HEALTH, CULTURE AND SOCIETY

Conceptual Legacies and Contemporary Applications

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In fond memory of the feminist scholar Deborah Lynn Steinberg, whose support, love and intelligence made this book possible.

Preface

For a number of years (2005–2011), I taught a course, 'Health, Culture and Society', to large groups of third-year sociology students at the University of Liverpool, England. I realised that the readings I assigned were dependent upon both sociological and anthropological perspectives. I engaged with and demonstrated a range of frames through which to interrogate health and illness. Set up that way, the distinctions between anthropologically framed questions and sociologically framed ones were placed in implicit dialogue. At that time, I thought it useful to write a book of the same title, explaining key concepts and making sense of diverse traditions of thought surrounding health and illness. This book has been a long time in the making but it has been worth it. I am happy to have recruited this group of talented co-authors as they have been a pleasure to work with.

Having said the above, I would contend that *Health, Culture and Society* is a 'discursive' conception explored by scholars across a variety of disciplines, particularly in medicine and the allied health professions (i.e. nursing, public health and rehabilitation sciences), anthropology, sociology, history and economics. And we hope scholars involved in these disciplines will be interested in our book. As co-authors, we trace the history of enduring concepts (i.e. meaning formative ones which have been foundational in the development of our disciplines) used in the broad area of health and look at how sociology and anthropology, through an analysis of these enduring concepts, can be applied. As a result, we emphasise the political implications of our disciplines vis-à-vis health research. Importantly, feminist legacies are explored, while authors will interrogate the philosophical and historical roots of medical sociology and anthropology.

Helsinki, Finland Elizabeth Ettorre

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Elizabeth Ettorre

Many of the issues explored in my chapters were developed for a new upper-level undergraduate module for sociology students, at the University of York, *The Global Transformation of Health*. I am grateful to the students who have taken the module over the last three years for their insights. Their debate of the topics has informed my writing.

Ellen Annandale

I am grateful to Renee Sentilles and Robert Walters, fellow members of *The Writing House*, who asked insightful questions about ethnographic research, midwifery and theories about gift giving. I thank Lee Hoffer for engaging in many thought-provoking discussions on the nature of reciprocity and gift exchange. I am grateful to Elizabeth Ettorre for her great generosity, leadership and continual support through the writing process. As always, I am thankful to the people of Sungai who have long hosted me with grace and patience while I asked what surely felt like endless questions.

Vanessa M. Hildebrand

I am grateful to excellent colleagues Dorothy Roberts and Maribel Blázquez-Rodríguez, who have provided stimulating discussions about classical kinship theories and repronormativity, which are the basis of my chapter. I also thank Elizabeth Ettorre for her continuous support through intimidating periods of blank pages and for making my writing more readable. I am also grateful to my fellow writers at Lancaster University who created a friendly atmosphere to enjoy writing and sharing. Finally, I am grateful to the National Institute of Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care North West Coast (CLAHRC NWC) for its intellectual support. The opinions expressed in this book are my own and do not reflect the view of the NIHR CLAHRC NWC.

Ana Porroche-Escudero

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Notes on Contributors

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Elizabeth Ettorre is Emerita Professor of Sociology at University of Liverpool, UK; Honorary Professor at Aarhus University, Denmark and at Plymouth University, UK; and Docent in Sociology, Helsinki and Åbo Akademi University, Finland. Besides this book, she has written 13 scholarly books. The most recent include *Autoethnography as Feminist Method*; *Gendering Addiction: The Politics of Drug Treatment in a Neurochemical World* (with Nancy Campbell); *Culture, Bodies and the Sociology of Health*; *Revisioning Women and Drug Use: Gender, Power and the Body*; *Making Lesbians Visible in the Substance Use Field*; and *Reproductive Genetics, Gender and the Body*.

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Barbara Katz Rothman PhD, is Professor of Sociology at the City University of New York, USA, where she runs the Food Studies concentration. Her books include *In labor*; *The Tentative Pregnancy*; *Recreating Motherhood*; *The Book of Life*; *Weaving a Family*: *Untangling Race and Adoption*; *Laboring On* (with Wendy Simonds); and the new, *A Bun in the Oven: How the Food and Birth Movements Resist Industrialization.* She is past president of Sociologists for Women in Society, the Society for the Study of Social Problems and the Eastern Sociological Society. She is a proud recipient of an award for ‘Midwifing the Movement’ from the Midwives Alliance of North America.

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Why *Conceptual Legacies and Contemporary Applications*?

Elizabeth Ettorre, Ellen Annandale,
Vanessa M. Hildebrand, and Ana Porroche-Escudero

The notion, ‘Health, Culture and Society’, has been explored in classic texts by a diverse range of scholars such as Blaxter (1990) (health and lifestyles); Bourgeois (1995) (substance misuse and deprivation); Bury (1997) (cultural narratives of illness); Clarke and Olsen (1999) (health, healing and women); Douglas (1969) (purity, danger and the body); Doyal (1979) (political economy of health); Farmer (2004) (health, politics and development); Franklin (1997) (assisted conception); Friedson

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(1970) (medicine and professionalisation); Good (1994) (cultures of biomedicine, illness narratives); Haraway (1991) (the interface between health, culture and technology); Helman (2007) (cross-cultural studies of health and disease); Inhorn (2003) (reproductive health); Jordan (1993) (cross-cultural studies of childbirth); Kleinman (1988) (illness narratives, social suffering and psychiatry); Lock (2002) (the body and new medical technologies); Lorber (1997) (gender and health); Lupton (1994) (medicine as culture); Martin (1987) (biomedical discourses and practices); Parsons (1951); Scheper-Hughes (1993) (body, illness, psychiatry, violence, genocide and social suffering); Strauss et al. (1964, 1985/1997) (cultural roles of patient and doctors); Rapp (2000) (new medical technologies, reproductive health); and Williams (2003) (chronic illness, the body and health) to name but a few of these classics.

As noted in the Preface, 'Health, Culture and Society' is a 'discursive' conception explored by scholars (i.e. similar to those above) from a range of disciplines. While we trace the history of enduring concepts in sociology and anthropology, we underline the political effects of our disciplines on health as well as the feminist implications in analysing health research practice. In selecting our concepts, we see ourselves as students of 'the rise of problematic neo-liberal societies' and 'contested notions of cultures' (White 2002: 39). There are few areas in society 'changing as rapidly as health care systems' (Conrad 2001: vii) and as observers of these systems, we explore our concepts in relationship to the social contexts in which people live as well as their embodied experiences of health and illness.

Health, Culture and Society: Conceptual Legacies and Contemporary Applications emphasises the political implications of our disciplines vis-à-vis health research. We want to demonstrate that enduring concepts have *consistently* been complex and contested, while we explore ones including society, differentiation, globalisation, self, normativity, embodiment, production, reproduction, consumption, kinship, blood, alliances, power, control, surveillance, gift-giving, reciprocity and exchange, and pose key questions about the ways they have been defined, used and applied to health. What is, for example, the relationship between the conception, Self, Body & Society in the context of Health, Culture and Society and how has this conception been defined, used and applied to health? (See Chap. 3). The chapters outline the contributions of influential authors and their role in building the development of what we see as enduring concepts that have been a part of our conceptual heritages and the 'building blocks' of most, if not all, intellectual excursions into the study of health and illness. Related to our formative concepts, we explore their related primary literature, secondary literature, subsequent use and misuse and their contemporary application to health. We examine the contributions of influential authors and their role in the development of these concepts, and we offer empirical examples, mindful of an international audience.

Our basic assumption is that we need to understand these enduring concepts as well as their development in order to use these concepts appropriately in our analyses. An underlying motivation is an awareness that there is much that is valuable in early sociological and anthropological theories and debates: some of the issues and concerns that preoccupied these scholars are still in evidence today, such as looking at specific events, regulatory regimes or practices from the standpoint of difference, including class, race, gender, sexuality, age, disability and so on; formulating theories about the emergence of various social issues and intransigent social problems; and understanding health and illness in light of cultural values and practices, social conditions, embodiment, human emotions and perceptions.

Some scholars may see this earlier work as lacking—the expression of individual points of view, the promotion of dogmatism, the offering of totalising (i.e. unifying) theories and so on. Contemporary scholars have become aware of the elitist nature or inherent sexism and racism of these early perspectives (Hill Collins 1986). In this context, health researchers often go to the latest thinkers. While this is understandable as one is initiated into this field of study, it is also important to understand original concepts and how they have been elaborated, which we do most definitely. Best and Keller (2001: 13) summarise how 'older theories' can provide important guideposts for thought and action today:

> Classical social theories are … outdated and even obsolete. Fresh theories need to be constructed … *using both the resources of the past and salient sketches of the contemporary era* [emphasis ours]. … Theories provide

> orientation, overviews and contexts. They show how parts relate to each other and to a larger whole. If something new appears on the horizon, a good map will chart and contextualize it …, including sketches of future configurations of potential promise and perils.

The goal of *Health, Culture and Society: Conceptual Legacies and Contemporary Applications* is to recharge arguments through grappling with formative concepts. We demonstrate the relevance of these concepts to practice, attempt to apply them in an overtly political way to the 'here and now', review and redefine them if necessary and de-construct them. Therefore, we take a unique approach to the configuration of 'Health, Culture and Society' and its entanglements. Despite the wealth of material in the area of medical sociology and medical anthropology, no existing texts attempt to take on the approach we offer. In our chapters, we will explain the different ways of thinking about and approaching these formative concepts in the broad area of health. Simply, we take these formative concepts, fundamental to sociology and/or anthropology and work through, as noted above, their conceptual heritage to their contemporary applications. Moreover, at a time when the disciplinary boundaries between anthropology and sociology are increasingly being blurred *Health, Culture and Society: Conceptual Legacies and Contemporary Applications* offers the reader an opportunity to understand the overlap as well as the unique contribution of each discipline to the field of health.

The fact that many of the concepts featured in our book have been taken for granted in studies focusing on health and medicine gives us an exceptional opportunity to stand back and assess their conceptual heritage and contemporary applications. Inevitably, this process will involve identifying multiple conceptions of the *elemental concept*, health. We do these tasks with the awareness that while these enduring concepts are commonly used, they are, at times, understood inadequately.

Thus, the aim of *Health, Culture and Society: Conceptual Legacies and Contemporary Applications* is to demonstrate the relevance of key formative concepts to understanding contemporary issues in health and illness. By the end of this book, readers will be able to understand clearly:

- ways in which sociological and anthropological approaches to health have been shaped by and shaped these formative concepts—their origins, applications and future relevance in the field;
- how and why key theorists and theoretical approaches have informed the sedimentation of these concepts; and
- how important examples of empirical research are linked to the development of these concepts in their social and political context.

While we are aware that some scholars may claim that the real focus of health is on medical services, we would contend that our use of the concept health is more than a type of functional embodiment or 'a state of being in which the body is not causing one much trouble, and in which the body is sometimes giving one some joy' (see Chap. 8). As Blaxter (2010: 2) states, 'Health is one of the most ubiquitous topics of conversation in everyday life … it is something on which individuals can have very different views … a concept which has inspired endless theorizing and dispute throughout the ages'. Given that sociology and anthropology are deeply involved in 'health' theorising and not just from the point of view of Western biomedicine, we are always already aware that a focus only on 'medical services' is both limiting and inadequate. While our work involves 'identifying multiple conceptions of the *elemental concept*, health' (as noted above), we offer implicit as well as explicit challenges to these multiple conceptions. Of course, one can view health as a 'broad church' including many varied and conflicting definitions—health as a state of well-being, as an absence of illness, as homeostasis, as balance, as functioning, as a present state, as a long-term status and so on. What we do is examine concepts which have surrounded academic understandings of 'health', with all the limitations this implies, but also create perspectives to judge fairly their conceptual legacy and contemporary usages. For us, health is an enduring concept but it is also an evolving one with far reaching political, social and cultural implications.

The Structure of the Book

In the following chapter, Chap. 2, 'Society, Differentiation and Globalisation', Ellen Annandale addresses in Part 1 theories of globalisation and their implications for the analysis of health issues. In particular, she emphasises that globalisation is embodied, something often overlooked by sociologists working outside of the field of health. Emphasis is given to the health vulnerabilities that arise from the heightened mobility, and connectivities that characterise globalisation, taking migration and health as an illustration. In Part 2, she turns to consider differentiation by highlighting disparities in health vulnerability and the capacity of social groups to protect their health. This is illustrated first by reference to the securitisation of health. A focus on the mental and physical health consequences of violent conflict then draws out the special vulnerabilities of children and of women. Finally, in Part 3, she reflects on the influence of interconnectedness of various national health care systems implications for the delivery of effective health care.

In Chap. 3 'Self, Normativity and Embodiment', Elizabeth Ettorre explores first the notion of 'embodied self' as a sort of corporeal overlay upon which healthy and unhealthy identities are fashioned. This notion allows for the introduction of the underlying concept, social interaction, implying diversity and the assumed need for 'normativity' as a powerful paradigm in which health and illness are often shaped as normal and deviant (with implications for those whose bodies fall short of being 'normal'). She offers an overview of the development of the concept, the body, as well as a sociology of the body. How the concept of the agentic self was formative in developing sociological ideas and constructions of the body; how and why the theoretical concerns of Mead, Goffman and Elias aid in this development and why the study of the body is important in sociology with reference to the work of embodiment theorists are explored. Second, she looks at case studies of medicalised bodies by focusing on 'techno bodies', 'abject bodies' and 'bodies in representation'. Third, she considers ways in which we might continue to work with the concept of the body. Recognising the significance of embodiment and the ubiquitous moralities of health helps us to consider the significance of embodied ethics. Genealogical in nature, the chapter outlines the past and related conceptualisations of the body that become sources for future conceptualisations.

In Chap. 4, 'Production, Reproduction and Consumption', Ellen Annandale first addresses the global production of health inequalities by looking at data on life expectancies in different regions and countries and considers them in the context of neo-liberal economic and social governance since the 1980s, mounting economic inequality and the marked pulling away of the richest of the population from the rest. She then touches upon the 'double burden' of disease that has emerged in many parts of the global south; that is, the heavy weight of infectious disease, alongside the rise of non-communicable or chronic conditions, such as heart disease. As a case illustration of how swift the impact of socio-economic change can be on population health, she considers health status in Eastern Europe looking in particular at 'lifestyle behaviours'. Second, she takes this discussion of 'lifestyles' further as she considers health identities and the 'consumption' and 'reproduction' of health. This brings us back to the associations between health and (bio) capital as she explores the governance of health in the milieu of prevailing individual lifestyle explanations for illness and 'mHealth' (i.e. mobile health technologies). Annandale takes the very different case of the global organ trade to delve into health expectations and the achievement of positive health through consumption. In the concluding section of the chapter, she focuses on reproduction of human life. Paying attention to global connectivity between markets and bodies, she considers 'biogenetic trade' and global 'reproscapes', taking 'egg donation' and commercial surrogacy as case examples.

Ana Porroche-Escudero explores the concepts 'Kinship, Blood and Alliances' in Chap. 5. According to two classical anthropological theories about descent and alliance, biological motherhood is a given, the genetic tie between parents and their children is unbreakable and love is intuitive. Also, heterosexual intercourse between spouses is thought to develop close bonds based on love, as the magic 'ingredient' for a harmonious family unit. While modern social scientists, in particular feminist scholars, have long debunked the descent and alliance theory, Porroche-Escudero argues that these traditional ideologies, traceable to the middle class, nineteenth-century Victorian period, continue to influence day-to-day practices, social norms, law, policy and health care, causing tremendous impact on people's lives. She explores three examples of how old kinship ideologies emerge in practice through: (1) the enforcement of heteronormative marriage under the threat of economic injustice; (2) the violence implicit in 'amorous thought' and how it shapes unhealthy relationships; and (3) how the quest for biological motherhood underlies an obsession to undergo relentless, sometimes invasive, use of new reproductive technologies. She argues that those persons who do not fit confined models of kinship are not only excluded from all the social and legal benefits granted by marriage and motherhood but also their sexualities and alternative kin arrangements are marginalised and even criminalised.

In Chap. 6, 'Power, Control and Surveillance', Elizabeth Ettorre discusses the 'power' of the medical profession alongside the interrelated sociological concepts of medicalisation, professionalisation and biomedicalisation. The aim of this chapter is to trace how power has been or is constructed in through these conceptualisations and their consequences. How power is delineated is discussed with reference to the work of male theorists, Parsons, Weber, Bourdieu and Foucault, the latter theorist whose ways of seeing power involved a new type of epistemology. Alternatively, the focus on biomedicalisation by feminist theorists (i.e. Clarke et al. 2003, 2010a, b; Clarke and Shim 2011) in the second half of the chapter is a prelude to understanding a case study of reproductive genetics in which a politics of embodiment vis-à-vis developments in Science and Technology Studies (STS) are seen as significant in the emergence of power as sociological concept. In presenting this case study, Ettorre includes the related concepts of biopolitics, procreative biosocialities, somatic society and reproductive asceticism. This chapter exposes the development of the concept of power within the sociology of health and demonstrates through empirical examples how some bodies are subject to more power and discursive control than others (i.e. female bodies, especially the pregnant body).

