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Helen Keane

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FEMINISM AND THE COMPLEXITIES OF GENDER AND HEALTH

Helen Keane

Abstract Feminist research and activism have made a distinctive contribution to social studies of health and have also had a significant impact on public health policy. Gender is widely recognised as a key driver in the social determination of health and is a well-established category of analysis in fields such as the sociology of health. As a response to Broom, this article focuses on two ways in which feminist social science has complicated the understandings of gender and health which underlie much health policy and research. The first is the framework of intersectionality, which emphasises the interactions between different aspects of social identity and reveals the limitations of a singular or primary focus on gender in analysing experiences of health and ill-health. The second is the critical analysis of health as a regulatory ideal, prompted by the rise of the 'new public health' and its emphasis on individual responsibility for risk reduction. Together these critical insights reveal some of the tensions embedded in feminist goals such as improving women's well-being.

Despite its equivocal conclusion, the impression left by Dorothy Broom's article is one of significant feminist impact on a field of research, brought about through a combination of engaged scholarship and astute advocacy. As her article outlines, feminist research and activism has made a distinctive contribution to social studies of health and has also had success in influencing public health policy. The significance of gender as a key driver in the social determination of health is acknowledged by governmental organisations. 'Women's health' and 'men's health' have become mainstream research and policy areas (Commission on Social Determinants of Health 2008). Moreover, in fields such as the sociology of health and illness, medical anthropology and the political economy of health, gender is a well-established and familiar category of analysis.

In this response, my aim is to expand on Broom's account by briefly exploring some of the ways feminist social science has complicated the understandings of gender and health which underlie much health policy and research. Due to limitations of space I will focus on only two points; the first is the framework of intersectionality and its impact on feminist research on health, and the second is the contemporary status of health as a site of moral performance and rational self-management (Williams 1998; Petersen, Davis, and Fraser 2010). These two points are quite different; one is related to theoretical developments within feminism, and the other one to biopolitical trends and the norms of neoliberal citizenship. They have in common, however, their destabilising impact on the topic of 'gender and health' and their complication of the relationship between feminist research, gender and health.

Before turning to these specific points, it will be useful to briefly consider a related topic: the extensive engagement of feminist scholarship with medical knowledge and practice as a site where the body and embodied sexual difference is constituted. The 'corporeal turn' which took place in both sociology and feminism in the later part of the twentieth century produced an explosion of interest in embodiment as a feature of human existence central to sociality and to subjectivity (Grosz 1994; Turner 1996; Witz 2000; Fraser and Greco 2005; Probyn 1999). The rise of embodiment as a theme within social and critical theory and in disciplines such as sociology arose as a response to the 'somatophobia' of Western knowledge, in which the body was either ignored or devalued as other to reason and the mind (Grosz 1994; Shildrick 1997). In 2000 Anne Witz argued that the two relatively new fields of the sociology of the body and the feminist philosophy of the body often worked counter-productively because the first paid insufficient attention to the differential inclusion of gendered bodies in the sociological tradition, while the second had a tendency to overwhelm the sociality of gender with a focus on corporeality. Thus feminist sociologists needed to negotiate their way carefully and critically through the 'corporeal turn' (Witz 2000, 2). Witz noted, however, that work on the 'lived body' by philosophers such as Rosalyn Diprose (1994) and sociologists such as Nick Crossley (1995) provided a 'promising coalescence' between the two fields (Witz 2000, 20). Feminist scholarship on the body in medicine is another example of fruitful coalescence between theoretical analysis of corporeality and specific lived experiences of embodiment.

Feminist scholars within sociology (and other disciplines such as history) have focused productively on medicine as a discursive field in which bodies are differentially constituted as healthy or disordered, normal or abnormal and whole or broken (de Ras and Grace 1997; Shildrick and Price 1998; Shildrick 2002). As many researchers observed, female bodies, particularly their reproductive processes, have been viewed within medicine as prone to illness and disorder (Ussher 2006; Hubbard 1990; Schiebinger 2004). They have been represented as 'Other' to the normal and stable male body, and frequently imagined as impure and polluting, with 'leaky' boundaries that can unsettle social order (Lupton 2012; Shildrick 1997). These theoretical insights into the differential embodiment of men and women have both fed into, and emerged from, feminist analyses of dominant medical discourses, such as those of menstruation and menopause as decay, waste and deficiency (Martin 1987; Lupton 1996).

