care "eliminates the need for a complete mastery of every group health beliefs" and gives the patient the ability to decide what aspects of their culture is relevant to the situation (1998, 121).

While I mostly agree with Tervalon and Murray-García, and this is useful for an overall approach, this approach especially pertains if a provider does not consistently work with the same population. Indeed, it would be difficult for a provider to have to learn extensively about every culture they see, and so interviewing with the focus on the patient's own perspective gives the provider the opportunity to learn what they need to understand for that patient's culture.

However, I believe that the model Tervalon and Murray-García propose does not go far enough in situations in which the provider is continuously working with the same population. In such contexts, it would be reasonable to expect the provider to commit to learning more in depth about that culture so they can assist that community to the best of their abilities. An example of this is provided in Chapter three, in which I examined how the midwives navigated giving birth control to patients but also staying within the bounds of *halacha*. Midwives Ava and Jackie both had a clear understanding of the laws surrounding birth control and were successfully able to prescribe it to their patients, as well as knew when a *heter* was needed before prescribing. This type of information is pertinent to their patients, and they took the time to educate themselves. This self-education does not preclude "patient-focused interviewing and care" that Tervalon and Murray-García propose, on contrary, these approaches go together to build a deeper, more meaningful relationship in the clinical encounter.

The midwives in this study offer admirable examples of cultural sensitivity, care, understanding, and humility. However, as midwife Chloe noted with a quote from the Talmud, "G-d asked us to live our mission, we are obligated to begin it, but we are not obligated to finish it. Because we are going to pass it on to the next generation." In other words, this competence cannot conclude with them, it must continue with every generation, hopefully excelling with each new group of medical professionals.

CHAPTER SEVEN:

CONCLUSIONS AND SIGNIFICANCE

Sex Through the Sheet, Antisemitic Rumors and How They Damage

My participants' personal accounts and my ethnographic fieldwork have shown that having a culturally competent, understanding, and/or culturally sensitive healthcare provider caring for Hasidic patients has a major effect on a patient's overall experience in a healthcare setting. I have argued in this thesis that clinicians' cultural understanding is important for many reasons, besides patient experience. I have also argued that the role of medical education is extremely important in promoting the value and hands-on practice of cultural humility and self-education among future healthcare providers who care for patients from religious communities.

Another important conclusion to underscore and that providers can help contribute to, is the fight against antisemitism. "For more than two millennia, Jewish communities around the world have found themselves the focus of speculation, misinformation, fear, derision, and at times, envy regarding the sexual beliefs and practices of its members" (Ribner and Kleinplatz 2007, 445). This misleading information has detrimental consequences for the Jewish people in general, and in healthcare settings specifically. One concerning example that may illustrate my point was related during the interview with Ava. Ava recalled[32] a midwifery student she had that had many preconceived notions about Judaism and said incongruous things. One of those

[32] I am aware that new data from my research participants is not typically presented in the conclusions and significance section, however the information I present here is most relevant to the significance of this study and not to the research questions of this project. For this reason, I am including some brief quotes from the interviews in this final thesis chapter.

instances was related to an event the midwifery school required the students to attend, The March of Dimes. Ava and other teachers and students that practiced religious Judaism could not attend the event that was close to the school as it was held on a Saturday, and the school gave them permission to attend a different one farther away that was held on a Sunday.[33] The student took great offense to this,

> Student: Why can't I go to Westchester [the place where the event was taking place on a Sunday]? I'm Jehovah's Witness, and that's my religion, and I keep Saturday not Sunday?
>
> Ava: You can go to the Sunday March; you just have to ask me to go if that's your religion.

