Medical Anthropology

Regional Perspectives and Shared Concerns

Edited by

Francine Saillant and Serge Genest

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Chapter 12

GENDER

Engendering Medical Anthropology

Carole H. Browner and Carolyn Sargent

Our objective in this chapter is to trace the theoretical and political trajectories that have shaped current research on gender in medical anthropology in the United States. In doing so we articulate explicit and implicit linkages between the fields of anthropology and gender studies and health. Here we focus mainly on US scholars – and Canadians to a lesser extent – in that most of this bridging scholarship emerged in this region. While anthropologists were not alone among social scientists in articulating a research agenda intended to reveal the social constructions of health and gender, for the most part we consider anthropological research, although we selectively include works by scholars from other disciplines. Also because most work in this area has looked at women, for the most part our review addresses issues associated with women's health. We consider male gender and health when there is relevant literature; this field is newly emerging and far more work is needed.[1]

Feminist activists of the 1960s contributed profoundly to the emergence of an anthropology of women and ultimately to feminist theories in anthropology by identifying the multiple and mutually reinforcing dimensions of gender inequality and the structures by which they are reproduced. Powerful social movements of that era sparked concerted efforts to revolutionalize women's health care. This dialectic between the 20th-century popular health and feminist movements mirrored that seen in the 19th century. At the same time, scholars within the academy looked to the evolutionary and cross-cultural perspectives of anthropology for the light they could cast on understandings about health, sexuality, and the female body.

The Anthropology of Childbirth and the Political Relations Surrounding Reproduction

The feminist project within medical anthropology was inspired by the activist challenge to the enduring male institutional domination over reproduction and the female patient. Reconstructing the processes that led to the radical transformation from female to male controlled healing traditions, feminist medical anthropologists, along with feminist scholars from other disciplines, showed that "the suppression of female healers by the medical establishment was a political

struggle . . . part of the history of the sex struggle in general" (Ehrenreich and English 1973:4).

Along with continued feminist activism, the proliferation of gender studies in anthropology in the 1970s revitalized scholarship on reproduction. In a series of richly detailed cross-cultural investigations, earlier ethnographers had introduced the study of reproductive behavior to the parent discipline; their work, however, was highly descriptive and atheoretical (Browner and Sargent 1996). It took the next generation of anthropologists to see the potential that studies on human reproduction held for defining a new research agenda with immediate political implications.

Brigitte Jordan's *Birth in Four Cultures* (1993) focused anthropological attention on the comparative study of birthing systems and in doing so single-handedly moved the nascent field beyond recording individual and isolated "birth practices" which had characterized earlier work on the subject. As Jordan astutely observed, "within any given system, birth practices appear packaged into a relatively uniform, systematic, standardized, ritualized, even morally required routine" (1993:2). A vast and important literature on the biocultural patterning of birth in both non-Western and Western societies quickly followed (Davis-Floyd and Sargent 1997). This literature, characterized by vivid ethnographic detail and careful analyses of how childbirth articulates with gender ideologies, domestic politics, religion and cosmology, occupational hierarchies, local medicine, and the structure of state-sponsored health services. It documented that birth practices within a particular society may be consensually shaped or bitterly contested (Davis-Floyd and Sargent 1997; Sargent 1989).

Studies by Browner (2000) and Ginsburg (1998), among others, illustrated that members of a given culture do not necessarily share reproductive goals regarding such issues as when to become pregnant or whether to continue an unintended pregnancy. Even in small-scale societies, husbands, kin, neighbors, and members of other social groups may have reproductive goals that conflict with one another – and with those of women themselves. This body of research focused attention on how decisions, including reproductive decisions, are actually made, thereby contributing to the central theme of the anthropology of women by studying what women really do as opposed to what ethnographers and male informants say they do. This work also informed newer anthropological recognition that intracultural diversity was as much a feature of pre-industrial as industrial societies.

Reproductive decision-making, however, concerns more than contested goals. Other social processes (e.g. historical relationships, negotiations among plural medical systems, religious traditions, variable conceptions of risk) also shape women's and men's reproductive decisions, as well as other aspects of their reproductive experiences. Allen's new monograph, for example, describes the competing definitions of risk – those drawn from international and national maternal health policies and those derived from local experience – and shows their effects on women's reproductive strategies and decisions in rural Tanzania (Allen 2002).

Within their continued efforts to analyze the broader social forces shaping women's reproductive experiences, medical anthropologists also focused on the ways the ideologies and practices of biomedicine determined women's reproductive options.

Synergism between feminist scholars and activists generated a political approach to women's health that was fundamentally different from the biomedical one and based on providing greater reproductive options and a redistribution of power between doctors and patients (Ginsburg and Rapp 1995; Morgen 2002).

The Medicalization of Reproduction

A consistent theme in this body of research is that the dominant cultural definition of birth in the United States is one in which pregnancy is viewed as a pathological state, requiring specialist attention and hospital delivery. Accordingly, the medicalization of childbirth, characterized by use of technological interventions during birth such as episiotomy (a surgical incision of the vagina to widen the birth outlet), intravenous medication, and the lithotomy (supine) position for delivery have become standard procedures (Davis-Floyd 1992; Jordan 1993), as has cesarean section, or surgical birth, which in many countries has reached 30% or higher (Sargent and Stark 1987). Davis-Floyd has shown that technocratic childbirth has become "an American rite of passage," in that 98 percent of women deliver in hospitals, in many hospitals more than 80 percent of women receive epidural anesthesia, and at least 90 percent are given episiotomies (Davis-Floyd and Sargent 1997:11).

In her now-classic cultural analysis of reproduction, Emily Martin (1987) extends the critique of medicalization to menstruation and menopause as well as childbirth. Analyzing women's narratives about their birth experiences, she describes their sense of alienation and fragmentation produced by reliance on technological interventions and specialist monitoring, revealing the deep ambivalence women feel about biomedical control as reflected in acts of resistance and opposition. At the same time, Margaret Lock and Dona Davis, among others, offer further cross-cultural analysis of the medicalization of menopause (Davis 1983; Lock 1993).