In Chap. 7, Vanessa Hildebrand examines the concepts 'Gift giving, Reciprocity and Exchange' with reference to her ongoing empirical research. Using Marcel Mauss's foundational concept presented in *The Gift*, that exchanging gifts or services is an act motivated by developing social relationships, Hildebrand examines attempts made by skilled birth attendants to provide maternal health care to women of rural Indonesia, the rural women's responses to the offered care and the social results of those interactions. She argues that by examining exchange and reciprocity important characteristics are revealed about how health care is given and received in contemporary society and how this impacts the health status of individuals. Of particular interest in her analysis is how power and inequality are enacted in the health care encounter.

In Chap. 8, 'Afterword', Barbara Katz Rothman provides her expert views on *Health, Culture and Society.* She offers a critical and contemporary perspective on the ideas presented in the earlier chapters in this book. Her overview should help readers to identify points of interest, tensions and future developments.

This book should make a major contribution to studies on health, culture and society because it is theoretically 'healthy' for those disciplines involved in studying health to constantly and critically review the field not only in the light of new thinking but by re-visioning what has gone before. By tracing these legacies, the authors attempt to unpack the assumptions in the ways researchers analyse and apply concepts to health. Moreover, in this process 'health' is itself problematised and re-visioned, identifying new directions for future interdisciplinary research and scholarship.

In conclusion, given that in the contemporary world health is a contentious concept and many deny that health is a human right, we have re-examined the concepts we use in order to strengthen their employment for the betterment of all. We wanted to show how our concepts can be employed in a political context and we hope that our voices have been heard. While saying, 'Health is a human right' is about understanding the complex interrelationship between 'Health, Culture and Society', it is also about taking a stance which demands that one's class, race, gender, sexuality, disability and so on do not determine how one is treated by health care providers or in any health care system. The only way we can eliminate health inequalities on a global scale is to demand that *all people* have a right to health. While *Health, Culture and Society: Conceptual Legacies and Contemporary Applications* may not appear to make that overt demand, we as feminist authors have been and are informed by that, call it political, point of view.

References

Best, S., & Keller, D. (2001). *The postmodern adventure: Science, technology and cultural studies at the third millennium*. London: Routledge.

Blaxter, M. (1990). *Health and lifestyles*. London: Tavistock/Routledge.

Blaxter, M. (2010). *Health* (2nd ed.). Cambridge: Polity Press.

Bourgeois, P. (1995). *In search of respect*. Cambridge: Cambridge University Press.

Bury, M. (1997). *Health and illness in a changing society*. London: Routledge.

Clarke, A. E., & Olsen, V. L. (Eds.). (1999). *Revisioning women, health and healing feminist, cultural and Technoscience perspectives*. New York/London: Routledge.

Clarke, A. E., & Shim, J. (2011). Medicalization and biomedicalization revisited: Technoscience and transformations of health, illness and American medicine. In B. A. Pescosolido, J. K. Martin, J. D. McLeod, & A. Rogers (Eds.), *Handbook of the sociology of health, illness and healing: A blueprint for the 21st century* (pp. 173–199). New York: Springer.

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2003). Biomedicalization: Technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review, 68*, 161–194.

Clarke, A. E., Mamo, L., Fosket, J. R., Fishman, J. R., & Shim, J. K. (Eds.). (2010a). *Biomedicalization: Technoscience, health, and illness in the U.S.* Durham: Duke University Press.

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2010b). Biomedicalization: A theoretical and substantive introduction. In A. E. Clarke, L. Mamo, J. R. Fosket, J. R. Fishman, & J. K. Shim (Eds.), *Biomedicalization: Technoscience, health, and illness in the U.S.* (pp. 1–43). Durham: Duke University Press.

Conrad, P. (2001). Preface. In *The sociology of health and illness: Critical perspectives*. New York: Worth Publications.

Douglas, M. (1969). *Purity and danger*. London: Routledge and Kegan Paul.

Doyal, L. (1979). *The political economy of health*. London: Pluto Press.

Farmer, P. (2004). *Pathologies of power: Health, human rights, and the new war on the poor*. Berkeley: University of California Press.

Franklin, S. (1997). *Embodied progress: A cultural account of assisted conception*. London: Routledge.

Friedson, E. (1970). *Professional dominance: The social structure of medical care*. New York: Atherton Press.

Good, B. (1994). *Medicine, rationality and experience: An anthropological perspective*. Cambridge: Cambridge University Press.

Haraway, D. (1991). *Simians, cyborgs and women: The reinvention of nature*. New York: Routledge.

Helman, C. (2007). *Culture health & illness* (5th ed.). London: Hodder Arnold.

Hill Collins, P. (1986). Learning from the outsider within: The sociological significance of Black feminist thought. *Social Problems, 33*(6), S14–S32. Special Theory Issue (October–December, 1986).

Inhorn, M. (2003). *Local babies, global science: Gender, religion and in vitro fertilisation in Egypt*. New York: Routledge.

Jordan, B. (1993). *Birth in four cultures: A cross-cultural investigation of childbirth in Yucatan, Holland, Sweden and the United States* (4th ed.). Prospect Heights: Waveland Press.

Kleinman, A. (1988). *The illness narratives*. New York: Basic Books.

Lock, M. (2002). *Twice dead: Organ transplants and the reinvention of death*. Berkeley: University of California.

Lorber, J. (1997). *Gender and the social construction of illness*. Thousand Oaks: Sage.

Lupton, D. (1994). *Medicine as culture: Illness, disease and the body in Western societies*. London: Sage.

Martin, E. (1987). *The woman in the body*. Milton Keynes: The Open University Press.

Parsons, T. (1951). *The social system*. Glencoe: The Free Press.

Rapp, R. (2000). *Testing the woman: Testing the fetus*. New York: Routledge.

Scheper-Hughes, N. (1993). *Death without weeping: The violence of everyday life in Brazil*. Berkeley: University of California Press.

Strauss, A. L., Fagerhaugh, S., Suczek, B., & Wiener, C. (Eds.). (1985/1997). *Social organization of medical work* (1st ed.). Chicago: University of Chicago Press. New Brunswick: Transaction Press (2nd ed.).

Strauss, A. L., Schatzman, L., Bucher, R., Ehrlich, D., & Sabshin, M. (1964). *Psychiatric ideologies and institutions*. Glencoe: Free Press.

White, K. (2002). *An introduction to the sociology of health and illness*. London: Sage.

Williams, S. J. (2003). *Medicine and the body*. London: Sage.

2

Society, Differentiation and Globalisation

Ellen Annandale

Introduction

Sociology was born of modernity and the conception of 'society' as a sovereign unit of analysis. Since the turn of the present century this has been subject to considerable critical analysis as it has been argued, with increasing force, that the discipline has entered a 'post-societal phase' as a consequence of globalisation, challenging as a consequence sociology's basic units of analysis, namely, the nation-state (Burawoy 2005). Urry characterises this as 'a theoretical and empirical whirlpool where most of the tentative certainties that sociology has endeavoured to erect are being washed away' (2000: 17). The effects are several, including the search for new theoretical frameworks and associated conceptual tools which turn from the traditional emphasis on stasis, structure and social order in favour of mobility, contingency and complexity (see e.g. Castells 2010; Walby 2009, 2015). Concurrently, theorists have re-examined the assumptions of modernity, or what it means to be modern, that shaped

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the discipline. As Connell (2007: 14) expands, 'sociology developed in a specific location: among men of the metropolitan liberal bourgeoisie'. The so-called founding fathers of the nineteenth century, such as Durkheim, Marx and Weber, were concerned principally with the social changes taking place as European societies modernised, processes such as socio-economic restructuring, loss of social cohesion and new forms of social inequality. Consequently, the very meaning of modernity itself was Eurocentric since the social was conceived as 'an internally coherent, bounded phenomenon that could be understood without any reference to external relations such as the colonial or imperial misadventures that were being undertaken at the time' (Bhambra 2007: 49). For example, Durkheim's (1964[1893]) analysis of the division of labour in society, especially his disquiet about excessive individualism and lack of social cohesion under organic solidarity, was approached overwhelmingly by reference to processes internal to a society.

Sociologists have questioned the constraints that this presents for an adequate understanding of social life in both the global north and the global south. But as Bhambra (2007: 6) argues, while sociologists are now far more inclined to discuss modernities in the plural, these often refer back to European analysis such that 'the West is understood as the major clearing house of modernity' to the rest of the world, meaning that non-Western peoples must now begin to engage their traditions with modernity in different forms of hybrid "modernities"'. As she continues, with globalisation these multiple modernities still tend to be seen as becoming global as they incorporate features of the West to local circumstances. Thus, as she puts it, while there is recognition of difference, that difference does not necessarily *make a difference* to sociological ways of thinking. Bhambra (2007) exemplifies this through the analogy of the spokes of a wheel where European modernity of the centre diffuses along the spokes of other parts of the world or countries in relation to their encounters with the West, with very little consideration given to how the spokes may relate to each other. Perforce there is a tenacious northernness to sociological theory which can result in the erasure of the experience of peoples outside of the metropole—the majority of the people of world—from the foundations of social thought (Connell 2007).

This has sizeable implications for the analysis of *society, differentiation and globalisation* and health. The connections between 'global' and 'health' are very far from given, rather, as this chapter seeks to show, global health problems and responses are 'enabled, imagined, and performed via particular knowledges, rationalities, technologies, affects, and practices across a variety of sites, spaces, and relations' (Brown et al. 2012: 1183). This means it is important not only to consider globalisation's processes and effects but also how they are theorised and the consequences that this might have for our understanding of health and healthcare in different parts of the world.

This chapter is organised as follows. Part 1 addresses theories of globalisation and their implications for the analysis of health issues. In particular I emphasise that globalisation is embodied, something often overlooked by sociologists working outside of the field of health (Turner 2004). Emphasis is given to the health vulnerabilities that arise from the heightened mobility, and connectivities that characterise globalisation, taking migration and health as an illustration. In Part 2, I turn to consider differentiation by highlighting disparities in health vulnerability and the capacity of social groups to protect their health. This is illustrated first by reference to the securitisation of health and (Elbe 2010a). A focus on the mental and physical health consequences of violent conflict then draws out the special vulnerabilities of children and of women. Finally, in Part 3, I reflect on neoliberalism as the dominant politico-economic policy framework driving health system change and on the increasing interconnectedness of various national health systems, and their implications for the delivery of effective healthcare.

Part 1—Conceptualising Societies, Globalisation and Health

As Turner emphasised over a decade ago, 'we can no longer study the treatment of disease in an exclusively national framework because the character of disease and its treatment are global' (2004: 230). The sociology of health needs to be global in scope and, crucially, the globalisation of health risks and of medical institutions should be added to globalisation theory as ‘the first steps toward a globalisation of the body’ (Turner 2004: 236). While Turner underlines that the spread of global health risks and global health institutions can be thought of as a new phase of globalisation, attention in these terms is wanting in most globalisation theories. Even so, they can provide a useful lens into the analysis of health in the global context.

As already noted, since globalisation is envisaged as a new social order, a substantially new theoretical framework is necessary to analyse what is envisaged as a ‘new unbounded social system’ (Connell 2007: 53). While popular thinking tends to equate globalisation with linear diffusion of Western values and ideas to the rest of the world and construe arrested globalisation as resistance to such a trend—such as in the interpretation of the rise of Islamic fundamentalism as a direct response to the spread of western political and cultural values into the Middle East—most social scientists maintain that globalisation has no one single logic. Instead of moving in one direction, they stress that it is multi-dimensional and multi-causal. Bauman (1998: 60) describes globalisation as uncontrolled, operating in what he depicts as a ‘vast – foggy and slushy, impassable and untameable – “no man’s land”’. Similarly for Beck (2000), there is no over-riding logic or driver, such as the economic; rather globalisation is multi-causal and multi-dimensional. Consequently it presents as a new form of radically uncertain modernity. According to Walby, globalisation is best identified as ‘a process of increased density and frequency of international interactions relative to local or national ones’ (2009: 36). She argues that this can be grasped most effectively through the lens of complexity theory. This entails a reworking of the concept and theory of society to bring system to the fore but in a substantively different way to erstwhile approaches such as that of Parsons (1951), where social systems were construed as entities made up of parts. By contrast, Walby (2015) proposes that sociology should be the study not of parts but of all of society as a set of relations. From this position, she maintains it is possible to ‘address multiple regimes of inequality existing within the same territory without assuming that they must neatly map onto each other or be confined to the same borders’ (Walby 2015: 166). This offers a new vocabulary with which to understand social change; that of co-emergence, non-linear processes and heterogeneity (Walby 2009), which draws attention to features of globalisation such as heightened mobility and new forms of connectivity between people, all of which have health implications.

In his theory of the networked society, Castells (2010) advances that social structure is always in the making, connecting the local and the global. While mobility is crucial, of equal importance for Castells is perpetual connectivity. Mobility stratifies through movement and through the lack of it. For some, 'space has lost its constraining quality and is easily traversed in both its "real" and "virtual" renditions'(Bauman 1998: 88), increasingly making it possible to move around the world for employment, in search of personal health and well-being and, as discussed in Part 3 of the chapter, for healthcare. Conversely, there are people, such as refugees, who, for reasons such as civil war and persecution, have no choice but to move and to keep on moving. Globalisation also makes visible the world of the 'locally tied' and globally many people are tied to risky communities that are damaging to their physical and mental health. (See Chap. 4.) In *Collateral Damage*, Bauman argues that 'the inflammable mixture of growing social inequality and the rising volume of human suffering marginalised as "collateral" is one of the most cataclysmic problems of our time' (2011). 'Collateral damage' is military in origin and refers to the unplanned effects of armed intrusions. Applying it to global societies, Bauman conveys how the poor become collateral damage in a profit-driven, consumer-oriented society. Although he does not address health and illness, it may be instructive to conceptualise those increasingly vulnerable to health inequity as a form of collateral damage. We turn to look at this now through the example of recent migration and health.

Migration and Health

The term migrant encompasses multiple forms of mobility. In broad usage, it is often taken to refer to people who move 'voluntarily' to live in another country for a year or more, such as 'economic migrants' and also 'irregular migrants' (those entering a country without required documents). By turn, 'forced migrants' comprises refuges, defined under the United Nations (UN) Refugee Convention of 1951 as those forced to flee to save their life or preserve their freedom; asylum seekers, or people seeking international protection, awaiting a decision on whether they have refugee status; and internally displaced persons (IDPs) forced to leave their homes to avoid armed conflict, natural or human-made disasters, or violations of human rights, but who have not crossed an international border. The UN Convention protects refugees, but asylum seekers and IDPs have few rights and hence limited protection.

The relationship between migration and health is complex for the reason that migrants are a heterogeneous group. Nonetheless, it can be useful to draw a general distinction between 'voluntary' and 'forced' migrants. Although we need to be wary of overgeneralising, where 'voluntary' movement is concerned, research points to health selection since migrants often are healthier compared to people in their country of origin, yet it is important to recognise that migration itself can carry risks such as those of transit and adjusting to life in a new country. From his in-depth consideration, Gatrell (2011) concludes that although migrants tend to be in better health than those left behind as well as than those in the new host population, these relative health advantages attenuate as immigrants adapt their behaviours, particularly their dietary and exercise behaviour, to the norms of the new community. This is borne out by Huijts and Kraaykamp's (2012) large-scale analysis of immigrant health in Europe. Based on European Social Survey data for 2002–2008, they analysed the health of over 19,000 immigrants from 123 different countries who had moved to 31 different European countries. Basing self-assessed health on a five point scale (i.e. very bad, bad, fair, good, very good), they analysed foreign born and second generation migrants in Europe with a focus on 'origin' and 'destination' effects on health. Characteristics of origin were found to have a lasting influence. For example, high levels of political oppression were associated with poorer health in both first and second generation migrants. Religion was found also to be influential. Notably, first generation immigrants from Islamic countries reported better health than those from countries where other religions predominate (all other factors being equal). The authors relate this to socialisation into positive health behaviours such as refraining from alcohol consumption and smoking, although, this did not apply to the second generation, something which they put down to the influence of culture in the destination countries. Overall then the health of immigrants shows a strong resemblance to the health of native inhabitants of the country of destination, but there are some lasting effects of origin countries (Huijts and Kraaykamp 2012).