Ava discussed, she thought there were other factors going on with the student,

> There's something going on there. So, then she got upset when they mentioned about the nurses, who … if they're not Jewish can really help if they [their patients] are sitting with the lights on [at night], then you [the nurses] could say, "Oh, I think you might want to sleep in the dark," or if it's in the middle of the day "I'm going to turn the lights on for you."
>
> Ava then recalled that the student said: "like that really makes me angry. It's like you guys get to go to heaven and we all get to go to hell."
>
> Ava responded: And I said: no, it's really not like that. Nobody believes that its incumbent these laws on Jews, not others.
>
> Student: "No, but my religion believes that people don't believe in my religion go to hell"
>
> I [Ava] said, "Yes, so that's not the belief here."

This interaction is unfortunate but not unique. Antisemitism is seen not just in healthcare but in everyday life, such as on college campuses in the US where it has risen substantially in the last few years (Abrams and Armeni 2023, Flasch 2020). In fact, the US Federal Bureau of Investigation's director Christopher Wray said that although Jewish people only make up around 2.4% of people in America "they account for something like 60% of all religious based hate

[33] For observant Jewish people, the work week starts on Sunday.

crimes" (Banner 2023). If this number was not astounding enough, 60% accounts for "more than the number of hate crimes committed against *all other* religious groups combined" (emphasis mine) (Kaufman et al 2020, 238). Jewish hatred does not need to be huge such as a hate crime, it can happen in little ways as well. These include, for example, small comments such as about husbands not being supportive towards their wives during labor; Ava called these "microaggressions."[34] She has never seen anyone among the healthcare providers refuse to take care of a patient who was Jewish, but instead they would make rude and offensive comments, or as Luna described, nurses talking at the nursing station and rolling their eyes about certain behaviors Hasidic patients engage in.

In the above examples antisemitism is very apparent, however it is not always so. There are many antisemitic notions that circulate around the world which may lead to people believing them. This research study is significant in dispelling some of these notions, and therefore humanizing the Hasidic women's practices. One such belief is that Orthodox Jewish couples have sex through a hole in the sheet. This rumor actually was brought up during my interview with rebbetzin Batsheva who clarified that "according to the Torah, you're supposed to be totally naked during sex," highlighting that not only is this notion false, it is forbidden in Jewish law to have any barriers during sex, and if a husband or wife were to suggest being dressed during sex this is grounds for divorce (Shulchan Arukh, Even HaEzer 76, 13). It is misinformation like this, or seemingly small rude comments that are said to make it important to remember, not just as healthcare providers, but all people, the importance of cultural relativism, not being ethnocentric,

[34] Microaggressions have been documented as a form of interpersonal violence and part of larger structural violence, including racism, misogyny, transphobia, homophobia, classism, ageism, ableism, xenophobia, and other forms of bigotry directed against minority and minoritized populations, including against the Jewish people in the form of religious microaggressions (Adler 2021).

and to not “exoticize” other people to emphasize their “otherness” from the rest of us. Cultural relativism as one of the foundational hallmarks of anthropology means realizing that no one people are above another, there is no “ethically, morally, and culturally absolute truth” (Price 2002). It can sometimes be hard to look at a different culture and not compare them to ourselves, but that is why it is imperative to not be ethnocentric; you may not practice the laws and traditions of another culture but that does not make one's own culture superior to another, even if someone disagrees with how the other culture practices.

Contributions to Scholarship and Future Research

My study adds to medical, cultural, and reproductive anthropology by bringing attention to how central midwives' roles are in the preservation of cultural preferences and desires of the patients in the biomedical setting. Midwives are not only “key figures in the anthropological study of reproduction” (El Kotni 2022, 455) but they also contribute greatly to the holistic model of care. Women will often seek out the care of midwives, as midwives are often associated with the less medicalized version of birth (Andaya and El Kotni 2022, 217). As a result of midwives understanding that labor is an organic part of life, they tend to focus less on the biomedical aspect and can consider the emotions and cultural factors of the laboring woman (Meroz and Gesser-Edelsburg 2015, 28). Specifically, my research contributes an ethnographic in depth understanding of how midwives are instrumental in helping Hasidic women practice their *halacha* and *minhag*. There are many midwives who believe that the reason their care differs from the medicalized birthing process is not just because they take a step back from technology, but also because they are more in touch with their patients. Robbie Davis-Floyd and Elizabeth

Davis write in their article “Intuition as Authoritative Knowledge in Midwifery and Homebirth” (1996) about this connection and show that midwives connect with their patients not just in the “physical, but also emotional and intellectual...” (246). By midwives practicing a more holistic version of care it creates opportunities for women like, Hasidic women, to feel comfortable and safe engaging in different rituals during labor.