Breathtaking yet at times dizzying developments in reproductive science and technology continue to change values and expectations associated with conception, pregnancy, and childbirth. Since the 1970s, sharply critical feminist writings have questioned the excessive medicalization of women's reproductive processes, including the harmful effects of routinely used pharmaceuticals such as thalidomide and DES and medical procedures including hysterectomies and sterilizations (Morgen 2002:120). In subsequent decades, along with other scholars, anthropologists further documented ways that pregnancy and childbirth had become increasingly mechanized and pathologized. In addition to childbirth technologies, anthropologists questioned the growing use of fetal diagnostic testing and surveillance technologies. Browner and Preloran (2000) find technologies for the monitoring and surveillance of pregnancy have grown so common that many US women

insist on having them, even in the absence of any medical indication. This is particularly true for ultrasound but increasingly for amniocentesis as well (Browner and Preloran 2000). These technologies are also rapidly becoming routine not just in the United States but in many other countries as well (Mitchell and Georges 1998; Morgan 1999; Taylor 2000), and used not just for diagnosing birth anomalies but also for sex determination that often leads to the selective abortion of female fetuses (Miller 2001). Rayna Rapp has eloquently reflected on some of the troubling moral issues inherent in the use of prenatal diagnosis. Through their use, she writes, "women are forced to judge the quality of their own fetuses, making concrete and embodied decisions about the standards for entry into the human community" (Rapp 1999:3).

Until the 1990s, work on the medicalization of reproduction focused largely on contraception, pregnancy, and childbirth; by contrast, infertility was almost completely ignored (Inhorn and Van Balen 2002). Since then a growing anthropological literature has looked at the devastating impact of pregnancy loss and infertility on the lives of those affected (Becker 1997; Layne 2002); there has also been a provocative ethnographic study of surrogacy (Ragone 1994). Marcia Inhorn's *Quest for Conception* (1994), the first comprehensive account of non-Western's women's experiences of infertility, depicted the struggles of poor, urban Egyptian women and their attempts to overcome infertility. Since then, other important cross-cultural accounts have appeared (Inhorn and Van Balen 2002). At the same time, feminist anthropologists warned about the disjuncture between the momentum of the technologies and their social and legal concomitants. The physically demanding and experimental nature of the new medical infertility procedures as well as their low success rates prompted alarm that women's bodies were becoming experimental sites. In this regard, Margarete Sandelowski compellingly describes what she characterizes as the "never-enough quality" of conceptive technologies (Sandelowski 1991). One of the newest directions in the anthropological literature on infertility is its personal and interpersonal impact on men.

The Paradigm of Authoritative Knowledge

A related body of important medical anthropological literature documents women's resistance in Western and non-Western societies to biomedical authority. Brigitte Jordan again broke new theoretical ground with the concept of "authoritative knowledge." She writes that "for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both" (Jordan 1993:152).

Her conceptualization of "authoritative knowledge" has proved extremely useful in analyzing the shifting power relations implicated cross-culturally in struggles for control over childbirth, making visible the enormous work involved in imposing a consensual reality across power differences. The authors of the collection *Childbirth and Authoritative Knowledge* extended Jordan's concept to other reproductive domains, including US pregnant women's self-care practices during pregnancy and the maintenance of indigenous knowledge systems in the face of the global exportation of biomedicine (Davis-Floyd and Sargent 1997).

This newly focused anthropological attention to the structure and organization of expert knowledge and their implications for broader power relations in a given society built on a longstanding anthropological interest in healers and the management of illness. However historically anthropologists, who themselves were mostly men, were more interested in the dramatic, colorful, and often supernaturally inspired male healing specialists, such as spirit-mediums, diviners, and priests, and specialists such as bone-setters and herbalists who controlled well-defined bodies of expert knowledge. Carol McClain's *Women as Healers* (1989) broke new ground by, among other things, describing women as unnamed and informal healers, analyzing why women may be reluctant to assume public healing roles, illustrating the ways that female and mother symbols characterize women's healing practices, and showing how global processes are transforming women's healing techniques and practices. This work also spawned a literature on women in nonbiomedical healing roles.

Midwives have long been a principal focus in the work on women healers, beginning with accounts by Lois Paul, Arthur Rubel, and Sheila Cosminsky (Cosminsky 1976; Paul 1975; Rubel et al. 1971). Cosminky's comprehensive review of the cross-cultural midwifery literature found that most works of that period were mainly descriptions of midwives' practices. Her own contribution was to examine variation in midwives' statuses and roles cross-culturally (Cosminsky 1976). Theories suggest that the social position of midwives derives from the social standing of women in the larger society, the status of healers who are not midwives (McClain 1989), the nature of the technical and ritual skills that midwives possess (Laderman 1983; Sargent 1989), and whether midwives are chosen by divine selection, self selection, inheritance, or in other ways (MacCormack 1982; Paul 1975). Nonetheless, there is no overarching single theory that fully explains variation in the social status of midwives cross culturally.

Political Economy, Health, and Gender

Within medical anthropology throughout the 1980s, a parallel intellectual orientation was developing focusing on political economy and health. Scholars working within this framework conducted macrolevel analyses of the effects of stratified socioeconomic and political relations within the world economic system on the distribution of disease and health services (Baer et al. 1997). However with rare exception (Morsy 1978), the earliest work in this area was oblivious to gender and it took another decade before researchers recognized that "the study of political economy, gender, and the social production of

health can overlap and mutually enrich the resultant analyses" (Whiteford 1996:243).