The deregulation of wars is one of globalisation's most ominous effects. As discussed further below, most present-day war-like actions are carried out by non-state entities and consequently associated with the erosion of state sovereignty and the burgeoning frontier-land conditions of 'supra-state global space' (Bauman 2007: 37). Populations who flee conflict in their homelands often find themselves as outcasts in camps where they are neither 'settled nor are they on the move; they are neither sedentary not nomadic', becoming 'undecidables' made flesh (Bauman 2007: 51). When analysing forced migration we need to think less in terms of individuals moving in a linear fashion from point A to point B and more of constructed group movement, where the journey from A to B is often protracted and involves periods of stasis in 'transit' locations such as IDP and refugee camps, as well as interception stages, such as border controls. Such journeys are risk-laden (Zwi and Alvarez-Castillo 2003). As Gostin and Roberts (2015: 2125) relate, 'each stage of the forced migration journey…poses health risks. Individuals face armed conflict, famine, or both in their home countries causing physical illness, severe mental distress, and lifelong trauma'. The body of a 3-year old Syrian refugee, Aylan Al-Kurdi, lying on a Turkish beach in September 2015 is an enduring image of the present European 'migrant crisis'. In 2016 alone, 5096 people were reported dead or missing in the Mediterranean Sea as they sought to escape conflict in countries such as Syria and Afghanistan (UNHCR 2017). Other health risks include injury and disability in transit and infectious diseases, such as measles, polio, cholera, tuberculosis, dysentery, and typhoid which can be rife in camps and exacerbated by food insecurity and lack of clean water. A report from UNHCR (Hassan et al. 2015) on the mental health and psychosocial well-being of Syrians affected by armed conflict draws attention to experiences of violence, exploitation, isolation and losses such as grief for loved ones, homes and possessions. This manifests in helplessness, loss of control and anxiety as well as social withdrawal (especially amongst women and young people), fatigue, sleep problems, loss of appetite, and unexplained physical symptoms. The authors detail that often suffering is understood as a normal part of life, not in need of medical attention. Most Arabic and Syrian idioms of distress do not separate physical experience and mental symptoms since body and soul are linked in explanations of illness. For example, '*habat qalb* or *houbout el qalb,* literally "falling or crumbling of the heart", corresponds to the somatic reaction of sudden fear', and '*kamatni kalbi* "my heart is squeezing"…generally refers to anticipated anxiety and worry' (Hassan et al. 2015: 23).

The health consequences of forced migration are a powerful illustration of the 'social suffering [that] results from what political, economic, and institutional power does to people, and reciprocally, from how these forms of power themselves influence responses to social problems' (Kleinman et al. 1997: ix). Bauman (2016) argues that, from the stance of the more secure in the world, migrants embody ambient fears of precarity and of people whose lives are defined by precariousness and anxiety. The insecure are less able to evade their own vulnerabilities, including fears of loss such as of work, homes and loved ones, that are intensified by their scattered and unpinpointable nature (Bauman 2016). Grove and Zwi (2006) draw on 'othering theory' to account for the responses of people in destination countries of the global north to forced migrants. The process of othering marks migrants out as different to 'us' and in the process shores up feelings of normalcy. Concurrently migrants are constructed as risky to 'us', as distant and strange others, as needy, as charity cases and as health services queue jumpers who create welfare overload. As Grove and Zwi (2006) discuss, the language used is that of burden to the neglect of the agency, resilience and skill of many migrants.

Part 2—Differentiation: Securitisation of Health and the Health Effects of Violent Conflict

The Securitisation of Health

The health of forced migrants is but one example of the negative health consequences of globalisation. It highlights differential health vulnerabilities and the (in)capacity of groups of people to protect their health, the focus of this section of the chapter. The concept of the 'other', referred to earlier, is a useful frame within which to approach the effects of the securitisation of health in global context.

Although there is a strong historical connection between health and the security of nations, such as in times of war, the notion of 'health security' is quite recent. The catalyst was the events of 9/11 in the year 2001. This occasioned the setting up of the Global Health Security Initiative, an international partnership between several countries, including Canada, France, Germany, Italy, Japan, Mexico, the UK and the US, intended to supplement and strengthen their preparedness to respond to threats to global health, not only in regard to terrorism, but also pandemic infection and bio-chemical warfare. By 2007, 'health security' was high on the global agenda, as reflected in the World Health Organisation's annual report, *A Safer Future* (WHO 2007). The Report defines health security as 'the activities required, both proactive and reactive, to minimise vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries' (WHO 2007: ix). This signifies a two-way relationship between health and security. First, the health of populations is seen increasingly in security terms; that is, there is a felt need to secure population health against threats. Concomitantly, the security of nations is viewed in medical terms. In *Security and Global Health*, Elbe (2010a) proposes that the medicalisation of security has three dimensions. The first is that national security moves from being only about military capabilities and the hostile intentions of other states to the proliferation of lethal medical problems in the bodies of citizens. An instructive way to consider this, and also to track changes in ways of thinking over recent time, is to consider responses to infectious diseases such as HIV/AIDS and SARS (severe acute respiratory syndrome). The AIDS epidemic (see also the discussions on AIDS in Chaps. 3 and 4), which began over 30 years ago in the 1980s, was perhaps the first time that governments, notably the US as a superpower, began to link pandemics to national security and to worry about the possible effects of illness on US interests abroad (McInnes and Ruston 2013). Several years on in 2001, then US President Clinton declared AIDS a national security threat to the country. First, and perhaps foremost, there was concern with high HIV prevalence in the armed forces in times of war and hence the capacity to protect the nation (Elbe 2010a). With the SARS epidemic of 2002, security concerns shifted from armed conflict and the stability of national states to mortality burdens and economic repercussions (Elbe 2010a). SARS was traced to Guangdong province in China, and thereafter it spread to Hong Kong, Singapore and Toronto. By 2003, the WHO was warning against all but essential travel to these countries. In Hong Kong, over 1200 people were subject to isolation orders. When SARS spread to the middle-class private housing complex of Amoy Gardens in Kowloon, the Department of Health quarantined 264 apartments (although by the time the police arrived most people had already fled). A headline in the Singapore *Straits Times* of May that year emblazoned that 'SARS is like Singapore's 9/11'. The security threat attended very much to the economic repercussions. With SARS respiratory droplets are produced when an infected person coughs or sneezes; this is largely invisible and unpredictable and hence hard to avoid. During the outbreak people began to keep away from public spaces, to minimise time spent outside home, and to wear face masks. The economic effects were predictable; with the avoidance of travel, retail sales declined and there were less business exhibitions and meetings. It was estimated that the Asian region as a whole lost the equivalent of 25–30 million US dollars. The Canadian government evaluated that three million dollars were lost to the country's economy in the first two weeks alone of the outbreak in Toronto (Elbe 2010a). This prompted wider concern that any epidemic outbreak could wreak havoc on the world economy, further boosting the medicalisation of security.

The second dimension of the medicalisation of security addressed by Elbe (2010a) is the expansion of medical power and accompanying influence. At the most general level this is evident in increased involvement of medically trained persons in national security circles, most notably in the US. A key turning point was when then President Clinton brought physicians into politics in relation to AIDS with the objective of using them in helping to defend the US population from disease. Of significance here is the shift in emphasis from physicians as not only treating disease in individuals but defending against disease in populations. Presently, the US Homeland Security hosts an Office of Health Affairs which has a division of Health Threats Resilience. The third and final dimension of the medicalisation of security brought to the fore by Elbe (2010a) is measures to secure, or attempt to secure, population health. The main strategy of governments to protect citizens has been the stockpiling of medical countermeasures to major illness as a readiness or preparedness against future uncertainly highlighted by Bauman (2016) as referred to earlier. This is exemplified by the stockpiling by several governments of the global north of the anti-viral Tamiflu during the 'Swine flu' (H1N1) outbreak of 2009. The differential consequences for populations of containment efforts can be illustrated by the race to secure antiviral medications and vaccines in the wake of the possible H5NI (Avian flu) pandemic in the mid-2000s. As recounted by Elbe (2010b), the majority of cases and of deaths at the time were in Indonesia (see also Chap. 7 regarding how rural poor women in Indonesia are at great risk for maternal mortality, morbidity and infant death). In 2006, the country's government stopped sharing its virus samples to WHO under the Global Influenza Surveillance Network because it discovered that they were being given to Western pharmaceutical companies and novel vaccines offered back at unaffordable commercial rates.

It is therefore important to underscore that the securitisation of health is practised through, and acts on, the bodies of populations; it is a fundamentally embodied phenomenon involving the surveillance and control of populations, their bodies and their health (see also Chap. 3 for a detailed discussion on embodiment). This is now pervasive for the reason that many of the health threats referred to are unpredictable—no one predicted the outbreaks of SARS in 2002 and Ebola Virus in 2014–2015, for example, and it is hard to know where future threats may come from and what they will mean. Future health pandemics have rogue status, as depicted in the metaphor of the black swan. Initially the notion of black swan was used to refer to unexpected events in financial markets, and then expanded to refer to any surprise event of major proportions. It has been evoked by the US National Intelligence Council (2012: 16), which advises that 'no one can predict which pathogen will be the next to start spreading to humans, or when or where such a development will occur. An easily transmissible novel respiratory pathogen that kills or incapacitates more than one percent of its victims is amongst the most disruptive events possible. Such an outbreak could result in millions of people suffering or dying in every corner of the world'. Uncertainly is associated with both vulnerability and the escalation of agencies of health security. While the securitisation of health might seem to the good for all individuals and all populations, it can also be divisive, highlighting our concern with differentiation. Among the questions to be posed are: To what extent is the concern with 'national security' and to what extent with 'human security'? (DeLaet 2015) Are differential health interests being served? It has been argued (Davis 2008) that the securitisation of infectious disease prioritises the health concerns of Western states. In this regard agencies such as WHO are not neutral actors; diseases come to be identified as a threat when Western states feel threatened; after the threats wane so does the support (Davis 2008). Securitisation is then state-centric and shaped by the interests of privileged populations. Disease that is seen as containable within national boundaries, such as diarrheal disease and the more hidden burdens such as maternal mortality, infant mortality, hunger and traffic deaths, fails to reach the level of concern that securitised infectious diseases evoke. Resources are directed away from public health actors and poverty-related health challenges in ways that do not accurately reflect the global burden of disease (DeLaet 2015).

Differential Health Vulnerabilities in Violent Conflicts

Based on data reported at the end of 2016, there were 43 extremely violent conflicts going on in the world in 2015 (OCHA 2016). As well as deaths, injuries and all the other effects of collective violence, there were 65.3 million forcibly displaced persons, including 21.3 million refugees, 3.2 million asylum seekers and 40.8 million IDPs (OCHA 2016). Most contemporary or 'new wars' involve a range of not only state but also non-state combatants who use violence to pursue exclusionary goals, such as religious, ethnic and economic interests, as exemplified by the civil war in Syria. Frequently in such contexts, civilian casualty is not a side effect but an aim in itself. To give an illustration, UNICEF (2016) reports that two million children are living in areas largely cut off from any humanitarian assistance; 2015 saw over 1500 cases of killing and maiming of children, as well as attacks on schools and hospitals and denial of humanitarian aid to children. When considering the health effects of armed conflict analysts can be inclined to focus on fatalities from direct combat or death from fatal injuries sustained in combat, including the deliberate use of starvation as a direct weapon of war. But, there are other direct effects such as significant physical and mental health problems amongst both the armed forces and targeted and untargeted civilians—such as illness resulting from disabilities (e.g. loss of limbs) and from atrocities of war, such as rape and torture, and sexually transmitted infections. There are also indirect effects of conflict. For example, health facilities, which may not have been of the highest standard even before the onset of conflict, can be destroyed, cutting off access to essential care. Moreover, disease spreads in insanitary conditions such as overcrowded refugee camps, and persons living in war-torn environments invariably suffer fear, insecurity and mental trauma (Levy and Sidel 2008).

The differentiation of peoples is fundamental here. In *Frames of War*, Butler (2010) counsels that wars seek to manage populations by distinguishing lives to be preserved from those that are dispensable. Some lives become grievable and others not, since to be grievable a life has to matter rather than to be seen as imminently destructible. Violent conflict is then one of the most radical inequalities imaginable as *some* deaths of *some* populations or groups are seen as necessary to protect the living of others. As will be discussed later, women and girls, and children in general are often differentially vulnerable. We will now take this further through two case illustrations: the health of former child soldiers and rape of women in war.

The term ‘former child soldier’ refers to children abducted into armies and rebel forces and then returned home. There are an estimated 300,000 child soldiers in the world today, of whom, over 40 percent are girls. The participation of children under the age of 18 years in armed conflict is generally prohibited under international law, and the recruitment of children under 15 into conflict is a war crime (Amnesty International 2017). Coerced, enticed or abducted, children serve as combatants, porters, spies, human mine detectors and sex slaves. Their health and lives are endangered. Many are forced to commit atrocities such as killing or maiming a family member in order to break ties with their community and to make it harder for them to return home. A high rate of mental health problems amongst returnees is inevitable, not the least because when they return home they can experience stigma due to perceptions that they are immoral or dangerous. It is unsurprising, therefore, that former child soldiers have high incidences of post-traumatic stress disorder (PTSD), which is associated not only with their experience during war, but its aftermath. Betancourt et al. (2010) researched children in Sierra Leone who were recruited into the national army and civilian defence during the civil war of 1991, most notably the Revolutionary United Front (RUF), which was responsible for brutal atrocities against civilian populations, including amputations to supress resistance, and large-scale abduction of children. The RUF forced children to commit atrocities including the murder of loved ones. Many were subject to repeated rape and forced to take drugs to reduce inhibition against committing violent acts.

After the war ended, programs were set up to reintegrate children into their former communities, yet this was very difficult as most faced fear and distrust and girls were seen as sexually promiscuous or defiled. Betancourt et al. (2010) studied the role of stigma in mediating children's exposure to war-related events and mental health outcomes. A total of 152 former RUF child soldiers aged between 10 and 18 years were interviewed at the end of the war in 2002 and again in 2004 with a focus on family and community acceptance and psychological adjustment, especially levels of depression, anxiety and hostility. The researchers found that the large majority of the respondents were involved with the rebels by force with an average age at abduction of 11 years. In all, 44 percent of the girls and 7 percent of the boys reported being a victim of rape; 31 percent of girls and 35 percent of boys had wounded or killed either a loved one or a stranger. Levels of depression were high and 79 percent felt local people acted afraid of them, and 82 percent that the local people felt threatend by them. As one child said, 'initially when I arrived [back home], people feared me. Some said I was a killer. There were times when I wanted to touch or play with other kids, but their parents will shout at me. I felt bad during those early days' (quoted in Betancourt et al. 2010: 24).

In conflict zones around the world, military forces use gender-based sexual violence (GBSV) to terrorise, humiliate and demoralise whole communities, including by the spread of a disease such as HIV and of sexually transmitted diseases—a clear illustration of illness as a tactic of war. Here the association between the individual and the collective becomes paramount. There has been a tendency to explain rape and sexual violence as random and opportunistic acts of war, that is, outside of the wider structural context of the society concerned. Yet gendered structural conditions are crucial. Indeed, it is arguably because of the normalisation of women's inequality in a society where GBSV appears logical and instrumental (Davis and True 2015). Though violent conflict and health is not their focus, Scheper-Hughes and Lock's (1987) theorisation of the 'mindful body' is a valuable lens through which to evaluate GBSV. (See Chap. 3 for a discussion of 'the mindful body' in the context of embodiment theory.) They draw attention to the *individually experienced* body-self, and also to the *social body* and its symbolic and representational uses, and to the *body politic*, or the regulation and control of bodies, for example in families and in medical systems. Research examples illustrate how the individual body, social body and body politics come together to help explain rape and sexual violence in war. In their research on GBSV in South Kivu, Democratic Republic of the Congo, Kelly and colleagues (2012) found that, absolutely vital though this is, rape goes far beyond individual physical and psychological trauma and becomes a societal phenomenon where isolation and shame often become as important as the attack itself. Analysis of focus group data revealed that many interpreted rape as a form of destruction to the community, associated with the spread of disease, the devaluation of women and the breakdown of families. As one respondent put it, 'if you are a girl [who has been raped], your parents will start mistreating you, they can't understand that you have been forced and that it was not your fault. You will never get married. They will throw you away because you are not worth anything; you will lose all value because nobody will marry you' (quoted in Kelly et al. 2012: 290). Husbands may view their wives as 'contaminated', such as by sexually transmitted infections, and also as morally contaminating since the rape of a wife can result in loss of pride and a feeling of impotence in being unable to provide support (Kelly et al. 2012). A second illustration of the power of collective structural context on individual experience comes from the Serbian occupation of Croatia in the early 1990s. Olujic (1998) argues that to understand what happens in war we must take account of the pre-war gendered context, especially meanings of female sexuality and the codes of honour and virtue that women represent in the family, alongside the role of men in protecting this honour. As she puts it, 'women's honour reflects that of men's, which, in turn, reflects that of the nation' (Olujic 1998: 38). Rape can then represent men's inability to protect women, an attack on their honour and a cause of their shame. Thereby the individual bodies of women become metaphoric representations of the social body and the injury to their bodies maims the family and the community. Based on fieldwork in hospitals in 'post-conflict' Erbil, Kurdistan, Keller (2012) explored women's expression of illness through presenting symptoms such as limb paralysis, convulsions and muteness. In women's own accounts, symptoms such as these were linked to home life, to experiences that were too much to bear and to lack of support. Keeler (2012) associated this with the imposition of global neoliberal agendas in the individual and social body: women's trauma narratives become (re)inscribed by their physicians as anti-modern, positioned as belonging to a 'bygone age'. Thus 'hysterical women' become a counter-narrative to the global prosperity trope and are medically silenced by the 'body politic' to 'expunge non-normative expressions of trauma' (Keeler 2012: 140) in post-conflict modernity. This occurs by such procedures as 'pain stimulation', including saline injections, the bending back of fingers and the threat of sexual trauma as 'medical treatment'.