Furthermore, my research contributes to public health scholarship, with its advocacy for quality, patient-centered care for a minority population. Furthermore, this research study is significant because Jewish people have always been a targeted nation, and recent escalations in antisemitism, as the number of countries persecuting Jewish people has risen from 89 in 2019 to 94 in 2020, making their future uncertain (Diamant 2023; Nadeem 2022). For this reason, the women in my research, whether a midwife or a Jewish woman, deserve to be heard and recorded, and more scholarship in anthropology and other disciplines documenting Jewish experiences and culture is needed to help build cross-cultural understandings regarding the Jewish people.

Many midwives are the bridge between the biomedical sphere and culture and religious customs (Barilan 2009-2019). This research is significant because understanding with an anthropological view the question of rituals of Hasidic Jewish women’s practices specifically through the perspective of US reproductive workers in Florida and New York, with an emphasis on midwives, bestows a more holistic view on the intersection of traditions and biomedicine. Midwives are not only advocates but also at times participants in the practices of Jewish Hasidic women, and it is their voice that I was interested in writing about.

Additionally, advocacy for Jewish Hasidic women is immensely important; the dominance of the biomedical world tends to sideline the culture of people as well as other aspects of their social, economic, or religious context leading to the notion that Hasidic

communities are “hard to reach” (Kasstan 2019, 98). Although they can appear as a very private peoples, this does not mean they should be excluded from social science and public health research and contributions (Kasstan 2019, 98). Additionally, public health workers should not worry that “traditional culture” will impede health outcomes (Obermeyer 2000: 180-181). It has been found that culturally aware providers have more successful results with their patients (Alizadeh and Chavan 2016, 128).

My research could elevate the practices and customs of the Hasidic women that may be ignored, forgotten, or misunderstood. The anthropological and ethnographic angle of analysis is an especially important contributor to this study as it grants an in-depth, immersive approach to the rituals as more than just an aspect of Jewish women but a reflection of parts of a culture.

I believe my ethnographic exploration into Hasidic Judaism opens the door to many different types of future research. It is well known that there needs to be a reform in education, especially regarding learning about diverse peoples and cultures that are not our own. But this type of research also reveals a less spoken about aspect of culturally-specific medicine and raises the question: Is there a time where a healthcare professional cannot accommodate a person’s specific needs pertaining to their culture? (Padela 2008). This question and many others like it are important to acknowledge and consider for exploration in the future.

My hope for the future is that scholarship will continue to grow and expand pertaining to various aspects of Judaism, especially Hasidic Judaism. This group of society is often marginalized and discriminated against, and it is partially due to the lack of knowledge about them. People fear what they do not understand. As this group is well-known for being private it is often hard for secular people to understand who these people are and why they protect

themselves by living excluded from larger society (Kasstan 2019). Future research should therefore contribute to learning more about their way of life to counter the television shows which often portray the dark side of Hasidic life thereby creating a false narrative and the only narrative the public gets to see. Future research which focuses on more nuanced and detailed aspects of their way of life can construct a basic understanding of this population from which to build upon. I believe that future literature can help dispense antisemitic notions and ideas and dispel the fear of the unknown surrounding this community. I conclude my thesis with a quote from Scarlet that I believe articulates this idea beautifully,

> You know when you grow up outside of this community, you always look at them like, that's kind of strange and they're different than you. And then when you work with them, you really learn that they're a woman just like anyone else. They have the same needs. They have the same desires. They're very, very family oriented. They're very nice people. And they almost made you feel like you were part of their family and, you know, as an outsider, you wouldn't feel like they would treat you like that. But they really do. They really come to respect you and you come to really respect them.