Work by scholars including Ellen Lazarus, Linda Whiteford, Lesley Doyal, and Soheir Morsy illuminated the links between gender, social class, and health. In Morsy's ethnographic study of an Egyptian Nile Delta village, she investigates the extent to which gender and social class are implicated in the condition of spirit possession known as "*uzr*." She shows that the incidence of illness and perceived stress in the community are related to asymmetrical power relations derived from subservient socioeconomic status within the national economy and deviation from culturally sanctioned sex role behavior (Morsy 1978). Morsy's work was far ahead of her time in that she presaged the feminist emphasis on difference among women with regard to class, age group, and family structure.

Others broadened their analytical gaze to include race as another powerful determinant. Linda Whiteford, for example, offers the case of an impoverished crack cocaine-addicted pregnant woman who is sentenced to prison. She situates the woman's predicament within the social construction of gender, race, and class and concludes that laws that punish pregnant women for addiction are less about protecting the fetus than about punishing women for being poor, pregnant, nonwhite, and addicted (Whiteford 1996). Ellen Lazarus considers medical choice, control, and social class in her research in an obstetric clinic in the United States. Focusing on what she refers to as the "intermediate" or institutional level of analysis, she shows that the power differentials between physicians and patients echoed the gender, race, and class hierarchies in the larger society, as the lower class patients in her study felt deserted by the very practitioners they thought would help them (Lazarus 1994). The health affects of race–class inequalities are further reflected in the epidemiological patterning of most diseases. For example, in the United States strokes occur far more often in black than white women and while black women are less likely to be diagnosed with breast cancer, they are more likely to die from it.

Lesley Doyal's classic overview from a political economic perspective, *What Makes Women Sick* (Doyal 1995), offers a comprehensive analysis of the global and local obstacles that prevent women from meeting their health needs, including the persistent gap between the poor and rich nations, poverty as a risk factor for HIV and other sexually transmitted diseases, unsafe sex practices, institutionalized violence against women, occupational hazards, the gendered division of labor, and lack of access to reliable means of regulating reproduction.

Women working outside the home typically spend only slightly less time in domestic work than full time housewives. Particularly in developing countries, women work longer hours than men and the poorer the country, the more hours the women work. Most spend from ten to sixteen hours a day preparing food, doing housework, and caring for children. Quantitative data consistently show that regardless of whether they work outside their homes, women work more hours each day than their husbands. The health effects of this "double day" have still not been well researched; Stellman points to some of the potential interactions:

> some of the major health hazards for women at work complement and exacerbate hazards at home. Back injuries and backaches are common to workers on the job as well as to the mother of young children and to the housekeeper at home. Skin irritation and disease are widespread among hospital workers, service workers, and industrial workers just as they are among women in the home role. (Stellman 1997:82)

For poor women in particular, the needs to both produce income and care for children may lead them to take jobs that are more poorly paid but allow flexible hours or permit them to bring along their children. And in the event that their economic burdens increase, they generally work longer hours while continuing to engage in their domestic responsibilities. In doing so, they appear not to trade off one activity for another but instead give up recreation and devote less time to sleep, rest, and relaxation. Competing demands on a woman's time for household versus market production may therefore constrain her ability to protect and promote her own and her family's health. For some women the demands of their multiple roles require more energy than their food intake provides, leading to further deteriorating health and malnutrition.

Several in-depth ethnographic accounts closely explicate the links between gender, political economy, and health by looking at the relationship between women's domestic and waged labor and their health. This was an important corrective in that it took the field beyond its initial focus on reproduction and reproductive health.

In this regard, MacCormack (1994) makes the helpful distinction between direct and indirect risks affecting women's health. Women experience direct risk when their work causes them to stand in water where they can be exposed to parasites such as schistosomiasis, onchocerciasis, and malaria. For example, in Sierra Leone, the sexual division of labor requires women to spend far more time than men working in stagnant water transplanting rice, collecting drinking water, washing clothes, and fishing (MacCormack 1994). Transporting heavy loads such as firewood and water is strenuous, demanding, and exhausting leading to physical effects such as fatigue and painful joints. Medical reports also document that carrying heavy loads can cause prolapsed uterus, spinal and pelvic damage, and reproductive problems. There are specific risks associated with the use of open stoves and cooking fires, including burns and smoke pollution. The activities of weeding, transplanting, postharvest production that are involved in cultivation often cause chronic back and leg problems and may expose women to pesticides.

Indirect risks arise from the consequences of the devaluation of girls and women – early age of marriage and family preferences for making social investments, including for food and health care – in men rather than women. Koblinsky and associates describe the myriad factors associated with health infrastructure and service organizations that restrict women's access to health care, including those associated with distance, transportation, and communication (Koblinsky et al. 1993). And although in most societies women are responsible for their family's health-care needs, these logistical difficulties are reinforced by cultural restrictions on women's mobility and their ability to interact with men.

An extreme example of this comes from Hemming's study of refugees living in Afghanistan under the Taliban regime. Women unaccompanied by male relatives were prohibited from leaving their compounds and often could not get needed medical care as a result (Hemming 1997). Hampshire's study of pastoral nomads in Chad reveals others ways that mobility can determine access to health care. As is true elsewhere in the world, most illness episodes were treated at home and women were responsible for home-based treatments; men, however, controlled the resources that would be needed to obtain medical care outside the home. However, the women who had large social networks had better access to health care when the group was not dispersed on seasonal migrations; when it was, women's health-care options become much more limited, often resulting in delayed treatment (Hampshire 1998).

Gender and HIV/AIDS

The HIV/AIDS pandemic highlighted sexuality and sexual practices as major public health issues. It also generated a vast anthropological literature that explicated links between gendered behaviors, gender ideologies, and risk of HIV infection. This anthropological research has revealed how these gender ideologies and practices embody power relations and assign meaning and value to certain sexual relationships and behaviors (Farmer et al. 1996). It also shows that issues surrounding sex, sexuality, and gender are integrally connected to intimate, private, and personal interactions between and among women and men and further reveal the multiplicity of ways that cultural models of heterosexual or homosexual relationships and family structures are conditioned by political economic relations (Sobo 1995). For example, Brooke Schoepf's extensive analysis of the cultural patterning of HIV risk in central Africa concludes that HIV spreads not through exotic sexual practices but through the contingencies of everyday life. Moreover, her observations confirm that many women at risk for HIV infection are not engaged in commercial sex and that most sexual risk is not under the control of women (Schoepf 1998).