The identification of women with the body, and the dualism which categorises knowledge and reason as separate from the body, relates to Broom's point about the hierarchy of knowledge in which the social sciences and feminist analyses are devalued because of their supposed subjectivity and distance from the scientific facts of epidemiology. Another element related to the cultural coding of disciplines which is not explicitly highlighted in Broom's article is the constitution of health as 'women's business' (although the feminised health work force she mentions is an aspect of this). The historical, symbolic and idealised associations between care, nurturance, embodiment and femaleness produce an overdetermined sense of fit between the category 'women' and the concerns and practices brought together under the term 'health' (in contrast to, for example, the gendered implications of 'politics' or 'knowledge'). 'Women's health' as a topic of investigation and site of intervention conforms to conventional understandings of gender and sexual difference. It can be argued that health as a topic of investigation has been relatively open to feminist influence in part because of this compatibility.

More broadly, categories such as 'women's health' almost inevitably reproduce a conventional model of gender as an inherent quality of individuals. The reiteration of 'women's health' as a topic of concern can act to draw attention away from the normative regimes and systems of relations which produce 'women' as a taken for granted category in the first place (Butler 1990). A conventional link between bodies and identities is solidified at the same time as the consequences of those links are examined and challenged. This is not to dispute that the feminist strategies and claims that were mobilised around 'women's health' were often radical and subversive of the status quo; for example, through their challenge to medical expertise and demands for reproductive autonomy (Broom 1991). As I will go on to discuss, feminist health scholars have produced powerful challenges to the binary and categorical approach to gender expressed in the terms 'women's health' and 'men's health'. As the two separate gender health policies discussed by Broom reveal, however, that these gendered categories are now stabilised and resilient global apparatuses, seemingly resistant to critique.

Intersectionality: Complications of Gender

Intersectionality is a framework of analysis that explicitly challenges 'single-axis thinking' which focuses only on the effects of gender or race or class or sexuality, as if these categories of difference are independent and separable in their effects. Instead it emphasises the 'simultaneous interactions between different aspects of social identity' and the interlocking nature of systems of domination (Hankivsky and Cormier cited in Hankivsky 2012, 1712). Intersectionality was developed by African American feminist scholars who highlighted the way Black women's unique experiences of oppression could not be captured by traditional antiracist and feminist politics (Crenshaw 1989, 1991). In the influential work of Patricia Hill Collins, an intersectional framework is expressed in a model of social power relations called 'the matrix of domination'. The matrix includes intersecting systems of oppressions whereby differently located subjects experience both privilege and penalty (Hill Collins 1990). Thus, in the context of vexed debates about difference and sameness which characterised late twentieth-century feminism, intersectionality produced awareness of the limitations of a gender focus in understandings of women's lives, not only because it masked the specificities of race, class, sexuality and age, but because it made invisible the power and privilege enjoyed by the white middle-class women who dominated the mainstream women's movement (hooks 1984; Spelman 1988).

Last year, a special issue of the journal *Signs* was devoted to the 'burgeoning' field of intersectionality studies, a field which includes both vigorous theoretical innovation and debate, and diverse applications of the intersectional framework in research, teaching and other forms of praxis. As the editors of the issue stated, the concept of intersectionality has been remarkably productive, both theoretically and in empirical research (Cho, Crenshaw, and McCall 2013). Despite criticisms that it lacks methodological strategies or the ability to identify specific targets for intervention, intersectionality has been put to use in disciplines such as history, sociology, philosophy, geography, anthropology and literary studies and has facilitated the consideration of gender, race, class and other axes of power in a wide range of contexts.

Studies of health have been one of the areas where intersectional analysis has been productively adopted, as demonstrated in a 2012 special issue of *Social Science and*

Medicine devoted to intersectional, relational and biosocial approaches to gender and health. In her article in this special issue, Olena Hankivsky argues that intersectionality has come to be recognised as 'a valuable normative and research paradigm for furthering understandings of the complexity of health inequalities' (2012, 1712). One of her examples is HIV/AIDS research. Interestingly, she discusses a recent study of HIV-positive migrants in the UK carried out by Lesley Doyal (2009). As outlined in Broom's article, Doyal was a pioneer in the feminist political economy of health. Her 1995 book, *What makes women sick?*, extended her earlier class-based analysis of health inequities to include structures of gender. Her 2009 study is noteworthy for its move from structures of gender and class to an explicitly intersectional analysis. Her study highlights the similarities and differences between the experiences of HIV-positive heterosexual women, heterosexual men and gay/bisexual men within a community of Black African migrants living in East London. The study used a multidimensional methodology in which each group of interviews was analysed separately and then comparatively. It was also sensitive to the contradictory influences of experiences such as migration on health and illness. For example, while their migrant status contributed to poverty, occupational downgrading, legal uncertainty and onerous family expectations about sending money home, it also gave the respondents access to healthcare and specialist services that they would not receive in their home country.