APPENDIX A: IRB APPROVAL LETTER

UNIVERSITY OF CENTRAL FLORIDA

Institutional Review Board
FWA00000351
IRB00001138, IRB00012110
Office of Research
12201 Research Parkway
Orlando, FL 32826-3246

EXEMPTION DETERMINATION

March 27, 2023

Dear Joanna Mishtal:

On 3/27/2023, the IRB determined the following submission to be human subjects research that is exempt from regulation:

Type of Review:	Initial Study, Initial Study
Title:	Jewish Women's reproductive health traditions from the perspectives of midwifes and other reproductive healthcare providers in the United States
Investigator:	Joanna Mishtal
IRB ID:	STUDY00005148
Funding:	None
Grant ID:	None
Documents Reviewed:	• Field Note Document , Category: Other; • Juroviesky Healthcare Workers Question Guide , Category: Interview / Focus Questions; • Juroviesky HRP-255-Form Clean, Category: IRB Protocol; • Juroviesky Religious Expert Question Guide , Category: Interview / Focus Questions; • Patient Consent and Explanation Clean and Revised, Category: Consent Form; • Provider Consent and Explanation Clean and Revised, Category: Consent Form; • Recruitment for patients, Category: Recruitment Materials; • Recruitment for Providers, Category: Recruitment Materials; • Recruitment for religious experts, Category: Recruitment Materials; • Religious expert Consent and Explanation Clean and Revised, Category: Consent Form

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made, and there are questions about whether these changes affect the exempt status of the

human research, please submit a modification request to the IRB. Guidance on submitting Modifications and Administrative Check-in are detailed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system. When you have completed your research, please submit a Study Closure request so that IRB records will be accurate.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu. Please include your project title and IRB number in all correspondence with this office.

Sincerely,

Jonathan Coker
Designated Reviewer

APPENDIX B: CITI TRAINING

Completion Date 30-Jan-2023
Expiration Date 30-Jan-2026
Record ID 53941287

This is to certify that:

Haley Juroviesky

Not valid for renewal of certification through CME.

Has completed the following CITI Program course:

Human Research
(Curriculum Group)
Human Subjects Research- Group 2.Social / Behavioral Research Investigators and Key Personnel
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

University of Central Florida

Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w90f3faff-a1a0-46e3-b346-25dc6dbb959c-53941287

APPENDIX C: RABBI/ RELIGIOUS EXPERT QUESTION GUIDE

Interview Guide for Rabbis Regarding Research Project:

"Jewish Women's reproductive health traditions from the perspectives of midwifes and other reproductive healthcare providers in the United States"

Thank you for taking the time to speak with me today. I'm Haley Juroviesky from the University of Central Florida, and I'm the researcher for the project titled "Jewish Women's reproductive health traditions from the perspectives of midwifes and other reproductive healthcare providers in the United States." I would like to interview you about your experience as a religious expert. All the information you give me will be confidential. The interview is voluntary. I would like to start now, is that OK?

Date:

Interviewee Number/ Pseudonym:

Q1: What makes a person Hasidic rather than simply "orthodox"?

a. Probe: When did the two split from each other?

Q2: Are there specific *halachas* regarding reproductive health?

a. Probe: What are they?
b. Probe: Where do they originate from?

Q3: Would you say these *halachas* have changed over time or no?

Q4: Are there minhag regarding reproductive health?

a. Probe: Do these minhag differ depending on community or country?
b. Probe: Have we lost minhag to time?

Q5: Are there superstitions around being pregnant, during labor, or after that you are aware of when it comes to Hasidic women?

a. Probe: If yes, what are they?

b. Probe: Where do they come from?

c. Probe: Are there any ways to prevent these fears around the superstition from happening?

Q6: What does Judaism say about birth?

a. Probe: Is it a mitzvah? An obligation?