This illustration directs our attention to the alliances between healthcare and political agendas. In the final part of the chapter, I reflect on the interconnections of healthcare systems and neoliberal political agendas.

Part 3—Globalisation and Health System Change

Health systems can be defined as the assemblage of public and private sector institutions and actors concerned with the support of health and the amelioration of illness. Even though globally many countries are grappling with common problems, such as increased health needs and demands for healthcare, alongside the rising costs of providing it, there is not one, simple international line of convergence towards a common form of health system. The reason is that health systems are shaped significantly by their centuries-old economic and political regimes. In addition, they take their form from 'national logics', that is, how a society defines and deals with issues of health and illness. Equally, cultural factors influence how populations respond to proposed changes to their health system as well as how those external to a country relate to it. Even so, without undue risk of overgeneralisation, we can point towards a worldwide drive towards the commercialisation of health systems and, where public provision exists, such as in our case example of the UK, to the roll-back of state or public provision in favour of the free market principles. Thus, most health systems around the world have or are moving towards a mix of public/private provision. With this point in mind, it has been argued that health services are now as much about investor potential as access to care for patients. Tritter and colleagues maintain that

> Health systems are no longer important primarily because they ensure that people gain access to health services when in need and irrespective of their ability to pay, that epidemics are prevented or controlled[...]or that the social determinants of health are addressed as part of public policies. In the emerging context of the reform policies, health systems are important not only as providers of products and services for which people are willing to pay, but also as an investment opportunity within global financial markets. (Tritter et al. 2010: 36)

Although they manifest in different ways across health systems, we can point to a set of three shared global influences: neoliberalism (see also the discussions on neoliberalism in Chaps. 4 and 6) as the dominant politico-economic policy framework driving system change; macroeconomic policies and structural adjustment programmes (SAPs); and international trade agreements.

As addressed elsewhere in this book, neoliberalism can be defined as a project of economic and social change based on the transfer of economic power and control from governments to private markets and the injection of market competition into areas such as education, housing and healthcare which, in many western countries at least, were once part of the welfare state (Scott-Samuel et al. 2014). As discussed in Chap. 4, neoliberalism is usually interpreted as a response to the period of structural crisis of the 1970s when, from mid-decade, countries such as the US and UK witnessed lower rates of financial accumulation and growth, rises in unemployment and rising inflation. Neoliberal economic policies encourage financial deregulation and the opening up of trade and investment by resource-rich countries in regions where social conditions afford high returns. Up to the late 1970s, the predominant approach to health improvement globally was to strengthen public health systems, especially access to primary health care. This was the position established by the WHO's influential Alma-Ata Declaration of 1978 which brought about access to healthcare as a human right. The World Bank (WB), the International Monetary Fund (IMF), the World Trade Organisation (WTO) and other agencies rebuffed this position in the 1980s as they established monetarist policies prioritising the achievement of macroeconomic stability by putting constraints on the growth of money supply and public spending. Supranational agencies, such as the IMF, WTO and the WB, have been key players in the spread of global neoliberalism in the health field. Their influence is often indirect comprising the development of trade and investment agreements negotiated at bilateral and multilateral levels and the promotion of market-friendly structures and regulatory reforms.

One of the most controversial of WB policies has been the pressure upon countries of the global south to adopt SAPs. As a condition of receipt of foreign aid and loans, structural adjustments comprise lowering trade barriers, the selling off of state-owned assets and cutting public sector budgets and public sector workforces (Rowden 2009). The stance of the WB is that structural adjustment stabilises economies, promotes investment and generates long-term economic growth. But it has been argued to the contrary that this leads directly to chronic underfunding of local public sector services, collapsing domestic industries in the face of cheaper imports, rural-urban migration, reduced health budgets (and less money for health workers) and the reduction of access to services by local communities. For example, it might be argued that the unpreparedness of Liberia, Sierra Leone and Guinea to deal with the Ebola Virus outbreak of 2014–2016 in West Africa was associated with a short-term focus on economic objectives and on profitable sectors, such as minerals (iron ore, gold, bauxite and rubber) at the expense of the public sector. Stubbs et al. (2017) explored the effects of IMF aid conditionalities on the provision of healthcare in 16 West African countries including the

Gambia, Liberia, Nigeria and Sierra Leonne, between 1995 and 2014. The number of conditions put on aid over the period amounted in total to 8344 in the region. IMF targets, such as budget deficit reduction, were found to crowd out or to reduce the space for investment in the health sector and aid conditions which stipulated staff layoffs or caps on public sector wages limited much-needed staff expansion of doctors and nurses. In other words, conditionalities of aid negatively impacted the provision of healthcare in the countries concerned.

The third significant influence on global health systems is international trade agreements, specifically the General Agreement on Trade in Services (GATS) and the associated proliferation of bilateral agreements. GATS, which came into effect in 1995, was the first set of multilateral rules governing international trade in services, such as education and healthcare, with the object of removing trade barriers. Ultimately, since it aims to liberate all services, it is a potential challenge to the sovereignty of national governments over policy-making in relation to public health and the provision of health services. For example, at the time of writing in March 2017, it is not clear whether the Transatlantic Trade and Investment Partnership (T-TIP) between the EU and the USA, presently in an eighth round of discussions, will exclude the UK NHS (National Health Service). If it does not then it could give transnational corporations the right to enter the UK market and operate without limits on their activities.

For the reasons referred to earlier concerning the different histories and cultural contexts, the organisation of health systems varies considerably in different countries. The US, for example, has always been a privately reimbursed system where citizens pay for care by insurance through employment or out of pocket. By contrast, in the UK health system since the inception of the NHS in 1948 most aspects of care have been provided free of charge through taxation. The same broadly applies to the Nordic countries, as well as others such as Italy. In between this many countries, such as Germany, Japan, Taiwan and France, have social insurance models whereby patients and employers pay into sick funds which contract with a range of health providers. But, to varying degrees and in different ways, almost all are moving towards a blending of public/private elements.

The UK has in many ways been at the fore in this regard, beginning with reforms of the Thatcher government in the 1980s. But the approach has been espoused internationally by countries as varied as Italy, Singapore, India, Taiwan, Malaysia, the Philippines and Russia. Fundamentally, the intent has been to introduce market mechanisms to control costs. Globally, though to varying degrees, healthcare costs have been rising at significant rates. For example, healthcare expenditure as percentage of GDP rose from 4.0 percent in 1970/1 to 9.8 percent in 2014 in the UK and, for the equivalent period, from 6.4 to 16.9 percent in the US, and from 6.2 to 11.1 percent in Germany (World Bank 2017).

In the UK and most notably England, an internal market was introduced in the early 1990s as a number of GP practices became fundholders who purchased care from hospitals and other providers on behalf of their patients (DoH 1989). The intention was that this would make them more cost conscious since they would be paying; that is, they would be deterred from referring patients too readily for tests and treatments, and that they would hold care providers, principally hospitals, to account for spending and quality of care for patients (Hunter 2016). The New Labour government of 1997 broadly extended this policy, merging general practices into Primary Care Trusts which jointly commissioned services for patients. The late 1990s into the early 2000s saw the further introduction of private providers into the NHS, for example, to run day surgery, pathology and diagnostic services (DoH 1997). In 2010, the new Coalition government consolidated this by the setting up of Clinical Commissioning Groups (CCGs) which hold approximately two-thirds of the NHS budget. CCGs currently purchase care on behalf of GPs for their patients. Moreover, under the new ‘any qualified provider’ provision, care could be commissioned not only from NHS providers but also from the for-profit and the not-for-profit third sector (charities and social enterprises) (DoH 2010). This overall policy remains in place at the time of writing in 2017 with recent concern focusing less visibly on structural reform and more on incapacity to meet demand—for example, in January 2017 the British Red Cross said that the NHS was facing a humanitarian crisis in the face of escalating demand and rising waiting lists for treatment.

Conclusion

Health, Culture and Society endorses the enduring conceptual legacies that have shaped and continue to shape our thinking. It seeks to understand not only where we have come from but where we are going to. This has been the focus of the current chapter as we have explored sociology's disquiet with 'society', as its erstwhile unit of analysis. While theorists of globalisation have given relatively little direct attention to matters of health, it has been suggested that the attention to international connections, mobility and new emergent forms of differentiation and inequality can be a useful point of departure for the analysis of health and healthcare. In these terms we have addressed several critical health issues of our time, such as migration and health, the securitisation of health, the health devastation wrought on civilians caught up in violent conflicts around the world, and the commercialisation of health systems.

References

Amnesty International. (2017). From cradle to war. http://www.amnestyusa.org/our-work/issues/children-s-rights/child-soldiers. Accessed 20 Mar 2017.

Bauman, Z. (1998). *Globalization: The human consequences*. Cambridge: Polity.

Bauman, Z. (2007). *Liquid times*. Cambridge: Polity.

Bauman, Z. (2011). *Collateral damage: Social inequalities in a global age*. Cambridge: Polity.

Bauman, Z. (2016). Why the world fears refugees. http://www.aljazeera.com/indepth/features/2016/10/world-fears-refugees-161013095315081.html. Accessed 27 Jan 2017.

Beck, U. (2000). *What is globalisation?* Cambridge: Polity.

Betancourt, T., Agnew-Blais, J., Gilman, S., Williams, D., & Ellis, B. (2010). Past horrors, present struggles: The role of stigma in the association between war experiences and psychosocial adjustment among former child soldiers in Sierra Leone. *Social Science & Medicine, 70*, 17–26.

Bhambra, G. (2007). *Rethinking modernity: Postcolonialism and the sociological imagination*. London: Palgrave.

Brown, T., Craddock, S., & Ingram, A. (2012). Critical interventions in global health: Governmentality, risk and assemblage. *Annals of the Association of American Geographers, 102*, 1182–1189.

Burawoy, M. (2005). For public sociology. *American Sociological Review, 70*(4), 4–28.

Butler, J. (2010). *Fames of war: When is life grievable?* London: Verso.

Castells, E. (2010). *The rise of network society* (2nd ed.). Oxford: Wiley-Blackwell.

Connell, R. (2007). *Southern theory*. Cambridge: Polity.

Davis, S. (2008). Securitizing infectious disease. *International Affairs, 84*(2), 295–313.

Davis, S., & True, J. (2015). Reframing conflict-related sexual and gender-based violence: Bringing gender analysis back in. *Security Dialogue, 46*(6), 495–512.

DeLaet, D. (2015). Whose interests is the securitisation of health serving? In S. Rushton & J. Youde (Eds.), *The Routledge handbook of global health security* (pp. 339–348). London: Routledge.

DoH (Department of Health). (1989). *Working for patients*. London: Stationary Office.

DoH. (1997). *The new NHS: Modern, dependable*. London: Stationary Office.

DoH. (2010). *Equality and excellence: Liberating the NHS*. London: Stationary Office.

Durkheim, E. (1964). *The division of labour in society*. New York: Free Press of Glencoe.

Elbe, S. (2010a). *Security and global health*. Cambridge: Polity.

Elbe, S. (2010b). Haggling over viruses: The downside risks of securitizing infectious disease. *Health Policy and Planning, 25*, 476–485.

Gatrell, A. (2011). *Mobilities and health*. Farnham: Ashgate.

Gostin, L., & Roberts, A. (2015). Forced migration: The human face of a health crisis. *Journal of American Medical Association, 314*(20), 2125–2126.

Grove, N., & Zwi, A. (2006). Our health and theirs: Forced migration, othering, and public health. *Social Science & Medicine, 62*, 1931–1942.

Hassan, G., Kirmayer, L., MekkiBerrada, A., Quosh, C., el Chammay, R., Deville-Stoetzel, J., Youssef, A., Jefee-Bahloul, H., Barkeel-Oteo, A., Coutts, A., Song, S., & Ventevogel, P. (2015). *Culture, context and the mental health and psychosocial wellbeing of Syrians: A review for mental health and psychosocial support staff working with Syrians affected by armed conflict*. Geneva: UNHCR.

Huijts, T., & Kraaykamp, G. (2012). Immigrants' health in Europe: A cross-classified multilevel approach to examine origin country, destination country, and community effects. *International Migration Review, 46*(1), 101–137.

Hunter, D. (2016). *The health debate* (2nd ed.). Bristol: Policy Press.

Keeler, S. (2012). First do no harm? Female hysteria, trauma, and the (bio)logic of violence in Iraq. *Medical Anthropology, 31*(2), 132–148.

Kelly, J., Kabanga, J., Cragin, W., Llcayna-Stevens, L., Haider, S., & Vanrooyen, M. (2012). 'If your husband doesn't humiliate you, other people won't': Gendered attitudes towards sexual violence in eastern Democratic Republic of Congo. *Global Public Health, 7*(3), 285–298.

Kleinman, A., Das, V., & Lock, M. (1997). *Social suffering*. Berkeley: University of California Press.

Levy, B., & Sidel, V. (2008). *War and public health*. Oxford: Oxford University Press.

McInnes, C., & Rushton, S. (2013). HIV/AIDS and securitization theory. *European Journal of International Relations, 19*(1), 115–138.

National Intelligence Council. (2012). *Global trends 2030: Alternative worlds*. A publication of the National Intelligence Council. Office of the Director of National Intelligence.

OCHA (Office for the National Coordination of Humanitarian Affairs). (2016). *Humanitarian data and trends 2016*. New York: OCHA.

Olujic, M. (1998). Embodiment of terror: Gendered violence in peacetime and wartime in Croatia and Bosnia-Herzegovina. *Medical Anthropology Quarterly, 12*(1), 31–50.

Parsons, T. (1951). *The social system*. New York: Free Press.

Rowden, R. (2009). *The deadly ideas of neoliberalism*. London: Zed Books.

Scheper-Hughes, N., & Lock, M. (1987). The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly, 1*(1), 6–42.

Scott-Samuel, A., Bambra, C., Collins, C., Hunter, D., McCartney, C., & Smith, K. (2014). The impact of Thatcherism on health and well-being in Britain. *International Journal of Health Services, 44*(1), 53–71.

Stubbs, T., Kentikelenis, A., Stuckler, D., McKee, M., & King, L. (2017). The impact of IMF conditionality on government health expenditure: A cross-national analysis of 16 West African nations. *Social Science & Medicine, 174*, 220–227.

Tritter, J., Koivusalo, M., Ollila, E., & Dorfman, P. (2010). *Globalisation, markets and healthcare policy*. London: Routledge.

Turner, B. (2004). *The new medical sociology*. London: W. W. Norton Company.

UNHCR Bureau for Europe. (2017). Desperate journeys. http://www.unhcr.org/uk/news/updates/2017/2/58b449f54/desperate-journeys-refugees-migrants-entering-crossing-europe-via-mediterranean.html

UNICEF. (2016). *No place for children – The impacts of five years of war on Syrian children and their childhoods*. New York: UNICEF.

Urry, J. (2000). *Sociology beyond societies*. London: Routledge.

Walby, S. (2009). *Globalization and inequalities: Complexity and contested modernities*. London: Sage.

Walby, S. (2015). *Crisis*. Cambridge: Polity.

World Bank. (2017). World development indicators: Health systems. http://wdi.worldbank.org/table/2.15. Accessed 24 Mar 2017.

World Health Organisation (WHO). (2007). *The world health report 2007 – A safer future: Global public health security in the twenty-first century*. Geneva: WHO.

Zwi, A., & Alvarez-Castillo, F. (2003). Forced migration, globalisation, and public health; getting the big picture into focus. In P. Allotey (Ed.), *The health of refugees: Public health perspectives from crisis to settlement* (pp. 14–34). South Melbourne: Oxford University Press.