Idioms of Distress

Research informed by the political economic orientation has also focused on how stresses produced by interactions between productive and reproductive responsibilities also put women at risk for a wide range of conditions that have been characterized as "idioms of distress" (Nichter 1981). The concept was developed by Nichter during his research in south India to describe how Brahman women with weak social support networks and few socially approved ways to express distress manifest suffering. These external projections of distress include spirit possession,

fasting, locally meaningful symptoms such as "overheat" and "hot head." Other examples of work focusing on folk illness and local idioms of distress are found in the large literature on *nervios* (nerves) in Europe, Latin America, and among US Latino groups (Low 1992; Jenkins 1996; Rebhun 1994). Researchers, who describe a very wide range of symptoms associated with the condition including dizziness, fatigue, headache, chest pain, and feelings of anger, anxiety, sadness, and desperation, tend to conclude that "nerves" is more an "idiom of daily life" than a medical complaint *per se*.

Rebhun (1994) illustrates how the suppression of strong emotions is linked with sickness. Working in northeast Brazil, she finds strong prohibitions against openly expressing the powerful negative emotions, especially jealousy, envy, anger, and hatred, that inevitably arise in the course of everyday life. These prohibitions are particularly problematic for women, who are expected to always be compassionate and selfless. Women use the expression "swallowing frogs" to refer to the need to suppress anger and endure unfair treatment such as husband's extramarital love affairs. Their anguish is expressed in several folk ailments including "nerves" *susto* (soul loss sickness), "open chest," and "blood-boiling bruises," small bruises on their thighs and arms that they attribute to their blood boiling in their veins with anger. Oths's analysis of *debilidad*, characterized by symptoms which include headache, dimmed eyesight, loss of appetite, and "aching or agitated heart," is often experienced by older women living in the northern Peruvian highlands after their children are grown. She ties the syndrome to the reproductive and productive stresses generated by the pressures of harsh social and economic conditions (Oths 1999).

Seeking a concept that transcends the particularistic formulations that have characterized much work on idioms of distress, Finkler proposes the concept of "life's lesions" which express through the body the negative conditions of existence such as poverty, malnutrition, and other adverse life events. Adding to these political and economic processes, she points to the importance of moral imperatives concerning proper behavior in social relations. She suggests that when these relationships are contested and remain unresolved they generate "life's lesions." "Under such circumstances, unresolved contradictions and moral indignations become inscribed on the body, ensuring symptomatology in overall discomfort, pain, and suffering" (Finkler 1994:16).

At the same time, both Michel Foucault and a number of major feminist theorists such as Jana Sawicki (1991) have drawn much needed attention to the many ways state politics and policies – and those of other powerful institutions – may be inscribed upon the body. Within this framework, female disorders such as anorexia and agoraphobia are an unconscious form of resistance. But whereas the idioms of distress literature focuses on the subjective experience of the sufferer (although in relation to political economy), feminists informed by Foucault additionally interrogate subjectivities made manifest by political oppression and social inequalities (see Scheper-Hughes 1992). Physical symptoms, then, are not just biological manifestations but also metaphors that reflect and represent political resistance. A parallel literature, derived from phenomenology, uses the concept of

"embodiment." Low (1992:159), for example, observed that women suffering symptoms of *nervios*, or "nerves" carry "the communicative force of culturally generated metaphors of distress that provide symbolic expression of personal conflicts, community upheaval, and social control through bodily experience" (see also Allen 2002 on managing and disciplining Tanzanian mothers and Van Hollen 2003:159 on female subjectivities and reproduction as an object of state surveillance in South India).

Violence Against Women

Among the most pervasive yet least recognized consequences of sexism throughout the world are the many forms of institutionalized violence against women. Heise defines gender violence to include "any act of force or coercion that gravely jeopardizes the life, body, psychological integrity or freedom of women, in service of perpetuating male power and control" (Heise 1993:171). It includes rape, battery, homicide, incest, psychological abuse, forced prostitution, trafficking in women, sexual harassment, acid attacks on girls and women involved in dowry disputes and domestic conflicts, dowry-related murder, or "bride-burning," and selective female infanticide and selective female abortion.

Given the global scope of these problems, it is surprising how little anthropological attention has been devoted to analyzing the responsible factors. For instance, it is estimated that at least 30 percent of US women will be beaten by a partner at some point in their lives. In Papua New Guinea, 67 percent of rural women and 56 percent of urban women report having experienced abuse. A survey from Santiago, Chile finds that 80 percent of women reported abuse by a male relative or partner (Heise 1993).

In parts of India, one in four deaths among women aged 15–24 were due to "accidental burns" and female deaths from burns have been increasing for the past 25 years in conjunction with the commercialization of dowry demands. It appears that homicides and suicides are being recorded as "accidents" rather than intentional injuries (Heise 1993). Additional evidence for this comes from a study in Bangladesh of deaths among women aged 15–44 during an eleven-year period. Eighteen percent of the women's deaths were from intentional or unintentional injuries, 52 percent of which occurred during or immediately after pregnancy. The authors conclude that the underlying causes of these violent deaths, primarily complications of induced abortion, suicides, and homicides, are clearly social and may be seen as a consequence of men's strict control over women's sexual and reproductive lives (Fauveau and Blanchet 1989).