Q7: Are there places in the Torah that midwives are contributing to Jewish history?

a. Probe: If yes, what was the first mention of them?

b. Probe: Are they important?

c. Probe: If yes, why are they important?

Q8: Are there any *halachas* surrounding midwives?

a. Probe: If yes, what are they?

b. Probe: What do they consist of?

Q9: Are there *minhags* that have to do with midwives:

a. Probe: If yes, what are they?

b. Probe: Where do they originate?

c. Probe: Do many sects of Judaism practice them or is it a more specific section?

Q10: Are there specific prayers that midwives are supposed to say before, during, or after helping a woman through labor?

a. Probe: If yes, what are they?

b. Probe: What do they mean?

c. Probe" Where do they originate from?

d. Probe: Is it known who wrote them?

Q11: Are there specific prayers that women or their husbands are supposed to say before, during, of after labor?

Probe: If yes, do midwives play a role in them?

a. Probe: What do they mean?

b. Probe" Where do they originate from?

c. Probe: Why are they said?

Q12: Where does *niddah* fit into birth?

a. Probe: When does it begin during birth?
b. Probe: Why is this *halacha* done?
c. Probe: Do you think this *halacha* would be considered "unsupportive" in the secular world or not?

Q13: Why does a women need to wait 7 days to go to the mikvah after having a boy or 14 after having a girl?

Q13: Do you need to follow the laws of *tznuit* during labor? Exp covering your hair, elbows...

Q14: Is the husband allowed to attend prenatal and postnatal appointments?

a. Probe: If yes is it typical for someone's husband to come with them to appointments?

Q15: Is the husband allowed to attend the birth?

a. Probe: If not, why is he not allowed?

b. Probe: What is the halachic reasoning for the husband not being allowed to attend the birth?

c. Probe: What exactly does the *halacha* state that is forbidden?

Q16: What is the significance of having a Shalom Zachar?

Q17: Do women come to you for advice about halachic decisions before giving birth?

a. Probe: What are some of the common challenges that you advise on?
b. Probe: Have you ever been asked to decide on an issue shortly before or during labor?
a. Could you give an example (without mentioning people's names)?

[Probe if he ever had to give advice that was in conflict with the medical recommendation or does, he generally advise to accept the medical recommendation? If his advice conflicted with the doctor's or midwife's recommendation, then how was it resolved in the end?]

Q18: Are there prenatal classes that Hasidic women/ couples take before getting pregnant or while being pregnant?

a. Probe: If yes, what do the classes entail?

Q19: Are there celebratory events after birth?

a. Probe: Do these differ for girls and boys?

b. Probe: Have these events always been done or is this more of a modern or recent experience?

Q20: Are there any specific actions that happen if an intersex baby is born?

a. Probe: Would the baby's gender be assigned based off of outside genitalia?

b. Probe: Would they get a celebratory event based off of said genitalia?

Q21: Are there any practices or customs done after the birth by the midwife?

a. Probe: Or the mother, or father?

b. Probe: If yes, what are they?

c. Probe: Why are they done?

d. Probe: What is their significance?

Q22: Is there anything else you would like to add or clarify?

Thank you very much for your time. Please don't hesitate to contact me if there's anything else that you would like to add that you have not had a chance to say during this interview.

My contact information is:

APPENDIX D: MIDWIFE/ REPRODUCTIVE HEALTH PROVIDER

Interview Guide for Reproductive Health Care Providers Regarding Research Project:

"Jewish Women's reproductive health traditions from the perspectives of midwifes and other reproductive healthcare providers in the United States"

Thank you for taking the time to speak with me today. I'm Haley Juroviesky from the University of Central Florida, and I'm the researcher for the project titled "Jewish Women's reproductive health traditions from the perspectives of midwifes and other reproductive healthcare providers in the United States." I would like to interview you about your experience as a reproductive healthcare provider for Hasidic women. All the information you give me will be confidential. The interview is voluntary. I would like to start now, is that OK?