Doyal's intersectional analysis was able to identify key differences in the experiences of the three groups. Most of the women interviewed were single mothers, and the difficulties they faced in meeting the responsibilities they perceived as maternal were central to their distressing experiences of illness. They were also aware that their HIV status was seen as a moral failure in relation to ideals of motherhood. While they faced emotional isolation in part due to reluctance to disclose their HIV status, motherhood also provided them with 'intense pleasure' and motivated creative survival strategies (Doyal 2009, 182). For the heterosexual men, a key issue was the difficulties of maintaining their status as African men alongside the 'weakness' which they saw as characterising not only their physical condition but also their economic and social status. For the gay and bisexual men, most of whom had not disclosed their sexual identity or their HIV status to their family, managing different social networks was complex and required 'constant juggling'. Many did not have contact with their communities of origin or their immediate families which added to the difficulty of managing the practical and emotional aspects of their illness (2009, 183). Doyal concludes that intersectional analyses are able to enhance the HIV literature by better diagnosing policy problems and prescribing solutions in the contexts of global, regional and local diversity.

As Doyal points out, the challenge with intersectional analysis is to increase complexity without losing intelligibility (see also McCall 2005). The difficulty is that there are a multitude of potential variables and axes of difference which can be investigated (this is sometimes referred to as the 'etc. problem' as in the open-ended list: gender, race, class, nationality, sexuality, age, etc.). And, while the intersectional framework undermines the static essentialism of studies based on men versus women, empirical social research such as Doyal's nevertheless relies on and reproduces categories such as 'Black African migrant'. Such categories obscure many significant cultural, social and geographical differences as Doyal herself acknowledges (2009, 177).

For philosophers such as Elizabeth Grosz, concerned with a more indeterminate notion of difference as a generative force in transformative politics, intersectionality only appears to acknowledge difference by expanding categories of subjectivity. In her view the focus on recognisable and mappable characteristics in fact acts to generate sameness and a schematic 'freezing' of identity (2010). Grosz's objection to intersectionality highlights the huge differences of disciplinarity which exist in feminist scholarship. These differences are not just to do with the particular methods and goals of different forms of knowledge production, but also include conflicting visions of politics and political change. While Grosz's critique may seem distant from the specific demands of health social science, it does raise the importance of continuing to reflect on the different methods informed by intersectionality and to question the dominance of particular analytical categories (McCall 2005).

One important point made by Hankivsky is that intersectionality is not prescriptive, in that it does not insist that any particular dimension of difference takes precedence over any other. Salient axes cannot be predetermined, but depend on the particular research being undertaken (Hankivsky 2012; Broom and Warin 2011). This point raises questions about the relationship of feminist health research to gender as an analytic category and women as an identity group. As Broom outlines, the research and advocacy of feminist health scholars has been successful in arguing that gender is a key determinant of health and that women have special needs that were not being met by existing services. While gender and health as a field has opened up to include considerations of masculinity and sexuality, there is still an assumption that feminist analyses are identifiably feminist in as far as they concentrate on gender. Some feminist researchers who are committed to intersectionality retain the view that gender should have some form of primacy in health research. For example, in her introduction to a special issue of the journal *Sex Roles* titled 'Intersectionality of Social Roles: A Gender Perspective', Stephanie Shields explains the focus on gender in the issue by stating that 'We do not suggest that gender is always and everywhere the most important social identity, but it is the most pervasive, visible, and codified' (2008, 307).

In Doyal's HIV study (and many others) gender and sexuality are highlighted as the axes that explain the different experiences of illness within the researched community, but in other areas of health research, gender may not be the most salient or meaningful social division or set of relations to study. From an intersectional perspective, the well-established field of gender and health research can appear less a feminist achievement and more an example of the hegemonic dominance of gender as a 'master' category which obscures other relations (Hankivsky 2012, 1714, 1717). While intersectionality is understood to be one of the major theoretical contributions made by feminist research (McCall 2005), it also brings into question some of the institutionalised effects of feminism and feminist knowledge.

Complications of Health

As Broom outlines, the relationship between feminist social science researchers and public health has been productive as well as challenging. Public health, as Broom notes, has an explicit mandate to prevent ill-health and promote well-being. Therefore feminists working in this area have been able to tie their academic work with advocacy for women's health issues. As feminists working in public health, Yancey, Leslie, and Abel (2006)

highlight similarities between the two fields, including 'a commitment to producing knowledge to advance social justice' (2006, 437). The rise of what is known as the 'new public health', however, makes the politics of health a complicated terrain (Petersen, Davis, and Fraser 2010; Petersen and Lupton 1996). The 'new public health' is characterised by an increased emphasis on individual responsibility for risk reduction through the adoption of a healthy 'lifestyle'. Health has become a site for the moral performance of the self, where individuals are encouraged to demonstrate the qualities of rational self-management and self-control central to neoliberal citizenship (Williams 1998). The goals of healthy living as expressed through public health campaigns have been convincingly critiqued as examples of contemporary biopolitics which aim to create 'docile bodies' through self-surveillance and self-discipline (Lupton 2010). Health has become an injunction backed up by a powerful array of moral discourses which replicate social norms of attractiveness and good behaviour (Moore 2008; Cheek 2008). In this context, what does it mean to be committed to a feminist goal such as improving women's well-being?