3

Self, Normativity and Embodiment

Elizabeth Ettorre

Introduction

In her now classic study, *The Woman in the Body*, Emily Martin (1992: xv)[1] observed that in birthing (see also discussions on reproduction in Chaps. 5 and 7), women tended to resist passivity (i.e. conformity), although this resistance had 'very different implications for women of different ethnic and class positions'. Her study showed that the 'hold on the body' has moved 'from law to science' (p. 19) and when 'science treats the person as a machine and assumes the body can be fixed by mechanical manipulations, it … encourages us to ignore other aspects of ourselves such as emotions or our relationships with other people' (pp. 19–20). This chapter looks at how health and illness[2] create complex spaces where bodies emerge as sites for resistance and rebellion[3] as well as conformity and normativity. I will demonstrate that a conception of the embodied[4] self is the template upon which health, social and cultural identities are fashioned and through which private and public emotions as well

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as health and social problems are played out. How social scientists are best able to contextualize the notion of 'healthy' and 'unhealthy' embodiments and understand the conditions and experiences of those with these embodiments are crucial. Studying the corporeal, affective body and its sociological and psychological (Wetherell 2015) ramifications is a prerequisite for understanding organic pathology and salubrity. In Part I, I provide an overview of the development of the concept of the body alongside an emergent sociology of the body. This begins with a discussion of the self, more specifically, the agentic[5] self, by focusing on the work of three key theorists: George Herbert Mead, Erving Goffman and Norbert Elias. I then proceed to a discussion of why the study of the body is important in sociology with a brief reference to key embodiment theorists including Kathy Davis (body beauty practices), Pierre Bourdieu (habitus), Nick Crossley (reflexive body techniques, RBTs), Michel Foucault (docile bodies) and Judith Butler (body performativity). In Part II, I provide case studies of medicalized bodies by focusing on 'techno bodies', 'abject bodies' and 'bodies in representation'. Here, we see how the concept of the body can be applied in health contexts. In Part III, I consider ways in which we might continue to work with the concept of the body. A combination of recognizing the significance of embodiment as well as all-pervasive moralities of health[6] surrounding biomedicine should lead us to consider the importance of embodied ethics.

Part I: Why Study the Body?: Agentic Selves, Sociology and Corpus Intersum[7]

In tracing conceptual heritages of sociological studies of the body, there is a lacuna. Turner notes (1991: 6) that classical sociology failed to generate a sociology of the body, while in nineteenth-century anthropology, the notion of the body was important in early explanations and theories of ritual, cosmology and social structure. Frank (1991: 41) argues that bringing bodies back in (i.e. to sociology) was made 'thinkable and imperative by the practical political program of women'[8] bringing themselves back into 'male sociology'. Feminist sociologists were influenced by the early politics of the Women's Liberation Movement (WLM). Studying the terrain of the body informed the politics of WLM, especially in the United States (Boston Women's Health Book Collective 1971) and over the years, an awareness of the feminist health issues raised in that compendium travelled across borders on a global scale (Davis 2007). As Frank (1991: 41) argues:

> Sociology has reflected a male domination which first *naturalizes* the capacities of bodies and then, legitimated by this naturalization, denies any domination at work in it, i.e., each does according to his or 'her natural' endowments.

This lack of a well-developed sociology of the body could also be linked to the development of sociology as a discipline—a sociology too interested in defining 'the characteristics of urban industrial society' (see Turner 1991: 6) and not at all concerned with how bodies survived in this society. Turner (2008: 33) argued that this lack could be explained because the epistemological foundations of modern sociology were rooted in a rejection of nineteenth-century positivistic biology—sociology took 'the social meaning of human interaction as its principal object of enquiry', claiming that 'the meaning of social action can never be reduced to biology'.

Here, the concept of the self becomes crucial. Yet, as Turner (2008: 35) argued, the idea that the body may be one component of the 'continuity of self' (i.e. extension of the self) was discarded in favour of the view that this continuity of self is based on others' perceptions. On the one hand, micro-sociology excluded the body because the self as a social actor was socially constructed in action, while on the other, macro-sociology excluded the body because its theoretical focus was on 'the social system' (Turner 2008: 35) and the self had agency only within this system.

The Concept of the 'Agentic Self'

The concept of the 'self' is fundamental in interpretivist[9] as well as classical or positivistic sociology. The concept of the *agentic self* confirms an agentic body. In this epistemological position, the resistance of medical professionals to a discerning conception of the embodied self[10] is not surprising given the traditional tension in sociology between positivism and interpretivism. As a reaction to positivism, interpretivism's starting point was the requirement that social scientists differentiate themselves from natural scientists on the basis of the nature of the investigated phenomena. Furthermore, sociologists distanced themselves from naturalistic accounts of the body which stressed the unchanging pre-social, organic or biological body as the basis for social relations, hierarchies and inequalities. In opposition to positivism, interpretivists contend that we cannot comprehend the self, why the self does what it does, and why particular cultures and societies exist and coalesce as they do without understanding how embodied selves interpret and make sense of their own worlds and the distinctive nature of their beliefs, attitudes and actions. Regardless of an inbuilt bias against a study of the embodied self within sociology, three theorists hinted at why this concept was important for understanding the body in society. George Herbert Mead and Erving Goffman looked at the self within an interpretivist perspective, while Norbert Elias's figurational sociology[11] and realist approach[12] offered a different viewpoint.

In a conscious rejection of Western Cartesian dualist thought George Herbert Mead's approach was 'a new orientation to the mind-body[13] problem' (Scheffler 1974: 8, 54). For Mead, while both the social and physical worlds are given, the self is formed within these worlds in a process of social interaction (p. 154). The social and physical worlds are the ontological starting points rather than individual minds and subjects. Implying that the mind is socially embedded and the interaction of the self and the mind is an embodied social process, Mead (1934: 187) says:

> The human body is, especially in its analysis, regarded as a physical thing. The line of demarcation between the self and the body is found, then, first of all, in the social organisation of the act within which the self arises, in its contrast with the activity of the physiological organism. The legitimate basis of distinction between mind and body is between the social patterns and the patterns of the organism itself.

Mead believed that structured education must bring the two (i.e. mind and body) closely together as opposed to further apart (p. 187). A 'thinker before his time', he contended that we have as yet 'no comprehending category' to talk about how the mind and body are one (p. 187). He did not mean to say 'that there is anything logically against it' (p. 187). Rather in his view, this lack of a comprehending category to understand the embeddedness of mind and body was 'merely a lack of our apparatus of knowledge' (p. 187). While Western sociology did not have the conceptual tools to shape this sort of debate, other cultures had already conceptualized the 'mindful body' (see Scheper-Hughes and Lock 1987). (See also Chap. 2 and the discussion of 'the mindful body' in the context of gender based sexual violence or GBSV.)

In Erving Goffman's work, the self is consistently situated in a social context and, like Mead, produced by it. For example, Goffman (1961: 154) says in his classic text, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*:

> Each moral career and behind this, each self, occurs within the confines of an institutional system, whether a social establishment such as a mental hospital or a complex of personal and professional relationships. The self, then, can be seen as something that resides in the arrangements prevailing in a social system for its members. The self in this sense is not a property of the person to whom it is attributed but dwells rather in the pattern of social control that is exerted in connexion with the person by himself (*sic)* and those around him (*sic.*).[14] This special kind of institutional arrangement does not so much support the self as constitute it.

In *The Presentation of Self in Everyday Life*, Goffman (1959) looks sociologically at face-to-face interactions which he defines as 'the reciprocal influence of individuals upon one another's actions when in one another's immediate physical presence' (p. 26). Interactions are embodied encounters, while performances, which we are all involved in, are 'all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants' (p. 26). When a self comes in contact with other selves, 'impression management' occurs. Simply, in order to prevent the occurrences of embarrassing incidents which are liable to occur in public interactions, individuals, as performers in these social situations, must take protective measures for 'saving the show' (p. 206–207). These sorts of ideas led Goffman to consider dramaturgical or performative analyses and to envisage the deeply related nature of all social interactions. In a related book, *Interaction Ritual: Essays on Face-to-Face Behavior*, Goffman (1967) explores the world of social encounters, including face-to-face encounters, in which the face is defined as 'the positive social value a person effectively claims for himself by the line' (i.e. pattern of verbal and non-verbal acts by which a person expresses one's views) 'others assume he has taken during a particular contact' (p. 5). Goffman believed that a person tends to experience an immediate emotional response to the face which a contact with others allows him (p. 6). Thus, Goffman demonstrated how the body is an interactional or dramaturgical resource (Williams 2003: 3) and the importance of the body's appearance and management for the creation of a social self and for maintenance of social interaction (Shilling 2005: 8).

Within Norbert Elias's (2007: 79) framework, the social sciences were distinct from the natural sciences in that they were 'concerned with conjunctions (i.e. interactions) of persons … people face themselves: the "objects" are also "subjects"'. His overall theoretical perspective arose out of his earlier 'historically grounded arguments about the civilizing process' (Elias 1978) and his interest in 'a sociology of emotions … and … self-regulation' (Morrow 2009: 216). Within his process sociology, the self emerges as key to understanding society. As Rojek (1986: 589) notes, 'The chains of interdependence between people lengthen and multiply. As people grow more dependent upon each other … their personality structure and social attitudes change'.

The Society of Individuals first published in 1939[15] provides important insights into Elias's ideas on the self. He believed that in terms of one's self image, there is a 'peculiar historical molding of the individual by the network of relations, by a form of communal life with a very specific structure' (p. 28). Simply, he was suggesting that the self is highly restrained (i.e. one 'affects control, renunciation and transformation of instinct' (p. 28) in social situations). A type of 'self-consciousness' in the self's 'psychological structure' is 'established at certain stages of the civilizing process' (p. 28). This structure is 'characterized by an especially strong differentiation and tension between the social commands and prohibitions inculcated as self-restraining and the uncontrolled or repressed instincts and inclinations within the human being himself' (p. 28). Elias observes a tension within the self: the self's 'privatization' (i.e. exclusion of certain spheres of life from social intercourse), which is linked to a 'socially instilled fear in the form of shame and embarrassment', causes one to feel that 'inside himself, he is something that exists quite alone' (p. 28). Elias (199: 28) envisaged 'the self' in what he refers to as 'highly individualized people' who when they reflect theoretically 'appear as an existential gulf and eternal conflict between the self and society'.

Elias's ideas on the self were transformative and vibrant. He spoke of how a clear distinction between 'the pure self' who enters relationships with other people (the subject of psychology) and 'society' (the subject of sociology) as 'something existing outside the self' is an 'inadequate' calculation if sociology is to develop and be 'widened' (p. 31). The self needs to see 'himself and his self-consciousness in the larger context of historical evolution' (p. 31). Elias (1991: 31) argued that we need a 'dynamic framework to understand individuals in changing relationships' as 'type of individualities' changes over time. For Elias (1991: 33):

> This self, this personal essence is formed in a continuous interweaving of needs, a constant desire and fulfillment, an alternating taking and giving. It is the order of this incessant interweaving without a beginning that determines the nature and form of the individual human being' (i.e. the self).

Elias's ideas on the self were fundamental to his ideas on the 'civilized body' (Elias 1978). For example, 'Elias … was the first male sociologist to take the body as an explicit focus … (he) … developed the concept of the "civilized body" as the product of three key social processes: Socialization, Rationalization and Individualization'.[16] Kingdon (2009) notes that Elias 'illustrated how in developed societies people are encouraged to hide their natural bodily functions through the process of socialization, … are supposed to be able to control their feelings through the process of rationalization, and … learn to maintain an acceptable distance from each other's bodies through individualization' (p. 97).

Mead's and Goffman's conception of the self allows for the introduction of the underlying concept of social interaction, which, in turn, allows for a broader understanding of the whys and hows of the construction of the social. Elias's conception of the self is more elusive and we are left with a 'pure' self in eternal tension, desiring solitude as well as sociability. I would contend that these social theorists' thinking introduced different levels of awareness of the body in society. As Shilling (2008: 11) asserts, it is 'the interaction between as well as the existence of, the external and internal environment that is vital to our understanding of embodied action'. While Mead, Goffman and Elias may not be considered embodiment theorists per se, their theories allowed for the notion, agentic selves, to become visible within sociology.

Sociology and Corpus Intersum (That Is, 'Attending to the Body')

The study of the body within sociology is important for five reasons: First, we, human beings are 'embodied' beings (see also the discussion on the securitization of health in Chap. 2). We are our bodies and it is with our bodies that we encounter, live and end our social lives. Furthermore, disease and illness are seen to be located within bodies. Fox (1998: 30) has argued that the first promise of post-modernism is the promise to fabricate our bodies, our health and illnesses. He argues that we are doomed to the ministrations of medicine's disciplinary practices aimed at obtaining health, which territorialize us as 'organisms'. Against this barrage, our bodies are 'provisional', meaning that we have a real say in what health means for our embodiment. We can refuse to engage in the labelling of our bodies as merely 'Bodies-with-Organs'. Davis's (1995) ground-breaking study shows how beauty practices (i.e. cosmetic surgery) are less about the beauty system oppressing its customers/patients and more about how women manipulate the medical system to meet their own needs (See also Davis 2009). Thus, women engaging in these practices become embodied subjects rather than 'just a body' or Bodies-with-Organs (Fox 1998: 12).

Second, our fleshy bodies carry meaning and provide the basis for making social distinctions of difference and inequalities based on race, ethnicity, sex, gender, age, ability, sexual orientation and so on. Bourdieu's

(1990: 55) concept of habitus[17] (i.e. the internal differentiating system which we learn, as a result of social hierarchy, how to live in society) is related to how we not only value ourselves but also our bodies within this social hierarchy. Social hierarchies and social distinctions affect the social patterning of health and illness, access to health care, attitudes of health care providers (Vågerö and Illsley 2004; Sheaff 2005; Payne 2006, Wilkinson and Pickett 2009; Shaw et al. 2002: 149–51) and epistemologies of public health practices (Phillips and Green 2015). In these processes, bodies are crucial.

Third, across cultures, what is taken to be a 'natural' or 'normal' body changes over time.[18] For example, tattoos used to be seen as the exclusive domain of rugged, masculine seamen and a distinctive way of marking one's body. Nowadays, tattoos, piercing and marking bodies have become a normalized, decorative practice of contemporary bodies for all ages and genders, as this is considered body art (Salecl 2001) or even 'high art' (Kosut 2014). Crossley's (2005: 2) ideas on RBTs,[19] the 'embodied and reflexive processes and practices involved in projects of body modification/maintenance' are instructive. Crossley (2005: 2, 19) contends that the overall repertoire of RBTs can be differentiated into: (1) clusters which all members practice (i.e. hand washing or tooth brushing), (2) clusters which the majority or a large minority practice (i.e. wear an earring/earrings) and (3) clusters which only a small minority practice (i.e. have a septum piercing or between one and three tattoos). Crossley (2006: 106) contends that:

> RBTs are body techniques whose primary purpose is to act back upon the body so as to modify or maintain it. … RBTs are generic body techniques which an agent annexes, in a specific context, for the explicit purpose of … modifying their body in a particular way.

What these ideas reveal is that the agentic, embodied self is able to engage with reflexive practices which may change one's body or maintain one's health (i.e. dieting, jogging, boxing,[20] etc.). That changes occur over time in embodied ways become clear: while we are our bodies, our body projects are 'reflexive projects' (Crossley 2005: 2).

Fourth, the body is increasingly the focus for regulation and surveillance. According to Foucault, the body has been at the core of productive control[21] that marks the concurrent sexualization and medicalization of the body in a new power configuration, biopower (Braidotti 1994: 58). (See the discussion on biomedicalization in Chap. 6.) For Foucault, modernity is the era of biopower—of constant normativity—of the creation of incessant practices to make bodies conform to the 'norm'. Foucault's (1979) bodies are 'docile bodies'—bodies that are shaped 'to obey the rules'. Biopower is all about the power of normativity over living organisms: the force producing and normalizing bodies to serve prevailing relations of dominance and subordination and total control over human living matter (Braidotti 1994: 58). Whether ill or healthy, normal or pathological, bodies are never free of relations of power. That bodies of bulimics or anorexics (Fallon et al. 1996; Gordon 2000) are used as examples of 'dis-ease',[22] which stigmatize sufferers,[23] and that this has the effect of the rejection of these sufferers by a 'healthy', 'normal' population tell us that the medical and lay discourses on health and illness and additionally, the scientific and popular ways of representing healthy and ill bodies are never value free. Morality is involved in these stigmatizing, medicalizing processes. Furthermore, the regulatory practices involved in the production of health and illness help to generate the reproduction of social inequalities and the fortification of normativity—the making of docile bodies. While health is all pervading in relation to the self, the rise of individualism and consumption practices,[24] health also intersects with bodies constructed as the sites for the life project within late modernity. Bodies are cultural and social beings—fleshy and 'boned' entities where we inscribe healthy and sick as well as normalized and stigmatized identities. The body, whether healthy or ill, is a central point for struggles over power: a foundation of social identities which are inscribed upon our social, relational and corporeal lives.

Fifth, studying the body provides us with important philosophical challenges. We are able to question dualistic assumptions, embedded in Western thought, such as mind versus body, nature versus culture, reason versus emotion, public versus private and so on. In this context, Pitts-Taylor (2016) highlights the entanglements of nature and culture by exploring the embodied mind and the 'embrained' body.[25] An embodiment perspective allows us to examine the bodily roots of subjectivity without the need for dualistic assumptions. Bodies provide us with a way of examining a classical sociological concern, based on another dualistic assumption—the tension between structure and agency. In the social sciences, structure versus agency is an ongoing debate where traditionally clear distinctions are made between *agency* as the capacity of individual selves to act with intentionality, independence or free choice, without constraints imposed from the larger *social structure* viewed as the networks of statuses and relative power which influence or limit the choices and opportunities available to us.[26] Within a body perspective, *agency* (or the agentic body) refers to the individual practices and strategies used within existing social conventions, values and sanctions in the struggle for social resources, while *structures* can be seen as the embodied spaces where social relations are reproduced as an outcome of power relations. This sort of body perspective has a tendency to break down the traditional dualism between structure and agency by emphasizing *agentic corporality*. Establishing agentic corporality is a key strategy in Butler's work (1990, 1993) and her ideas on how gender is artificially constructed and performed are instructive. Butler (1990) contends that 'performance or parodic practices' (i.e. cross-dressing, etc.) that 'exist from within gender essentialist culture expose and subvert that culture and its belief in a true gender identity' (Bordo 1993: 255).