Date:

Interviewee Number/ Pseudonym:

Q1: Could you explain what work you do as a midwife with Jewish women?

a. Probe: What is it exactly that called you to practice?

Q2: How long have you been assisting in the birthing process of women, especially in the Hasidic community?

a. Probe: How many Hasidic babies do you think you have delivered?

Q3: When you started working as a midwife did you purposefully want to work with Hasidic women?

a. Probes: If yes, why did you want to work with Orthodox women? How did you seek out these patients?

b. Probe: If no, how did you come about to work with Orthodox women?

Q4: Do you work with patients who prefer a more home-based or less clinical approach to care? Like giving birth at home, etc.

Q5: What do you think is the difference between your work in the secular community and the Hasidic?

a. Probe: What is the biggest difference?

Q6: Are you aware of any *halacha* regarding the practice of giving birth?

a. Probe: If yes: Would you personally intervene in order to make sure the correct halachic practices are done?

a. If yes: is there an instant that sticks out in your mind, or do you have an example of such a case happening?

Q7: Are there instances when halachic questions arise during birth?

a. Probe If yes: When a halachic question arises do you consult rabbinical authority?

Q8: Have there been any reproductive rituals or traditions that your patients wanted to follow, and you participated in or facilitated or observed?

a. Probe: Could you give some examples? Who was making requests (the woman, the husband, others)?

b. Probe: Do you see a difference in birthing experiences for the women who practice rituals versus those who do not?

Q9: Typically, are there people in the birthing room or checkups besides you and the patient?

a. Probe: If Yes: who?

Q10: How do the state of [New York or Florida] health regulations accommodate any religious minorities needs your preferences from your experience?

a. Probe: How does the city or county you work in accommodate any religious minorities needs your preferences from your experience?

Q11: Are there any experiences that have really stuck with you practicing in the Jewish community?

a. Probe: Could you describe it?

Q12: Have there been situations where the Hasidic woman's wishes (as related to her religion/spirituality in reproductive healthcare) couldn't be fulfilled?

a. Probe: Could you describe the situation? How was it resolved?

b. Probe: Do you think that influences how you practice medicine?

Q13: Have there been instances where a Hasidic woman wanted a custom done in a clinical setting but was denied?

a. Probe. If yes, what occurred after the woman was denied?

Q14: Have you ever encountered an intersex baby while working with Hasidic women?

Probe: If yes, how was the situation handled?

Probe: Did the parents assign a gender to the baby?

Probe: Did a rabbi need to be called?

Q15: What are some of the lessons you learned as a midwife/doctor from working with Hasidic women?

Q16: Is there anything else you would like to add or clarify?

Thank you very much for your time. Please don’t hesitate to contact me if there’s anything else that you would like to add that you have not had a chance to say during this interview.

My contact information is:

APPENDIX E: EXPLANATION OF RESEARCH FORMS REPRODUCTIVE HEALTH PROVIDER, RELIGIOUS EXPERT, PATIENT

UNIVERSITY OF CENTRAL FLORIDA

EXPLANATION OF RESEARCH

Title of Project: "Jewish women's reproductive health traditions from the perspectives of midwives and other reproductive healthcare providers in the United States."

Co-Investigator: Haley Juroviesky, BA Honors Student, Department of Anthropology, UCF

Principal investigator: Joanna Mishtal, PhD, Department of Anthropology, UCF

You are being invited to take part in a research study. Whether you take part is up to you.

Study purpose: The purpose of this research project is to explore the relationship between Jewish cultural practices and how they fit into biomedicine when Hasidic women seek reproductive healthcare.

What you will be asked to do in the study: You will be asked to participate in a voluntary interview. I will also ask for permission to shadow you during your care provision to Hasidic women patients. At any point during the shadowing and observations, you are free to ask me to stop.