In certain parts of the world, these gender ideologies that hyper-value men have produced not just selective neglect of female children but infanticide and the selective abortion of female fetuses. The classic anthropological work on the subject is Miller's demographic and ethnographic analysis of gender, culture, and mortality in north India (Miller 1981). She shows that the dramatic sex ratio imbalances

favoring men which historically had been due to outright infanticide continue today in more subtle ways including discrimination in the allocation of food and medical care. Yet even as feminists throughout the world have forcefully spoken out against these discriminatory practices, new forms of gendered violence are emerging, as Miller shows in her highly disturbing analysis of selective female abortion throughout Asia (Miller 2001). Several million female fetuses have been aborted in the last two decades of the 20th century. This is made possible by the growing availability of technologies, mainly ultrasound and amniocentesis that permit prenatal sex determination.

Medical anthropologists have also analyzed the consequences of war, rape, and genital cutting for women's health and well-being. In a series of insightful papers, Jenkins analyzes female Salvadoran refugees' experiences of trauma and political violence and the effects of these experiences on their mental health. Her objective is to expand anthropological discourses on emotions by examining the linkages among state construction of political ethos, personal emotions, and mental health consequences for refugee women. One of her analyses seeks to explain why some women manifest symptoms of post traumatic stress disorder after experiencing the events and conditions of political violence such as warfare, torture, detention, and sexual assault, while others describe them as mundane. She hypothesizes that the extreme and the mundane may be different expressive modalities for the same severe emotional responses (Jenkins 1996:286). Analysis of the life histories of women who experience political and other forms of violence could help explain the observed variation.

While Jenkins has focused on women who experienced the trauma of warfare, Olujic draws links between the violence women experience in war and peacetime in Croatia and Bosnia-Herzegovina. She shows how wartime gender violence draws on preexisting gender-based power relations and ideologies and concludes that war rapes in this region would not have been as effective as weapons of terror and torture against women were it not for the associations between honor, shame, and women's bodies (Olujic 1998).

The incidence or absence of sexual assault against women is shaped by many factors including a society's overall tolerance for violence, the socialization of boys, and values governing relations between the sexes. In a study of US fraternity gang rape, she shows that masculinist values and practices that encourage the use of force against women are seen in a fraternity culture that emphasize toughness, physical force, and an interpersonal style de-emphasizing caring and sensitivity. She describes in graphic detail drinking, coercive sexual behavior, and the degradation of women that form a central part of much fraternity social life (Sanday 1990).

There are other settings where male violence against women is considered inevitable. The institutionalized battering of women in many societies throughout the world is one example. Another is male violence associated with "survival sex." Some poor women in parts of South Africa have sex with men who they meet in taverns in exchange for money but do not consider themselves commercial sex workers. She shows such women are at risk for violence due to pervasive attitudes

condoning forced sex and lack of sanctions against battering women. "This type of environment, where it is socially acceptable for a man to demand sex from a woman for whom he buys drinks or gives gifts, and where short skirts are believed to lead naturally to rape, contributes to a sense of inevitability on the part of women who engage in survival sex" (Wojcicki 2002:278).

Feminist Activism and Women's Health

Since the mid-1970s, women's health care has been dramatically transformed as feminist activists created self-help groups, health collectives, clinics, and organizations that advocated for change in the structure and delivery of women's health care and the principles on which they were based (Morgen 2002). Their work was infused with the understanding that politics saturates all aspects of women's health and health care. Feminist activists engaged in important struggles over contraceptives, abortion, HIV, adolescent pregnancy, forced cesarean deliveries, breast cancer, hormone replacement therapy, environmental causes of cancer and other chronic illnesses, premenstrual syndrome (PMS), female genital cutting, and disability which had far ranging consequences.

Feminist anthropologists have become involved in defining the terms of the debates in many of these issues. For example, Martha Ward's cultural analyses of the politics surrounding teenage reproduction critiques US public and educational programming (Ward 1986). Jordan and Irwin challenge the role of the state as ultimate arbiter of how pregnant women give birth by impelling those who resist their doctors' diagnosis of fetal distress to undergo cesarean deliveries (Jordan and Irwin 1989). Scholars including Barroso and Correa have shown that long acting injectable contraceptives such as Depo-Provera and subdermal implants like Norplant which have serious known side effects are more likely to be given to poor women than to others (Barroso and Correa 1995). Such practices allow the medical establishment and the state to control women's fertility, denying a sense of agency to women themselves (Morsy 1998). The political movements around breast cancer and the use of mammography have to date had little impact on the anthropological literature. An important exception is Kaufert who observes that feminist medical anthropologists have focused more on individual women's experiences with their physicians, tending to ignore the broader corporate structure of medicine such as the economic interests that drive the mammography industry (Kaufert 1996).

Patricia Kaufert has also pioneered in focusing anthropological attention on the contentious issue of routine hormone supplementation for perimenopausal women, which like mammography has been challenged by feminist activists and scholars as driven by economic interests. Kaufert notes that the nature of debates on the safety of estrogen supplements are shaped by the fact that estrogen is prescribed only for women. In tracing the history of the controversy she shows how technological developments in the area of women's health may be

determined more by ideological and sociopolitical factors than by women's own interests and needs (Kaufert and McKinlay 1985), thus ignoring the fact that such treatments may have negative consequences for women's health (Anglin 1997).

In contrast to the limited attention anthropologists have paid to certain aspects of medicalization and women's health, they have been deeply involved in articulating the political, ethical, and medical dilemmas raised by cultural practices of female genital cutting. The resurgence of international efforts to eradicate this practice during the last part of the 20th century has forced scholars to confront a pivotal question: "Who has the moral authority to condemn this practice?" (Shell-Duncan and Hernlund 2000). In defining research that traced the history of the movement against female genital cutting in the Sudan, Gruenbaum shows that attempts to develop policies outlawing the practice have failed to acknowledge the linkages between genital cutting and the social goal of marrying daughters in strongly patriarchal societies. She argues effective change can only come about in the context of local women's movements oriented toward ameliorating basic social problems affecting women such as economic dependency, lack of education, and obstacles to employment (Gruenbaum 2001). By contrast, Gordon indicts anthropologists for their failure to take a universalistic moral position against female genital cutting despite militant international women's health movements' agenda for its eradication. He further accuses anthropologists of contributing to a cover-up about its medical risks by instead emphasizing local meanings linked to the practice (Gordon 1991; Obermeyer 1999). Janice Boddy (1991) rebuts those who castigate cultural relativism in their critiques of female genital cutting by observing that understanding a practice is not the same as condoning it. Broadening the debate she adds, "clearly, a central question epitomized so horribly by the practice of female 'circumcision' is why female bodies in virtually every society should be subject to alteration, maiming, mutilation, [and?] control" (Boddy 1991:16).