Examining the bodily roots of subjectivity or agentic corporality, we discover how varieties of bodies perform social practices (i.e. health and illness), how bodies are marked by cultural signification and how class and other social distinctions such as race, ethnicity, ability, sexual orientation and so on interact. We are able to gain an objective analysis of the structures which frame, limit, control and influence agentic, corporeal bodies. 'Subjective' agentic bodies are seen to be embedded in so-called objective structures and *vice versa*. By emphasizing the materiality of the body and its performativity, as Butler does, we break down the tension between agency and structure. Turner (1992: 162–163) suggests that a sociology of the body offers sociology of health and illness[27] an opportunity to become the leading edge of contemporary sociological theory (see Table 3.1). Furthermore, Turner (1992: 169–170) contends that as an 'organising principle in sociology of health and illness', the 'sociology of the body is the most important issue behind the question of agency and

Table 3.1 Sociology and the body

Key thinkers	Key contribution	Key work/s
George Herbert Mead	The interaction of the self and the mind is an embodied social process.	(1934) *Mind, Self and Society from the Standpoint of a Social Behaviorist*
Norbert Elias	The concept of the 'civilized body' is the product of three key social processes: Socialization, Rationalization and Individualization.	(1939) *The Civilising Process. Volume 1: The History of Manners* (1939) *The Society of Individuals*
Marcel Mauss[a]	The notion 'techniques of the body' emerged from his anthropological, 'descriptive ethnology'. They refer to the behaviours in which 'from society to society men know how to use their bodies'.	(1973) *Techniques of the Body, Economy and Society*, 2:1, 70–88
Michel Foucault	'Docile bodies' are bodies that are shaped 'to obey the rules' in society.	(1979) *Discipline and Punish*
Pierre Bordieu	Habitus is the internal, differentiating system with which we learn, as a result of social hierarchy, how to live in society. It is related to how we not only value ourselves but also our bodies within this social hierarchy.	(1984). *Distinction, a Social Critique of the Judgement of Taste*
Judith Butler	Agentic corporality is a key strategy. How gender is artificially constructed and performed emphasizes the materiality of the body and its performativity. The tension between agency and structure is broken down.	(1990) *Gender Trouble: Feminism and the Subversion of Identity* (1993) *Bodies that Matter: On the Discursive Limits of 'Sex'*
Kathy Davis	Body beauty practices (i.e. cosmetic surgery) are less about the beauty system oppressing its patients and more about how women manipulate the medical system to meet their own needs.	(1995) *Reshaping the Female Body*
Nick Crossley	Reflexive body techniques (RBTs) are the 'embodied and reflexive processes and practices involved in projects of body modification/maintenance'.	(2006) *Reflexions in the Flesh*

[a] See Chap. 7 for an in-depth discussion of Mauss's ideas on gift exchange.

structure' because as opposed to offering the rationality and cognition of traditional theories, it offers affect, emotion and feeling of embodied social agents.

Part II: Applying the Concept of the Body in Health Contexts

Biomedicine has privileged a type of technoscientific, biological determinism to explain social injustice as natural and necessary, while economic inequalities, resulting in the experience of disease, the global food crisis (Shiva 2016), inequalities in health, the subordination of women and people of colour, and the untimely HIV-related deaths[28] of millions on a global scale are considered an epiphenomena of biology (Urla and Terry 1995: 2). Examining the links between the body and deviancy, Urla and Terry contend that biomedicine has been instrumental in privileging 'embodied deviance', the 'historically and culturally specific belief that deviant social behaviour (however that is defined) manifests itself in the materiality of the body, as a cause or an effect, or perhaps as merely a suggestive trace' (p. 2). Their main contention is that medicine along with the other modern life sciences has surveyed, observed, assessed and reported on bodies, while at the same time clinicians construct bodies through particular investigative techniques and culturally lodged research goals (p. 3). Urla and Terry (1995: 3) demonstrate that bodies are not natural entities with a generic core; rather, bodies are effects, products or symptoms of specific techniques and regulatory practices—bodies are points on which and from which the disciplinary power of scientific investigations is exercised. The lesson we learn is that bodies, whether sick or ill, bad or good, moving or stationary, are never free of relations of power. This is because medical and lay discourses always already bind bodies into larger systems of knowledge production and moral discourses.

While it is true that medical sociology has produced important contributions to the renewal of the body's conceptualization (Berg and Akrich 2004), an emergent and indeed important task of sociologists and anthropologists interested in health and illness is to bear witness to all forms of embodied oppressions and to contextualize both the 'healthy' and 'ill' body as a politically, morally inscribed entity, its biology and histories/herstories shaped by practices of surveillance, containment and control. Medicalized bodies are embedded in moralities of health and illness, appearing as shaped by the 'individuality', 'freedom' and 'rationality' concerns of conventional bioethics. Yet, at the same time, post-conventional moralities of health locate classed, raced, ethnic, gendered, disabled and aged bodies as being 'leaky', that is, as bodies which undermine traditional dualistic assumptions or binaries and challenge ontological and epistemological closure (Shildrick 1997) as well as biomedical fixity. When moral judgements are made about how ill health and health 'in bodies' affect relations of power, inclusion and exclusion (Ettorre 2005), bodies become more malleable and unstable as they are designated as healthier and less sick or vice versa. But as Moore and Casper (2015) insist, 'Bodies are anything but simple'.

'Health' and 'ill health' are terms that are culturally and socially defined; all cultures have known concepts of these terms.[29] These concepts may vary from culture to culture (Fortun 2001; Farmer 2005) according to how sick and healthy bodies become visible and more importantly, the magnitude and breadth of what Braidotti (1994) calls the scopic drive—a drive compelling bodies to be deeply involved in an 'ethics of risk' (Shildrik 1997: 212). Whether classed as sick or healthy, bodies within biomedicine are viewed as empirical objects to be quantified, classified, surveyed and ultimately controlled. Alongside these complex processes, new forms of social mediation are being developed under the guise of biomedicine. Late modern medicine or the new public health privileges risk and widens the relevant points of contacts between professionals and patients into different sites, locations and social interactions towards the social body (Bunton and Burrows 1995: 207). But what are these bodies? I focus on three: 'techno bodies', 'abject bodies' and 'bodies in representation'.

'Techno Bodies'

Medical cultures have become increasingly dependent upon advancements in technoscience, a term which has been used by those working in the domain of Science and Technology Studies (STS) to emphasize the distinct focus on science, including medical science, and its material practices. Fuller (2007: 2) argues that STS's emphasis on technology may underplay the ideological uses of science—that is, what science means, does to and for people, both policy makers and the public, who are removed from these practices. Technoscience includes laboratory and industrially based medicine that draws on a wide range of technologies—such as genetics and informatics—to quarry pathology and the very structure of the body itself (Webster 2007: 38), a definition which highlights the pervasive way that medical knowledge works as well as the increasing power of orthodox medicine over the human body.

In whatever ways we define technoscience, the resultant advancements in medical technology sustain biomedicine as a dominant paradigm on the body in Western thought. In turn, biology becomes increasingly the filter through which humans are expected to interpret the world (Lundin 1997). Contemporary biomedicine upholds various technologies as emblematic of how successfully medical expertise has been able to manage, alter, control and 'cure' the human body. According to Webster (2007: 2), these medical technologies have two sides: they provide new, more detailed sources of information about illness, while they offer new forms of uncertainty and risk. In contemporary society, we are witnessing the explosion of medical technologies into many areas of modern social life. Medical technologies, such as genetic technologies, affirm political processes (Bowring 2003) vis-à-vis 'technologized' bodies. To confront the genome is to confront the contradictions of contemporary politics and life itself (Ettorre et al. 2006: 141). In the field of reproductive genetic technologies, we speak of 'prenatal politics' and the bodies of pregnant women as good examples of techno bodies (Ettorre 2002).

Most definitely politics are embedded in the use of medical technologies—as technologies they operate historically on material human bodies, particularly those marked by gender, race and class or combinations thereof (Stabile 1994: 4). We need to map out the implications of such technologies for the material practices, complex processes, embodied experiences and cultural and social formations they produce. On the one hand, subjects of technologies or patients are situated at intersections of the medical world, individual interest and relational obligations

(Nordqvist and Smart 2014) as well as being co-producers of technological practice (Cambrisio et al. 2000: 11). On the other hand, the application of specific medical procedures reflects ideological beliefs and they are seen to be played out on 'docile bodies', viewed as the 'raw' material needed to successfully implement and employ various technological processes. The workings of technoscience in biomedicine expose a modern unease that technological interventions on human bodies transform sick bodies from fragmented subjects with concerns for 'sustainability', 'responsibility', 'agency', and 'empathy' to fixed objects of medical care focused on 'beneficence', 'sameness', 'mutual reciprocity' and 'rationality'.

'Techno bodies' have deep cultural consequences for human embodiment, social identity and medical governance. Most importantly, these bodies have the power to shift our comprehension of the boundaries of life itself. There is a series of bodies envisaged as techno bodies: bodies with prosthesis; bodies tested for diseases genes; pregnant bodies screened prenatally; bodies eating GM foods; bodies using prescribed drugs; bodies involved in gender reassigned surgery; bodies using end-of-life technologies; X-rayed bodies; MRI scanned bodies; bodies with transplanted organs; bodies with new corneas; sporting bodies undergoing biotechnical measurements and so on.

Taking a different tack on bodies and technoscience, we can look at the body as a location for sport, positioning embodied subjects differentially within this medico-cultural sphere (Shilling 2005: 104). Partaking in sporting activities implicates bodies engaging in cultural and material practices that give new meaning to temporal movements in social space outside biological, physiological and morphological body features and functions (Tulle 2007). Traditionally in popular culture, the movement of the body combined with the continual improvement in the efficient function and form of, for example, a running body, emphasizes the body as a machine.[30] A continuum of technologies from the banal to the spectacular captures this body and the idea of 'going to the gym' would not exist without the idea of the body as a high performance machine (Howson 2004: 89). Here, the concentration is on improving this 'machine'. The health of the body is not one that can be simply measured by being disease free but is one that must also be able to demonstrate its fitness through the appropriate body pursuits to achieve a desired, healthy body image. Medical technology is often directed towards sports, requiring the existence of highly trained, highly paid, drug-free, record breaking sporting bodies. These bodies provide a basis on which rationalization in society can be naturalized and viewed as the fulfilment of human destiny rather than as a technologically directed process imposed on humans (Shilling 2005: 113). This is regardless of the fact that these bodies undergo multiple, biotechnical measurements of their physiological capacities such as blood volume, heart rate, oxygenation and so on (Lorber and Moore 2007: 71). For an athlete, adding drugs and foods known as 'nutraceuticals' to one's diet does not seem like a major step or technological intervention; it is just another part of the training routine (p. 71). The modern individual in consumer culture is made conscious that he/she speaks not only through his/her lifestyle which becomes a 'healthy' life project but also through the medicalization, aestheticization and stylized effect of his/her body on changing cultural contexts (Featherstone 1991: 86).

Abject Bodies

Very often biomedicine in relationship to the body overlooks difference, agency, subjectivity and the cultural implications of materiality. In contrast, a more recent social science mandate has been to bring whole, sentient bodies back into our social consciousness. One key aim has been to generate an awareness that the traditional neglect of the body reproduced in non-reflexive, imperialistic, hegemonic and masculinist social sciences naturalized bodies and legitimated control of privileged bodies over less privileged ones. Feminists have documented the types of regulation, restraint, provocation and resistance experienced by gendered bodies. But also an awareness of the exclusions of black women's bodies as well as disabled women's bodies needs to be put into the frame of the excluded, abject body. While we need to reclaim the lived experiences of these excluded and abject bodies, we should become increasingly aware that what all gendered bodies experience, feel, suffer, bear, desire and consume should be the foundation stones for our sociologies (Frank 1995).

Regardless of the culture, society or defined social space in which certain individuals find themselves, some are viewed as more abject than others. Here, abject refers to the realm outside of culture which threatens to reduce culture to chaos; 'it is shapeless, monstrous, damp and slimy, boundless and beyond the outer limits' (Brook 1999: 14). Being abject places one in a liminal state. It emphasizes that one has failed as an acceptable member of society and confirms the essential monstrosity of one's body—their abjection. As long as the monstrous remains the absolute other in its corporeal difference, it poses a few problems and can be clearly put into an oppositional category of 'not me' (Shildrick 2002: 2–3). Abject is not about affirming positive aspects of embodiment and subjectivity, rather, abject denotes negativity. In examining the relationship between abjection and disgust, Ahmed (2004: 88) argues that when we think about how bodies become objects of disgust, we come to see how disgust is crucial to power relations and how becoming an abject body is all about the powerful role disgust has in the 'hierarchizing of spaces as well as bodies'.

Examples of abject bodies in biomedicine include racialized bodies, obese bodies, anorexic bodies, pregnant drug-using bodies, disabled bodies, deformed, scarred or burnt bodies, sexual-aged bodies, bodies with AIDS and dead bodies. The notion of abject bodies as referring to the space outside of culture is clearly shown in my work on pregnancy and drug use (Ettorre 2007, 2015). I illustrate how pregnant drug users are abject bodies and being abject involves their body being disciplined by specific rituals and regulations of containment, such as specific medical and dietary regimes, strict drinking practices and so on, invoking notions of embodied, monstrous deviance, abnormal activities, inexcusable performances and involvement in what is perceived as 'bad' material practices (Ettorre 2007: 99–100). While the cultural representations of ideal motherhood versus unhealthy or dangerous drug use are presented, the regulatory regime of reproduction with special reference to the power of normativity surrounding pregnancy and drugs use is analysed. The pregnant drug user becomes a visible feature, if not potent symbol, of the somatic society and exposes how the personal and public problem of 'drug addiction' during pregnancy can reflect simultaneously embodied desires for an unfettered womb and an open ingesting body as well as the cultural need for bodily restriction, control and regulation (p. 93). Of course, her race, class and age will govern both the formulation of her desires and the way culture controls these seemingly 'uncontrollable' desires. The 'real' material sites (i.e. bodies) upon which the 'madness' and disorder of female drug use are inscribed become visible. Many discourses (e.g. biomedical, legal, media, drugs) regulate this gendered body and shape it as deviant, abject and 'monstrous'—one to be disassembled and reassembled and coded into diseased objects of knowledge and sites of intervention (Urla and Terry 1995).

The pregnant drug-using body is not only the abject body who threatens to leak but also the 'bad' body whose leakiness contaminates the rational, public world of the logocentric economy.[31] This body infects or contaminates the intimate, private spaces related to goodness and badness, inside and outside, self and other and mother and foetus. Here, we understand the importance of resistance to the dominant ideologies of reproduction by those, such as pregnant drug users, who can be seen to embody a political identity, opposition to this sort of visualization and a type of adversarial consciousness. In a 'cyborgian' sense, this resistance means that many, if not all, forms of women's embodiment are deeply related to their adaptation to normality and cultural management on a global scale.[32] Female bodies do matter in this global assimilation or manipulation. Attitudes towards, values about, discourses on and tools of prevailing technologies surrounding pregnancy and drug use enforce and shape novel cultural relations for women's bodies on this global scale. A cyborg identity gives potential embodied agency to those declined secure 'race, sex and/or class membership' such as women drug users who are able to have the cultural know-how in interpreting networks and/or technologies of power.

Bodies in Representations

How are bodies represented in order to be manipulated, managed and normalized through the relentless and constant engagement with the techniques of power, biopower? Shilling (2005: 2) argues that new forms of cultural consumption exhibit the sort of discipline, physical control and stylization commensurate with the display of a hyper-efficient embodied, performing self in consumer society. The rise of consumer society has given rise to a new body—the consuming body, a site for the nurturing of taste, the production of desire and the selling and consuming of goods, services, and pleasures (Falk 1994). Consumption involves the pursuit of embodied lifestyles through the acquisition of desired goods that suggest shared symbolic meanings and codes of stylized conduct. Identifiable regimes of modification or discipline are used to improve or perfect our bodies. Here, I hint at a tension between biopower and discipline and people's agency to improve their bodies—a tension demonstrated so well in Davis's (1995) work which was mentioned earlier.

We can identify bodily regimes of dieting, weight watching, self-starvation, body building, weight training, running, cosmetic surgery, bodies with Body Integrity Identity Disorder (BIID), reconstructive surgery, liposuction, yoga, military drills, meditation work, taking drugs—laxatives, taking hormone replacement, vitamins and so on. Here, I focus on social representations of the body, body practices and disciplinary regimes related to the Internet.