Location: The interview may take place in person or via Zoom or telephone, whichever is mutually agreed upon by the investigator and the participant. If shadowing is allowed, this would be in your practice or potentially at your Hasidic female patient's home, if they consent.

Time required: The interview may last approximately 45 to 80 minutes. The interview will take place at a time that is convenient for you, the participant, as well as the researcher. If you agree for Haley Juroviesky to shadow you there will be an additional time commitment, depending on midwives' availability.

Audio recording: With your permission, the investigator will record your interview using an audio-recording device. This recording is optional, and you will still be able to participate in the study even if you do not give the permission to record the interview. If you opt for your interview to be recorded, then immediately following the interview, the audio file will be transferred from a Sony recorder to the investigator's password-secured UCF OneDrive. The audio recordings for the interviews will be transcribed automatically by Microsoft Teams, and then corrected for accuracy by me within the Microsoft Teams platform. Only the PI will have access to the recordings in the Teams platform.
This study is confidential: A pseudonym or a number will be assigned to you in order to ensure confidentiality. Any contact information acquired by the investigator for the purpose of scheduling an interview will not be associated in any way with the transcript or audio of your interview. Any identifiable data will be stored separately from deidentified data. Only the PI or approved study team members will have access to the data. All data will be safely stored for 5 years year study closure per Florida law, and it will be stored on the investigator's password-secured UCF OneDrive. Any publications resulting from the study will not include identifiable information.

Inclusion Criteria: You must work as certified midwife (must be female) or an OBGYN with Hasidic patients working with the Hasidic community for over 2 years. You must be over the age of 18 and speak English.

Contact information for questions about the study or to report a problem: If you have questions or concerns about your participation in this research study, please contact the Haley Juroviesky, Honors Student, Department of Anthropology, at 314-359-6980 or by email at hjuroviesky@knights.ucf.edu. The Faculty Adviser for this study is Dr. Joanna Mishtal, PhD, Department of Anthropology at 407-823-3797 or via email at jmishtal@ucf.edu.

University of Central Florida IRB
IRB Number: STUDY00005148
IRB Approval Date: 3/27/2023

IRB contact about your rights in this study or to report a complaint: If you have questions about your rights as a research participant, or have concerns about the conduct of this study, please contact Institutional Review Board (IRB), University of Central Florida, Office of Research, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901, or email irb@ucf.edu.

UNIVERSITY OF CENTRAL FLORIDA

EXPLANATION OF RESEARCH

Title of Project: "Jewish women's reproductive health traditions from the perspectives of midwives and other reproductive healthcare providers in the United States."

Co-Investigator: Haley Juroviesky, BA Honors Student, Department of Anthropology, UCF

Principal investigator: Joanna Mishtal, PhD, Department of Anthropology, UCF

You are being invited to take part in a research study. Whether you take part is up to you.

Study purpose: The purpose of this research project is to explore the relationship between Jewish cultural practices and how they fit into biomedicine when Hasidic women seek reproductive healthcare.

What you will be asked to do in the study: You will be asked to participate in a voluntary interview.

Location: The interview may take place in person or via Zoom or telephone, whichever is mutually agreed upon by the investigator and the participant.

Time required: The interview may last approximately 45 to 80 minutes. The interview will take place at a time that is convenient for you, the participant, as well as the researcher.

Audio recording: With your permission, the investigator will record your interview using an audio-recording device. This recording is optional, and you will still be able to participate in the study even if you do not give the permission to record the interview. If you opt for your interview to be recorded, then immediately following the interview, the audio file will be transferred from a Sony recorder to the investigator's password-secured UCF OneDrive. The audio recordings for the interviews will be transcribed automatically by Microsoft Teams, and then corrected for accuracy by me within the Microsoft Teams platform. Only the PI will have access to the recordings in the Teams platform.