Emerging Issues

"I am reminded of the sheikh invited to a function in the garden of the Governor General's palace in Khartoum at the outset of this century who, upon spying for the first time a wasp-waisted European woman, inquired how the effect was achieved. On being enlightened, he replied, "It is barbaric! Where does she put her food?" (Boddy 1991:16–17).

Despite an exhaustive literature on body image and eating disorders in the social, psychological, and clinical sciences, anthropologists have paid scant attention to this important topic. Mimi Nichter's recent groundbreaking ethnography *Fat Talk*, however, explores body image and eating habits among European American, African American, and Latina female adolescents (Nichter 2000). In her book, we hear girls' voices explaining how they feel about their own bodies and their

mothers' bodies and describe the strategies of restrictive eating, excessive exercise, and a rhetoric of "fat talk" in the absence of dieting (see Becker 1994). A similarly important topic that has also received little anthropological attention is the use and meanings of cosmetic surgery for women and men (Kaw 1993). In spite of these excellent works, far more research is needed on how cultural expectations, media representations of the body, and fashion and fitness industries shape women's and men's ideas about their bodies.

Women's experiences with disability are opening up another set of important issues that deserve far greater anthropological attention from a feminist perspective. Research on attitudes toward disability has focused primarily on the populations most directly affected, such as families of children with disabilities or teachers or other professionals who work with disabled individuals (Press et al. 1998). Most of this work has been informed by the discipline of psychology. Recently, however, disability activists and researchers have begun to examine how individuals construct the meaning of particular disabilities in general or in specific contexts, how they come to determine what it means to be "human" or "normal," and the importance of these qualities for social relationships and social interaction (Landsman 1998). Gender constructs also deeply affect the way individuals with disabilities perceive their sense of who they are in the world (Frank 2000) but this remains an understudied area. An agenda that prioritizes research on the intersections between gender ideologies and disability including the construction of sexuality for those with physical and mental impairments and how gender roles may be compromised by disability or transcended in the establishment of gendered relationships is urgently needed.

Conclusion

In this analysis of the most important research trends at the intersection of medical anthropology, the anthropology of women, and gender studies, we sought to show how the second wave of feminism that began in the 1960s helped define key research agendas.

However, gender studies in medical anthropology have done more than contribute to these anthropological subfields. They have provided rich insight and helped build theory in the larger discipline of anthropology in areas including the political relations surrounding human reproduction, the production and transformation of knowledge systems, the social dilemmas that the increasingly ubiquitous reliance of medical technologies produce, the consequences for women's health of institutional forms of sexism that legitimize male violence against women, and how articulations between class, race, gender, and health help shape human experience. We are optimistic that this fruitful dialectical collaboration between feminist activism and research will continue and that it will continue to help define research issues, enrich the discourses surrounding them, and chart future directions for more equitable and more just societies.

Note

1. In the United States, there is no single journal devoted to this area of inquiry. However, the main feminist journals including *Feminist Studies, Signs,* and *Gender and Society,* the chief journals that publish medical anthropology such as *Medical Anthropology Quarterly, Medical Anthropology,* and *Social Science and Medicine,* and the general anthropology journals including *the American Anthropologist, American Ethnologist, Cultural Anthropology,* and *Ethnology* run articles and occasional theme issues. Similarly, there are no programs that specialize in gender studies in medical anthropology. However, the University of California at Los Angeles, San Francisco and Berkeley, New York University, Southern Methodist University, Case Western University, and the University of Michigan are among the schools with faculty whose interests lie at the intersection of gender and health and inform student specializations.

References

ALLEN D. R., 2002, Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania. Ann Arbor: University of Michigan Press.

ANGLIN M., 1997, Working from the Inside Out: Implications of Breast Cancer Activism for the Policies and Practices of Biomedicine. Social Science and Medicine 44(9):1403–1415.

BAER H. A., M. SINGER and I. SUSSER, 1997, Medical Anthropology and the World System. A Critical Perspective. Westport: Bergin and Garvey.

BARROSO C. and S. CORREA, 1995, Public Servants, Professionals, and Feminists: The Politics of Contraceptive Research in Brazil. *In* Conceiving the New World Order. F. Ginsburg and R. Rapp, eds. Pp. 292–307. Berkeley: University of California Press.

BECKER A. E., 1994, Nurturing and Negligence. Working on Others' Bodies in Fiji. *In* Embodiment and Experience. The Existential Ground of Culture and Self. T. Csordas, ed. Pp. 100–116. Cambridge: Cambridge University Press.

BECKER G., 1997, Healing the Infertile Family. Strengthening Your Relationship in the Search for Parenthood. Berkeley: University of California Press.

BODDY J., 1991, Body Politics: Continuing the Anti-circumcision Crusade. Medical Anthropology Quarterly 5(1):15–16.

BROWNER C. H., 2000, Situating Women's Reproductive Activities. American Anthropologist 102(4):773–788.

BROWNER C. H. and H. M. PRELORAN, 2000, Para sacarse la espina (To Get Rid of the Doubt). Mexican Immigrant Women's Amniocentesis Decisions. *In* Bodies of Technology: Women's Involvement with Reproductive Medicine. A. R. Saetnan, N. Oudshoorn and M. Kirejczyk, eds. Pp. 368–383. Columbus: Ohio State University Press.

BROWNER C. H. and C. SARGENT, 1996, Anthropology and Studies of Human Reproduction. *In* Medical Anthropology. C. Sargent and T. Johnson, eds. Pp. 219–235. Westport, CT: Praeger Publishers.