While the majority of us are engaged in some kind of body project, body training or body discipline, this may reach an extreme or excessive level in one's efforts to perfect the body. If we strive for this ideal or perfectible body, we may be seen as well-disciplined but we may also be seen as 'sick'. This is because biomedicine has identified anxieties, phobias and obsessions underlying various illnesses. Two of these anxieties, phobias or obsessions, self-starvation and the desire to amputate part of a limb, are compared by Conrad and Rondini (2010). Their basic assumption is that the worldwide web has become a medium for endorsing or criticizing medicalized approaches to human troubles, while the internet has facilitated the extension of medicalization debates on a global scale. The individuals involved in Conrad and Rondini's two embodiment quandaries employ the worldwide web to advance their opinions and assert their demands. Anorexics search for de-medicalization and a certain amount of legitimacy, while wannabe amputees desire the opposite, medicalization in order to be cured. The authors contend that web activities of 'pro ana' sites demonstrate the emergence of a global 'counter narrative' in opposition to the medical opinions that are accessible universally. In contrast, 'wannabe amputees' or 'transabled bodies' share their desire to having their 'disorder', BIID, recognized as a medical problem. While pro ana's bodies may be emblematic of our culture's obsession with non-attainable ideals of attractiveness and conventional body shape and size, wannabe amputees' challenge established conceptions of disability, choice and medicalized bodies.

While all of us experience the social and cultural burden to shape our bodies according to precise body images, pro ana bodies expose identifiable regimes of conceivably excessive discipline and bodily control, while 'transabled bodies' depict particular regimes of possibly extreme bodily modification—all done in the context of improving or perfecting one's body. What the representation and construction of these bodies tells us is that while there may appear a variety of social bodies to choose from in society, the sorts of regimes in which medicalized bodies are conceived have different meanings for different individuals. Throughout human history, and in different cultures, we have decorated, clothed and modified our bodies in different ways to fulfil particular cultural and social purposes. Indeed, the body is a bearer of symbolic value and a form of physical capital: a possessor of power, status and distinctive symbolic forms that is integral to the accumulation of various resources (Bourdieu 1984). Nevertheless, individuals and groups have unequal opportunities for producing symbolically valued bodily forms and converting them into other resources. In this sense, medicalization may appear as an additional extra, but it is essential in helping to shape the desires and body practices of both anorexic bodies and wannabee amputees.

Part III: A Way Forward: Embodied Ethics

If we are not moral bodies, we cannot function properly or 'freely' in society as 'biological citizens'. Rose (2001: 19) contends, 'As somatic individuals[33] engage with vital politics, a new ethics of life is taking shape … within this new ethics, the human vital order has become so thoroughly imbued with artifice that even the natural law has to be produced by labour on the self'. As we increasingly come to understand ourselves in somatic terms, corporeality has become one of the most important sites for ethical judgements and techniques (p. 21).

Frank (1991, 1995) argues that there is a need for an ethics of the body that shapes a sociology of the body. However, before creating an ethics of the body, bodily ethics, somatic ethics or embodied ethics—all quasi synonymous terms, we need a basic ingredient 'intelligent vitality'. This means that as different bodies are produced and eradicated, we are able to situate the circumstances for what constitutes unethical practices (Braidotti 2013: 2). Ethical work implies being aware of somatic expressions of difference—not locating some position of absolute uniqueness which is being an Other to oneself. Rather, it means we are dependent upon differences in our knowing and ethical judgements, while disavowing fixity.

Thus, in wanting to develop the concept of the body, we create embodied ethics based on the logic of: (1) *homo empathia* as a relational vitality; (2) ontological openness to difference, (3) an economy of embodied emotions and (4) radical inclusive embodiment, generating moral effervescent (i.e. vitality).

Employment of *Homo Empathia* as a Relational Vitality

While feminists have argued that medicine (and I would add biomedicine) needs healing, the feminist project of healing biomedicine utilizes 'epistemic empathy'. Epistemic empathy offers oppressed groups help and insights based on gender sensitive theories and practices (Holmes 1992: 3). Epistemic empathy becomes a somatic expression of compassion with people's suffering. We need to employ our own *homo empathia,* witnessing suffering and giving careful consideration to tormented bodies in order to bear witness to what bodies suffer. *Homo empathia* means that I offer real (not artificial) reflections that are empathetic as well as attentive to bodies. I do not consider 'moral' issues in a gender, ethnicity, race and class neutral manner. *Homo empathia* considers these differences and others (i.e. sexuality, ability, age, etc.) as being crucial to maintain embodied ethics as well as uphold care and justice (Mahowald 1994: 67). Related to *homo empathia* is the 'differend', the ethical response to the tragedy of the intolerable or irreconcilable (Braidotti 2013: 148), developed through radical epistemologies such as women's, gender, queer, post-colonial and race studies. These epistemologies deal with the intolerable while at the same time 'they fulfill a healing function in relation to the legacy of pain and hurt which the horrors of life entail' (Braidotti 2013: 148). Furthermore, alongside these radical epistemologies, *homo empathia* needs to love and embrace otherness as well as cherish becoming, flux and instability (Ahmed 2002: 559).

Ontological Openness to Difference

We need to cherish the human and non-human differences without seeking to destroy or fundamentally change these. Braidotti (2013: 63) argues that 'the opportunistic, political, biogenetic capitalism induces, if not the actual erasure, at least the blurring of the distinction between the human and other species when it comes to profiting from them'. However, the position of post-human subjectivity is rarely upheld given that 'a categorical distinction between the given (nature) and the constructed (culture) is consistently posited' (Braidotti 2013: 2). In our ethical strategies, we need to reject dualism, especially the nature culture one and emphasize the self-organizing force of living matter—all living matter. Garland-Thomson (2012: 389) introduces the notion of 'eugenic logic', defined as 'a utopian effort to improve the social order, a practical health program, or a social justice initiative that is simply common sense to most people and is supported by the logic of modernity'. Eugenic logic asks questions such as, 'Why should the world we make and occupy together include disability at all?' (p. 340). Garland-Thomson does not tell us what kinds of eugenic logic are acceptable and unacceptable. Rather she puts forward what she refers to as a 'counter-eugenic logic', a way of thinking that does not rely on the assumption that disability should be eliminated and envisages disability as a narrative, epistemic and ethical resource (p. 347). Her argument is about 'preserving disability and disabled people in that it proposes preserving rather than improving through changing the embodied status quo' (p. 348). She envisages that 'with eugenics the very idea of shaping a community or a national citizenry through the technological and legislative practices that control reproduction is distinctly modern' (p. 351).

Eugenics is all about controlling the future. Thus, disability represents a 'problem with temporality' as it is formulated in modernity. Disability and illness 'frustrate modernity's investment in controlling the future … and in containing difference' (p. 352). Thus, in pondering the importance of differences and all that they imply in our world, we need to nurture an honesty, a frankness, an openness to all that is different and all that our world attempts to subjugate through the process of normalization.

An Economy of Embodied Emotions[34]

Embodied ethics are responsible ethics framed by and through embodied relationships. When medical experts deal with pregnant bodies, these experts should be aware that these pregnant bodies are not only gendered but also can become morally judged as good or bad reproducers. Embodied ethics engages with the corporeal experiences of moral, gendered individuals. Consistency (Kuhse and Singer 1999) and factual accuracy not embodiment and emotion have been the traditional requirements of defensible bioethical positions. In the field of reproductive ethics, moral analysis and rational argument are used to bring about moral agreement (Bayles 1984: 3). Emotions have not been part of the equipment to discern moral answers (Little 1996). In reproductive genetics, 'emotion' narratives (Williams and Bendelow 1996: 47) are able to become stories of dynamic interactions mixed with organic, genetic, biosocial and gendered processes between pregnant bodies, biopolitics, biosocialities, somatic experts and reproductive biomedicine. As these narratives unfold, they become raw data for somatic relationships—'the stuff' from which professional discourses surrounding the intricacies of reproductive biomedicine are being formed as well as tales of comfort, hope (Franklin 2006), insecurity, uncertainty, measured trust, health, risk and surveillance. Here we see ethos and pathos merge.

Radical Inclusive Embodiment

To illustrate how ethics that are embodied expand our traditional disembodied ethical practices let us look at transgendered and gender non-conforming people[35] and reproductive technologies to demonstrate radical inclusive embodiment.

In her exploration of 'the crossroads where sex without reproduction meets reproduction without sex', Mamo (2007) studied the complications of lesbian reproductive desire, how this process has been biomedicalized and how it reflects 'hybrid-technology practice' (p. 129). In this context, transgender females do not necessarily identify as lesbian and have different reproductive needs than cis females. The needs of transgender males and females are highlighted by Murphy (2012: 313):

> Access to assisted reproductive technologies (ART) has been debated … as society and professional groups have deliberated the merits of offering clinical assistance to people outside of marriage, to same-sex couples, to single individuals regardless of sexual orientation, and to people above certain ages.

For Murphy, it is not remarkable that doubt exists regarding the fitness of transgender men and women to be parents, given that they appear by certain standards as 'mentally disordered'. Indeed, the *International Classification of Disease* (2014) under Code f 64 defines 'gender identity disorder' (GID) as:

> A disorder characterized by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex (manifested in adults, for example, as a preoccupation with altering primary and secondary sex characteristics through hormonal manipulation or surgery).

Regardless of the classification of GID, the World Professional Association for Transgender Health (WPATH) in their publication, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (Coleman et al. 2011: 197), states:

> MtF[36] patients … should be informed about sperm-preservation options and encouraged to consider banking their sperm prior to hormone therapy. Reproductive options for FtM[37] patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with

> a surrogate woman to carry to pregnancy. … Transsexual, transgender, and gender-nonconforming people should not be refused reproductive options for any reason.

Reflecting the views of WPATH, Murphy (2012) contends that helping a transgender man or woman with their reproductive needs requires 'interventions used in fertility biomedicine, such as donor sperm, donor ova, in vitro fertilization (IVF), embryo transfer, preimplantation genetic diagnosis, surrogate mothers, etc.' Belgian researchers (De Sutter et al. 2002) did a survey of transgender women where the vast majority felt that the availability of freezing sperm should be discussed and offered by the medical world, while many expressed regret that they could not become pregnant and have a child themselves.

Biomedicine has confronted this issue—that transgender people want to become parents. In an embodied ethics perspective, trans people's needs should be met as a form of inclusive embodiment.[38] For MtF or FtM trans people not having wombs or penises respectively does not bar the possibility of having children. The biomedical world may see their bodies and indeed their minds as fragmented if not broken but there are possibilities which are open to them as to all with embodied reproductive desires. Ethical problems arise when transbodies are coded as non-reproductive and regretfully, the embodied practice of respect, reverence and esteem for vital life does not touch them. As Wahlhert and Fiester (2012: 282) note when considering the reproductive choice of IVF treatment for one HIV-discordant transgender couple, 'It is simply not true that any and all questioning of patients' clinical choices is fair game; if we subjected a heterosexual couple to this kind of minute inquiry, they would be highly offended—with cause'.

Conclusion

Tracing conceptual heritages of sociological studies of the body is not easy—there exists a lacuna as 'classical sociology' failed to generate a sociology of the body by its lack of dissociation from positivistic biology. Aware of this gap in sociology, I have traced the development of the notion, the self and specifically, the agentic self as a way of entry into sociological ideas on embodiment. All discussions have been based on both empirical and theoretical explorations and have illustrated the importance of contextualizing the body as a cultural and indeed gendered entity (as put forward by early feminists). These demonstrate that the spaces and boundaries between healthy bodies are becoming more diverse than ever before on a global level. A key element of my explorations is how moralities of health embedded in our cultures have been concerned with constructing the material, fleshy body as well as surveying, managing and controlling 'it' and 'its' movements. Uncovering the more hidden aspects of the cultural fabrication of health requires detailed examination of the regulatory practices used by experts in biomedicine and the material requirements of our global consumer culture which target bodies. These developments involve an understanding of the intricate processes by which the age of modernity marks the emergence of the material bodily self at the centre of our theoretical attention.

The final discussion on embodied ethics demanded radical (i.e. as in root), effervescent forms of knowing and discerning that reach all vital lives and go beyond doxa (i.e. common-sense belief). Through 'biological citizenship' we are compelled to make judgements, decisions and choices with the backdrop of respect. We need to celebrate difference and not to see difference as 'pejoration'[39] (Braidotti 2013: 15). As Rose (2007: 254) contends, 'Our biological life has entered the domain of decision and choice; these questions of judgment have become inescapable … as "we live in an age of biological citizenship", of "somatic ethics" and of "vital politics"'. When we become more aware of our embodied lives, we come to understand that, corporeality is paramount as a site for bioethical judgements and biotechnologies. Thus, re-shaping bodies in the social sciences means that we must re-shape our political awareness of the body as well—a goal which has scholarly interest for all interested in health, culture and society.

Notes

1. *The Woman in the Body* was first published 1987.
2. As 'intertwined signatures of life' (see Schillmeier 2014: 174).

3. See Martin (1992: 181–193).
4. Embodied means related to the body or give human form or shape to 'something'.
5. Agency is the capacity of individual selves to act with intentionality, independence or free choice. See discussions below.
6. See Metzl and Kirkland's (2010): *Against Health: How Health Became the New Morality: Biopolitics, Medicine, Technoscience, and Health in the 21st Century* in which a series of authors examine how health has become defined as a moral obligation. See especially, Metzl's Introduction, 'Why against health?' pp. 1–12.
7. In Latin this means 'attend to the body' or 'being present to the body'.
8. Feminist sociologists supported by feminist activists.
9. This term refers to an anti-positivist perspective (or interpretivism), a tradition in sociology related to interactionism and/or the *verstehen* sociology of Max Weber. (See Chap. 6 for a discussion of Max Weber's notion of power.)
10. See for example, Hollin and Pilnick (2014).
11. Or process sociology, a sociology concerned with process, focusing on 'figurations of humans'—changing networks of humans who are interdependent with one another.
12. Especially in his description of how the state could sustain peace while at the same time prepare for war (See Elias 2006). Realists assume that the state or any social structure has an existence over and above the existence of individuals in society and is independent of our conception of them.
13. 'The Cartesian legacy also differentiated the spirit from the matter; the real (visible and measurable) from the unreal (invisible i.e. chronic pain; women's mindful nipple); nature (i.e. women's complains are the result of their uterus)-culture'. A special thanks goes to Ana Porroche-Escudero for this helpful intervention.
14. As the reader will see language used by these authors is not gender sensitive—it reveals the antiquated sexist language of our forebears, reflecting patriarchal thinking. Thanks to Barbara Katz Rothman for suggesting I make a point of this.
15. The same year as *The Civilizing Process.*
16. See Kingdon (2009: 97).
17. For a full discussion of habitus, see the discussion of Bourdieu's work in Chap. 6.
18. See Koffman's (2014) argument about changes in perceptions of the bodies of adolescent mothers.

19. A precursor to the idea of Crossley's RBTs was the notion, 'techniques of the body'. This notion was developed by the anthropologist Marcel Mauss (1973:70) and emerged from his 'descriptive ethnology'; it refers to 'the ways in which from society to society men know how to use their bodies'.
20. For an interesting gender analysis of the latter two practices, see Allen-Collinson and Owton (2015).
21. Chapter 6 includes discussions on Foucauldian notions of power. Power is seen to be constructed as a moral imperative and the actions of bodies as being surveyed, regulated and disciplined through the movements it exercises as a way of defining power.
22. Musolino et al. (2015) offer a view on 'healthy anorexia' when bodily practices that involve 'natural, medical and ethical concerns' are effectively integrated into an anorexic's eating repertoires and 'embodied as a logic of care'.
23. The bodies of black mothers or undocumented migrants who are forcibly sterilized are also very good examples. Thank you to Ana Porroche-Escudero for pointing this out to me.
24. Including digitized practices. See Barker (2008) and Lupton (2013, 2014).
25. See also Campbell and Ettorre (2011).
26. For a full discussion of the co-constitutive nature of structure and agency with special reference to health, see Maller (2015).
27. Notable works by sociologists of health have focused on the body and show how the body has come to assume an important place in modern societies. They include for example: Annandale (1998), Armstrong (2002), Casper and Moore (2009), Frank (1991, 1995, 2001, 2004), James and Hockey (2007), Lupton (1994, 1995), Lyon and Barbalet (1994), Moore and Casper (2015), Nettleton (1995), Nettleton and Watson (1998), Peterson and Bunton (1997), Pitts-Taylor (2016, 2007, 2003), Scambler and Higgs (1998), Shilling (2005), Turner (1987, 1992), Williams and Bendelow (1998), Williams (2003) and the list continues to grow.
28. While dying with HIV-related illnesses has been a global health problem, recent research (Bernays et al. 2015) demonstrates how the problems of growing up with HIV especially for children in the global South need to be less hidden.
29. This is why there is a need to look beyond Western conceptions of health and illness (See Amzat and Razum 2014).