This study is confidential: A pseudonym or a number will be assigned to you in order to ensure confidentiality. Any contact information acquired by the investigator for the purpose of scheduling an interview will not be associated in any way with the transcript or audio of your interview. Any identifiable data will be stored separately from deidentified data. Only the PI or approved study team members will have access to the data. All data will be safely stored for 5 years year study closure per Florida law, and it will be stored on the investigator's password-secured UCF OneDrive. Any publications resulting from the study will not include identifiable information.

Inclusion Criteria: You must be a Rabbi or a Rabbinical Assistant or a Rebbetzin practicing outside of rabbinical school for 5 years in a Hasidic community. You must be over the age of 18 and speak English.

Contact information for questions about the study or to report a problem: If you have questions or concerns about your participation in this research study, please contact the Haley Juroviesky, Honors Student, Department of Anthropology, at 314-359-6980 or by email at hjuroviesky@knights.ucf.edu. The Faculty Adviser for this study is Dr. Joanna Mishtal, PhD, Department of Anthropology at 407-823-3797 or via email at jmishtal@ucf.edu.

IRB contact about your rights in this study or to report a complaint: If you have questions about your rights as a research participant, or have concerns about the conduct of this study, please contact Institutional Review Board (IRB), University of Central Florida, Office of Research, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901, or email irb@ucf.edu.

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UNIVERSITY OF CENTRAL FLORIDA

EXPLANATION OF RESEARCH

Title of Project: "Jewish women's reproductive health traditions from the perspectives of midwives and other reproductive healthcare providers in the United States."

Co-Investigator: Haley Juroviesky, BA Honors Student, Department of Anthropology, UCF

Principal Investigator: Joanna Mishtal, PhD, Department of Anthropology, UCF

You are being asked if the researcher may be present for your reproductive care. You may agree or decline for her to be present.

Study purpose: The purpose of this research project is to explore the relationship between Jewish cultural practices and how they fit into biomedicine when Hasidic women seek reproductive healthcare.

What is being asked of you: For the Investigator, Haley Juroviesky, to shadow your reproductive provider for the duration of your appointment. To observe reproductive customs that the Hasidic patient and/or provider participate in the examination room. Observations may include the midwives' interactions with the Hasidic patients during pre-natal care, post-natal care, births, baby-naming events etc.
Before each observation, I will ask you if you are comfortable with me doing the observation. At any point during the event being observed, you are welcome to ask me to leave. Your decision to be observed for this study will NOT affect the care you receive. I will not ask you or your doctor any questions during the appointment, I will only be observing.

Location: The midwifery, or OBGYN private practice, or your home.

Data Collected: During these observations, I will be taking field notes. All field notes will be handwritten. Observations written in my field notes are related to traditions, customs, and practices, as well as interactions between the provider and patients. This can also include notes taken during shadowing of clinicians, participating observing, or information participants tell me while out in the field. Observations may include pre-natal care, post-natal care, births, baby-naming events etc.

This study is confidential: No personal identifiers will be collected from yourself or any other patients participating in the study. A pseudonym or a number will be assigned to you in order to ensure confidentiality. Although there is no intention of collecting identifiable data via the observational field notes, I will review all observational field notes and deidentify them if identifiable data is unintentionally collected. All data will be securely stored on UCF OneDrive for 5 years after the study's closure. Only the approved research team will have access to the data.

Inclusion Criteria: Hasidic women over the age of 18, receiving care from an OBGYN or certified nurse midwife.

If participation has caused you to experience any kind of distress or made you feel uncomfortable in any way, please contact:
For New York: NYC Well https://www.nyc.gov/site/doh/health/health-topics/nyc-well.page
For Florida: UCF Community Counseling https://ccie.ucf.edu/ccrc/

Contact information for questions about the study or to report a problem: If you have questions or concerns about your participation in this research study, please contact Haley Juroviesky, Honors Student, Department of Anthropology, at 314-359-6980 or by email at hjuroviesky@knights.ucf.edu. The Faculty Adviser and Principal Investigator for this study is Dr. Joanna Mishtal, PhD, Department of Anthropology at 407-823-3797 or via email at jmishtal@ucf.edu.

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