COMINSKY S., 1976, Cross-Cultural Perspectives on Midwifery. *In* Medical Anthropology. F. Grolling and H. Haley, eds. Pp. 229–249. Paris: Mouton.

DAVIS D., 1983, Blood and Nerves. An Ethnographic Focus on Menopause. St Johns: Memorial University of Newfoundland and Institute of Social and Economic Research.

DAVIS-FLOYD E. R., 1992, Birth as an American Rite of Passage. Berkeley: University of California Press.

DAVIS-FLOYD E. R. and C. F. SARGENT, 1997, Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives. Berkeley: University of California Press.

DOYAL L., 1995, What Makes Women Sick. Gender and the Political Economy of Health. New Brunswick: Rutgers University Press.

EHRENREICH B. and D. ENGLISH, 1973, Witches, Midwives, and Nurses. A History of Women Healers. Brooklyn: The Faculty Press.

FARMER P., M. CONNERS and J. SIMMONS, eds, 1996, Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence. Monroe, ME: Common Courage Press.

FAUVEAU V. and T. BLANCHET, 1989, Deaths From Injuries and Induced Abortion Among Rural Bangladeshi Women. Social Science and Medicine 29(9):1121–1127.

FINKLER K., 1994, Women in Pain. Gender and Morbidity in Mexico. Philadelphia: University of Pennsylvania Press.

FRANK G., 2000, Venus on Wheels. Two Decades of Dialogue on Disability, Biography, and Being Female in America. Berkeley: University of California Press.

GINSBURG F., 1998, Contested Lives: The Abortion Debate in an American Community. Berkeley: University of California Press.

GINSBURG F. and R. RAPP, eds, 1994, Conceiving the New World Order. The Global Politics of Reproduction. Berkeley: University of California Press.

GORDON D., 1991, Female Circumcision and Genital Operations in Egypt and the Sudan: A Dilemma for Medical Anthropology. Medical Anthropology Quarterly 5(1):3–14.

GRUENBAUM E., 2001, The Female Circumcision Controversy: An Anthropological Perspective. Philadelphia: University of Pennsylvania Press.

HAMPSHIRE K. R., 1998, Fulani Mobility. Causes, Constraints and Consequences of Population Movements in Northern Burkina Faso. Ph.D. thesis, University College London.

HEISE L., 1993, Violence Against Women. The Missing Agenda. *In* The Health of Women. A Global Perspective. M. Koblinsky, J. Timyan and J. Gay, eds. Pp. 171–197. Boulder: Westview.

HEMMING I. M. W., 1997, Gender and Islam, Purdah and Power: The Production and Management of Afghan Women's Health and Illness. Ph.D. Dissertation, Department of Anthropology, University of California, Los Angeles.

INHORN M. C., 1994, Quest for Conception: Gender, Infertility, and Egyptian Medical Traditions. Philadelphia: University of Pennsylvania Press.

INHORN M. C. and F. VAN BALEN, eds, 2002, Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies. Berkeley: University of California Press.

JENKINS J. H., 1996, The Impress of Extremity: Women's Experience of Trauma and Political Violence. *In* Gender and Health. C. Sargent and C. Brettell, eds. Pp. 278–292. Upper Saddle River, Prentice Hall.

JORDAN B., 1993 [1978], Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States. Prospect Heights: Waveland Press.

JORDAN B. and S. L. IRWIN, 1989, The Ultimate Failure: Court-Ordered cesarean Section. *In* New Approaches to Human Reproduction. Social and Ethical Dimensions. L. Whiteford and M. Poland, eds. Pp. 13–25. Boulder, Westview Press.

KAUFERT P., 1996, Women and the Debate over Mammography: An Economic, Political, and Moral History. *In* Gender and Health: An International Perspective. C. Sargent and C. Brettell, eds. Pp. 167–187. Upper Saddle River: Prentice Hall.

KAUFERT P. and S. MCKINLAY, 1985, Estrogen-replacement Therapy: the Production of Medical Knowledge and the Emergence of Policy. *In* Women, Health and Healing. E. Lewin and V. Olesen, eds. Pp. 113–139. London: Tavistock.

KAW E., 1993, Medicalization of Racial Features: Asian American Women and Cosmetic Surgery. Medical Anthropology Quarterly 7(1):74–89.

KOBLINSKY M., J. TIMYAN and J. GRAY, eds, 1993, Health of Women: A Global Perspective. San Francisco: Westview.

LADERMAN C., 1983, Wives and Midwives: Children and Nutrition in Rural Malaysia. Berkeley: University of California Press.

LANDSMAN G. H., 1998, Reconstructing Motherhood in the Age of Perfect Babies: Mothers of Infants and Toddlers With Disabilities. Signs 24(11):69–99.

LAYNE L. L., 2002, Motherhood Lost: A Feminist Account of Pregnancy Loss in America. New York: Routledge.

LAZARUS E., 1994, What do Women Want? Issues of Choice, Control, and Class in Pregnancy and Childbirth. Medical Anthropology Quarterly 8(1):25–47.

LOCK M., 1993, Encounters with Aging. Berkeley: University of California Press.

LOW S., 1992, Embodied Metaphors: Nerves as Lived Experience. *In* Embodiment and Experience. T. Csordas, ed. Pp. 139–163. Cambridge: Cambridge University Press.

MACCORMACK, C. P., 1982, Ethnography of Fertility and Birth. 2nd edition. Prospect Heights, IL: Waveland Press.

——, 1994, Risk, Prevention, and International Health Policy. *In* Gender and Health. C. Sargent and C. Brettell, eds. Pp. 326–338. Upper Saddle River, NJ: Prentice-Hall.

McCLAIN C. S., ed., 1989, Women as Healers: Cross-Cultural Perspectives. New Brunswick: Rutgers University Press.