The issue of obesity provides a vivid example of the tensions involved in feminist interventions into health. Feminist researchers have long been attentive to the potent negative meanings of fat, especially female fat, in contemporary culture and to the punitive and misogynist aspects of 'weight management' (Fraser, Maher, and Wright 2010; Murray 2005). In her classic work, Susan Bordo examined the connections between the ideal of the slender and firm body and cultural anxieties about female desire, transgression and 'internal processes out of control' (1993, 189). Thus one important response to the current preoccupation of public health with obesity has been to highlight the way supposedly objective claims about the dangers of fat and the pathology of the fat body replicate cultural norms and act to further publicly degrade the already stigmatised fat body (LeBesco 2011). Other critical feminist work has challenged the veracity of the claims made via constructs such as body mass index (BMI) and highlighted the way mothers are blamed for child obesity (Bell, McNaughton, and Salmon 2009; McNaughton 2011).

Other feminist researchers have criticised what they regard as the lack of feminist engagement with the serious health-damaging consequences of obesity and of the obesogenic environment. Yancey, Leslie and Abel present overweight and obesity in the United States as an urgent issue of social justice which is being generally ignored by feminists in favour of a preoccupation with the cultural promotion of female thinness which they argue produces health consequences only for a small minority of women (2006, 426). They emphasise the higher risks of overweight and obesity among women, especially poor women and women of colour, and the burden of chronic disease suffered by the disadvantaged. They call for a 'feminist agenda for change' focused on policies supporting active recreation, public transport, access to affordable healthy food and other changes to neighbourhood environments (2006, 436). In their view the 'wide gap' between public health and women's studies on the issue of obesity represents a failure of feminist engagement. From a different perspective, Elspeth Probyn has also criticised feminist attempts to revalue the fat body and transform the meanings of fat, stating: 'There is something seriously wrong with an analysis that leaves untouched the socioeconomic structures that are producing ever larger bodies' (2008, 402).

In a rigorous dissent from the environmental account of obesity, Anna Kirkland has in turn criticised authors such as Yancey, Leslie and Abel (2006) and Probyn for echoing the public health perspective on obesity, accepting its claims about the health effects of the 'epidemic' and failing to interrogate the elitist, moralising and punitive policies which

are supported by such claims (2011). Kirkland argues that while the environmental approach to obesity supported by Yancey, Leslie and Abel appears to be a progressive and structural counter to stigmatisation and responsabilisation, it 'ultimately rebounds to a micropolitics of food choice dominated by elite norms of consumption and movement' (2011, 464). For her, the tension around obesity and food politics is indicative of a broader tension in which well-intentioned feminist efforts to improve women's living conditions at a collective level often end up as 'intrusive, moralizing, and punitive direction of their lives' (2011, 464). Similar points could be made about feminist responses to other forms of 'risky consumption' such as smoking and drinking, and to maternal health issues, such as breastfeeding (Keane 2000, 2006; Wolf 2007).

The tensions embedded in the goal of improving women's well-being, identified by Kirkland, are produced in large part by the range of concepts and practices included in the category of health. In this sense they are not specifically feminist. It does seem clear that feminist engagement with health requires a careful and reflective approach which is attentive to the nature of its relationship with the pervasive and relentless ethics of self-management which have become synonymous with 'being healthy' (Moore 2008). As Broom and Warin argue in relation to the gendered and classed nature of obesity in Australia, the task of social scientists is to problematise the nature of evidence and to be critical of pathologising discourses which target certain groups of people as 'failing society and future generations' through their body composition (2011, 461). They also note, however, that social scientists need to acknowledge the materiality of bodies, and the complex biocultural interchange of health and bodies, which includes attention to health-damaging practices (2011, 461). Balancing these different demands in the face of proliferating discourses of risk, responsibility and healthy living will continue to be one of the characteristic challenges of feminist health research.

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Helen Keane teaches gender studies and sociology at the Australian National University. Her research focuses on drug and alcohol use, including pharmaceutical, recreational and illicit drugs, with a particular interest in understandings and practices of addiction. She is the author of *What's Wrong with Addiction?* (New York University Press, 2002) and co-author of *Habits: Remaking Addiction* (Fraser, Moore & Keane, Palgrave Macmillan, 2014).