MARTIN E., 1987, The Woman in the Body: A Cultural Analysis of Reproduction. Boston: Beacon Press.

MILLER B. D., 1981, The Endangered Sex: Neglect of Female Children in Rural North India. Ithaca: Cornell University Press.

——, 2001, Female-Selective Abortion in Asia: Patterns, Policies, and Debates. American Anthropologist 103(4):1083–1095.

MITCHELL L. and E. GEORGES, 1998, Baby's First Picture. The Cyborg Fetus of Ultrasound Imaging. *In* Cyborg Babies. R. Davis and J. Dumit, eds. Pp. 105–125. New York, Routledge.

MORGAN L. M., 1999, Ambiguities Lost: Fashioning the Fetus into a Child in Ecuador and the United States. *In* Small Wars. The Cultural Politics of Childhood. N. Scheper-Hughes and C. Sargent, eds. Pp. 58–75. Berkeley: University of California Press.

MORGEN S., 2002, Into Our Own Hands: The Women's Health Movement in the United States, 1969–1990. New Brunswick: Rutgers University Press.

MORSY S., 1978, Sex Roles, Power, and Illness in an Egyptian Village. American Ethnologist 5:137–150.

——, 1998, Not Only Women: Science as Resistance in Open Door Egypt. *In* Pragmatic Women and Body Politics. M. Lock and P. Kaufert, eds. Pp. 77–98. Cambridge: Cambridge University Press.

NICHTER M., 1981, Idioms of Distress: Alternatives in the Expression of Psychosocial Distress: A Case Study From South India. Culture, Medicine and Psychiatry 5:379–408.

——, 2000, Fat Talk: What Girls and Their Parents Say About Dieting. Cambridge: Harvard University Press.

OBERMEYER C. M., 1999, Female Genital Surgeries: The Known, the Unknown, and the Unknowable. Medical Anthropology Quarterly 13(1):79–106.
OLUJIC M. B., 1998, Embodiment of Terror: Gendered Violence in Peacetime and Wartime in Croatia and Bosnia-Herzegovina. Medical Anthropology Quarterly 12(1):31–50.
OTHS K. S., 1999, Debilidad: A Biocultural Assessment of an Embodied Andean Illness. Medical Anthropology Quarterly 13(3):286–315.
PAUL L., 1975, Recruitment to a Ritual Role: The Midwife in a Maya Community. Ethos 3(3):449–467.
PRESS N., C. H. BROWNER, D. TRAN, C. MORTON and B. LEMASTER, 1998, Provisional Normalcy and Perfect Babies: Pregnant Women's Attitudes Toward Disability in the Context of Prenatal Testing. *In* Reproducing Reproduction: Kinship, Power, and Technological Innovation. S. Franklin and H. Ragone, eds. Pp. 46–65. Philadelphia: University of Pennsylvania Press.
RAGONE H., 1994, Surrogate Motherhood. Conception in the Heart. Boulder, CO: Westview.
RAPP R., 1999, Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America. New York: Routledge.
REBHUN L. A., 1994, Swallowing Frogs: Anger and Illness in Northeast Brazil. Medical Anthropology Quarterly 8(4):360–382.
RUBEL A. J., W. T. LIU, M. TROSDAL and V. PATO, 1971, The Traditional Birth Attendant in Metropolitan Cebu, the Philippines. *In* Culture and Population: A Collection of Current Studies. Monograph 9. S. Polgar, ed. Pp. 176–186. Carolina Population Center: UNNC Chapel Hill.
SANDAY P. R., 1990, Fraternity Gang Rape: Sex, Brotherhood, and Privilege on Campus. New York: New York University Press.
SANDELOWSKI M., 1991, Compelled to Try: The Never-Enough Quality of Contraceptive Technology. Medical Anthropology Quarterly 5(1):29–47.
SARGENT C., 1989, Maternity, Medicine and Power. Berkeley: University of California Press.
SARGENT C. and N. STARK, 1987, Surgical Birth: Interpretations of Cesarean Delivery among Private Hospital Patients and Nursing Staff. Social Science and Medicine 25(12):1269–1276.
SAWICKI J, 1991, Disciplining Foucault: Feminism, Power and the Body. New York: Routledge.
SCHEPER-HUGHES N, 1992, Death without Weeping. The Violence of Everyday Life in Brazil. Berkeley: University of California Press.
SCHOEPF B. G., 1998, Inscribing the Body Politic: Women and AIDS in Africa. *In* Pragmatic Women and Body Politics. M. Lock and P. Kaufer, eds. Cambridge: Cambridge University Press.
SHELL-DUNCAN B. and Y. HERNLUND, eds, 2000, Female Circumcision in Africa: Culture, Controversy, and Change. Boulder: Lynne Reinner Publishers.
SOBO E. J., 1995, Choosing Unsafe Sex: AIDS-Risk Denial Among Disadvantaged Women. Philadelphia: University of Pennsylvania Press.
STELLMAN J., 1997, Work Is Dangerous to your Health: A Handbook of Health Hazards in the Work Place and What You Can Do about Them. 2nd edition. New York: Pantheon.
TAYLOR J. S., 2000, Of Sonograms and Baby Prams: Prenatal Diagnosis, Pregnancy, and Consumption. Feminist Studies 26(2):391–418.

VAN HOLLEN C., 2003, Birth on the Threshold. Childbirth and Modernity in South India. Berkeley: University of California Press.
WARD M., 1986, Poor Women Powerful Men: America's Great Experiment in Family Planning. Boulder: Westview Press.
WHITEFORD L. M., 1996, Political Economy, Gender, and the Social Production of Health and Illness. *In* Gender and Health. C. Sargent and C. Brettell, eds. Pp. 242–260. Upper Saddle River, NJ: Prentice-Hall.
WOJCICKI J. M., 2002, She Drank His Money: Survival Sex and the Problem of Violence in Taverns in Gauteng Province, South Africa. Medical Anthropology Quarterly 16(3):267–293.