30. On a deeper level, Manning (2014) argues that a body is its movement and a philosophy of the body never begins with the body: it bodies.
31. An economy that depends on everyone being 'normal'.
32. See Ortiz-Gómez and Santesmases (Eds.) (2014) especially Part III: Users and Abusers Then and Now: Discourses and Practices.
33. This refers to individuals, defined by their bodies which are constantly normalized.
34. Embodied emotions are what our bodies tell us when we are doing or feeling emotions and are connected to *homo empathia* which direct these emotions outwards to others.
35. It is interesting here to note the work of McDermott and Roen (2016: 2) who reveal the trouble created when queer youth reject the type of 'embodiment needed for neoliberal heteronormative subjecthood.'
36. Male to Female.
37. Female to Male.
38. Yet, inclusive embodiment tends to be foreclosed given the barriers to quality health care (Roberts and Fantz 2014) and the stigma and discrimination experienced by trans people (Cruz 2014), especially trans youth (Castaneda 2014). In this context, another group worthy of inclusive embodiment are intersexed bodies (see e.g. Davis and Murphy 2014).
39. This means to interpret difference (i.e. class, race, sex, gender, etc.) in a pejorative or negative way.

References

Ahmed, S. (2002). This other and other others. *Economy and Society, 31*(4), 558–572.

Ahmed, S. (2004). *The cultural politics of emotions*. New York: Routledge.

Allen-Collinson, J., & Owton, H. (2015). Intense embodiment: Senses of heat in women's running and boxing. *Body and Society, 21*(2), 245–268.

Amzat, J., & Razum, O. (2014). *Medical sociology in Africa*. Dordrecht: Springer.

Annandale, E. (1998). *The sociology of health & medicine: A critical introduction*. Cambridge: Polity Press.

Armstrong, D. (2002). *A new history of identity: A sociology of medical knowledge*. Basingstoke: Palgrave.

Barker, K. K. (2008). Electronic support groups, patient-consumers, and medicalization: The case of contested illness. *Journal of Health and Social Behavior, 49*, 20–36.

Bayles, M. D. (1984). *Reproductive ethics*. Englewood Cliffs: Prentice-Hall, Inc.

Berg, M., & Akrich, M. (2004). Introduction – Bodies on trial: Performances and politics in medicine and biology. *Body and Society, 10*, 1–12.

Bernays, S., Seeley, J., Rhodes, T., & Mupambireyi, Z. (2015). What am I 'living' with? Growing up with HIV in Uganda and Zimbabwe. *Sociology of Health & Illness, 37*(2), 270–283.

Bordo, S. (1993). Feminism, Foucault and the politics of the body. In C. Ramazanoglu (Ed.), *Up against Foucault: Explorations of some tensions between Foucault and feminism* (pp. 179–202). London: Routledge.

Boston Women's Health Book Collective. (1971). *Our bodes ourselves: A book by and for women*. New York: Simon and Schuster.

Bourdieu, P. (1984). *Distinction, a social critique of the judgement of taste*. London: Routledge and Kegan Paul.

Bourdieu, P. (1990). *The logic of practice*. Stanford: Stanford University Press.

Bowring, F. (2003). *Science, seeds and cyborgs: Biotechnology and the appropriation of life*. London: Verso.

Braidotti, R. (1994). *Nomadic subjects: Embodiment and sexual difference in contemporary feminist theory*. New York: Columbia University Press.

Braidotti, R. (2013). *The posthuman*. Cambridge: Polity Press.

Brook, B. (1999). *Feminist perspectives on the body*. London: Longman.

Bunton, R., & Barrows, R. (1995). Consumption and health in the 'epidemiological' clinic of late modern medicine. In R. Bunton, S. Nettleton, & R. Burrows (Eds.), *The sociology of health promotion* (pp. 206–222). London: Routledge.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. London: Routledge.

Butler, J. (1993). *Bodies that matter: On the discursive limits of 'sex'*. New York: Routledge.

Cambrisio, A., Young, A., & Lock, M. (2000). Introduction. In M. Lock, A. Young, & A. Combrisio (Eds.), *Living and working with the new medical technologies: Intersections of inquiry* (pp. 1–16). Cambridge: Cambridge University Press.

Campbell, N., & Ettorre, E. (2011). *Gendering addiction: The politics of drug treatment in a neurochemical world*. Houndmills/Basingstoke: Palgrave Macmillan.

Casper, M. J., & Moore, L. J. (2009). *Missing bodies: The politics of visibility*. New York: New York University Press.

Castaneda, C. (2014). Developing gender: The medical treatment of transgender young people. *Social Science & Medicine*. doi:10.1016/j.socscimed.2014.11.03.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., Lev, A. I., Mayer, G., Meyer-Bahlburg, H., Hall, B. P., Pfaefflin, F., Rachlin, K., Robinson, B., Schechter, L. S., Tangpricha, V., van Trotsenburg, M., Vitale, A., Winter, S., Whittle, S., Wylie, K. R., & Zucker, K. (2011). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, *13*, 165–232. © WPATH website http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926. Accessed 21 Mar 2014.

Conrad, P., & Rondini, A. (2010). The internet and medicalization. In E. Ettorre (Ed.), *Culture, bodies and the sociology of health* (pp. 107–120). Farnham: Ashgate.

Crossley, N. (2005). Mapping reflexive body techniques: On body modification and maintenance. *Body & Society, 11*, 1–35.

Crossley, N. (2006). *Reflexions in the flesh*. Buckingham: Open University Press.

Cruz, T. M. (2014). Assessing access to care for transgender and gender nonconforming people: A consideration of diversity in combating discrimination. *Social Science & Medicine, 110*, 65–73.

Davis, K. (1995). *Reshaping the female body*. London: Routledge.

Davis, K. (2007). *The making of our bodies ourselves: How feminism travels across borders*. Durham: Duke University Press.

Davis, K. (2009). Revisiting feminist debates on cosmetic surgery: Some reflections on suffering, agency, and embodied difference. In C. J. Heyes & M. Jones (Eds.), *Cosmetic surgery. A feminist primer* (pp. 35–48). Surrey: Ashgate.

Davis, G., & Murphy, E. L. (2014). Intersex bodies as states of exception: An empirical explanation for unnecessary surgical modification. *Feminist Formations, 25*(2), 129–152.

De Sutter, P., Kir, K., Verschoor, A., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women. *The International Journal of Transgenderism, 6*, 3. Website http://web.archive.org/web/20070502000918/http://www.symposion.com/ijt/ijtvo06no03_02.htm#Introduction. Accessed 21 Mar 2014.

Elias, N. (1978 first published 1939). *The civilising process. Volume 1: The history of manners*. Oxford: Basil Blackwell.

Elias, N. (1991 first published 1939). In M. Schröter (Ed.), *The society of individuals.* New York: The Continuum International Publishing Group.

Elias, N. (2006). *The court society*. Dublin: University College Dublin Press.

Elias, N. (2007). In S. Quilley (Ed.), *Involvement and detachment, the collected works of Norbert Elias* (Vol. 8). Dublin: University College Dublin Press/ Dufour Editions.

Ettorre, E. (2002). *Reproductive genetics, gender and the body*. London: Routledge.

Ettorre, E. (2005). Gender, older female bodies and medical uncertainty: Finding my feminist voice by telling my illness story. *Women's Studies International Forum, 28*, 535–546.

Ettorre, E. (2007). *Revisioning women and drug use: Gender, power and the body*. Basingstoke: Palgrave Macmillan.

Ettorre, E. (2015). Embodied deviance, gender, and epistemologies of ignorance: Re-visioning drugs use in a neurochemical, unjust world. *Substance Use & Misuse, 50*(6), 794–805.

Ettorre, E., Rothman, B. K., & Steinberg, D. (2006). Feminism confronts the genome: Introduction. *New Genetics and Society, 25*(2), 133–142.

Falk, P. (1994). *The consuming body*. London: Sage.

Fallon, P., Katzman, M. A., & Wooley, S. C. (1996). *Feminist perspectives on eating disorders*. New York: Guilford Press.

Farmer, P. (2005). *Pathologies of power: Health, human rights and the new war on the poor*. Berkeley: University of California Press.

Feathersone, M. (1991). *Consumer culture and postmodernism*. London: Sage Publications.

Fortun, K. (2001). *Advocacy after Bhopal; environmentalism, disaster, new global orders*. Chicago: University of Chicago Press.

Foucault, M. (1979). *Discipline and punish*. New York: Vintage.

Fox, N. (1998). The promise of postmodernism for the sociology of health and medicine. In G. Scambler & P. Higgs (Eds.), *Modernity, medicine and health: Medical sociology towards 2000* (pp. 29–45). London: Routledge.

Frank, A. (1991). *At the will of the body: Reflections on illness*. Boston: Houghton Mifflin.

Frank, A. (1995). *The wounded storyteller: Body, illness and ethics*. Chicago: University of Chicago Press.

Frank, A. (2001). Can we research suffering? *Qualitative Health Research, 11*(3), 353–362.

Frank, A. (2004). *The renewal of generosity: Illness, medicine, and how to live*. Chicago: University of Chicago Press.

Franklin, S. (2006). The IVF stem cell interface. *International Journal of Surgery, 4*, 86–90.

Fuller, S. (2007). *New Frontiers in science and technology studies*. Cambridge: Polity Press.

Garland-Thomson, R. (2012). The case for conserving disability. *Bioethical Inquiry, 9*, 339–355.

Goffman, E. (1959). *The presentation of self in everyday life*. Harmondsworth: Penguin.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Harmondsworth: Penguin.

Goffman, E. (1967). *Interaction ritual*. New York: Pantheon Books.

Gordon, R. A. (2000). *Eating disorders: Anatomy of a social epidemic*. Oxford: Blackwell Publications.

Hollin, G. J. S., & Pilnick, A. (2014). Infancy, autism, and the emergence of a socially disordered body. *Social Science & Medicine*. doi:10.1016/j.socscimed.2014.07.050.

Holmes, H. B. (1992). A call to heal medicine. In H. B. Holmes & L. Purdy (Eds.), *Feminist perspectives in medical ethics*. Bloomington: Indiana University Press.

Howson, A. (2004). *The body in society: An introduction*. Cambridge: Polity Press.

International Classification of Disease (ICD – 10). (2014). Geneva, World Health Organization. Website http://www.icd10data.com/ICD10CM/Codes/F01-F99/F60-F69/F64-/F64.1. Accessed 21 Mar 2014.

James, A., & Hockey, J. (2007). *Embodying health identities*. Houndmills/Basingstoke: Palgrave Macmillan.

Kuhse, H., & Singer, P. (1999). Introduction. In H. Kuhse & P. Singer (Eds.), *Bioethics an anthology* (pp. 1–7). Oxford: Blackwell Publishers.

Kingdon, C. (2009). *Sociology for midwives*. London: Quay Books.

Koffman, O. (2014). Fertile bodies, immature brains?: A genealogical critique of neuroscientific claims regarding the adolescent brain and of the global fight against adolescent motherhood. *Social Science & Medicine*. doi:10.1016/j.socscimed.2014.10.

Kosut, M. (2014). The artification of tattoo: Transformations within a cultural field. *Cultural Sociology, 8*(2), 142–158.

Little, M. O. (1996). Why a feminist approach to bioethics? *Kennedy Institute of Ethics Journal, 6*(1), 1–18.

Lorber, J., & Moore, L. J. (2007). *Gendered bodies: Feminist perspectives*. Los Angeles: Roxbury Publishing Company.

Lundin, S. (1997). Visions of the body. In S. Lundin & M. Ideland (Eds.), *Gene technology and the public*. Lund: Nordic Academic Press.

Lupton, D. (1994). *Medicine as culture: Illness, disease and the body in western societies*. London: Sage Publications.

Lupton, D. (1995). *The imperative of health: Public health and the regulated body*. London: Sage Publications.

Lupton, D. (2013). Quantifying the body: Monitoring and measuring health in the age of mHealth technologies. *Critical Public Health, 23*(4), 393–403.

Lupton, D. (2014). The commodification of patient opinion: The digital patient experience economy in the age of big data. *Sociology of Health & Illness, 36*(6), 856–869.

Lyon, M. L., & Barbalet, J. M. (1994). Society's body: Emotion and the 'somatization' of social theory. In T. J. Csordas (Ed.), *Embodiment and experience: The existential ground of culture and the self* (pp. 48–66). Cambridge: Cambridge University Press.

Mahowald, M. B. (1994). Reproductive genetics and gender justice. In K. Rothenberg & E. J. Thomson (Eds.), *Women and prenatal testing: Facing the challenges of genetic testing*. Columbus: Ohio State University Press.

Maller, C. J. (2015). Understanding health through social practices: Performance and materiality in everyday life. *Sociology of Health & Illness, 37*(1), 52–66.

Mamo, L. (2007). *Queering reproduction: Achieving pregnancy in the age of technoscience*. Durham: Duke University Press.

Manning, E. (2014). Wondering the world directly – Or, how movement outruns the subject. *Body and Society, 20*(3&4), 162–188.

Martin, E. (1992). *The woman in the body: A cultural analysis of reproduction*. Boston: Beacon Press.

Mauss, M. (1973). Techniques of the body. *Economy and Society, 2*(1), 70–88.

McDermott, E., & Roen, K. (2016). *Queer youth, suicide and self-harm: Troubled subjects, troubling norms*. Basingstoke: Palgrave Macmillan.

Mead, G. H. (1934). *Mind self and society from the standpoint of a social behaviorist*. Chicago: University of Chicago Press.

Metzl, J. M., & Kirkland, A. (Eds.). (2010). *Against health: How health became the new morality: Biopolitics, medicine, technoscience, and health in the 21st century*. New York: New York University Press.

Moore, L. J., & Casper, M. J. (2015). *The body: Social and cultural dissections*. London: Routledge.

Morrow, R. A. (2009). Norbert Elias and figurational sociology: The comeback of the century. *Contemporary Sociology, 38*(3), 215–219.

Murphy, T. F. (2012). The ethics of fertility preservation in transgender body modifications. *Bioethical Inquiry, 9*, 311–316.

Musolino, C., Warin, M., Wade, T., & Gilchrist, P. (2015). 'Healthy anorexia': The complexity of care in disordered eating. *Social Science & Medicine, 139*, 18–25.

Nettleton, S. (1995). *The sociology of health and illness*. Cambridge: Polity Press.

Nettleton, S., & Watson, J. (1998). *The body in everyday life*. London/New York: Routledge.

Nordqvist, P., & Smart, C. (2014). *Relative strangers: Family life, genes and donor conception*. Basingstoke: Palgrave Macmillan.

Ortiz-Gómez, T., & Santesmases, M. J. (2014). *Gendered drugs and medicine historical and socio-cultural perspectives*. Farnham: Ashgate.

Payne, S. (2006). *The health of men & women*. Cambridge: Polity Press.

Peterson, A., & Bunton, R. (Eds.). (1997). *Foucault, health and medicine*. London: Routledge.

Phillips, G., & Green, J. (2015). Working for the public health: Politics, localism and epistemologies of practice. *Sociology of Health & Illness, 37*(4), 491–505.

Pitts-Taylor, V. (2003). *In the flesh: The cultural politics of body modification*. Basingstoke: Palgrave Macmillan.

Pitts-Taylor, V. (2007). *Surgery junkies: Wellness and pathology in cosmetic culture*. Rutgers: Rutgers University Press.

Pitts-Taylor, V. (2016). *The brain's body: Neuroscience and corporeal politics*. Durham: North Carolina, Duke University Press.

Roberts, T. K., & Fantz, C. R. (2014). Barriers to quality health care for the transgender population. *Clinical Biochemistry, 47*, 983–987.

Rojek, C. (1986). Problems of involvement and detachment in the writings of Norbert Elias. *British Journal of Sociology, 37*(4), 584–596.

Rose, N. (2001). The politics of life itself. *Theory, Culture & Society, 18*(6), 1–30.

Rose, N. (2007). *The politics of life itself: Biomedicine, power and subjectivity in the twenty-first century*. Princeton: Princeton University Press.

Salecl, R. (2001). Cut in the body: From clitoridectomy to body art. In S. Ahmed & J. Stacey (Eds.), *Thinking through the skin* (pp. 21–35). London: Routledge.

Scambler, G., & Higgs, P. (Eds.). (1998). *Modernity, medicine and health: Medical sociology towards 2000*. London: Routledge.

Scheffler, I. (1974). *Four pragmatists: A critical introduction to Peirce, James, Mead and Dewey*. London: Routledge & Kegan Paul.

Scheper-Hughes, N., & Lock, M. M. (1987). The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly, 1*(1), 6–41.

Schillmeier, M. (2014). *Eventful bodies: The cosmopolitics of illness*. Farnham: Ashgate.

Shaw, M., Doröling, D., & Mitchell, R. (2002). *Health, place and society*. Harlow: Pearson Education.

Sheaff, M. (2005). *Sociology & health care*. Maidenhead: Open University Press.

Shildrick, M. (1997). *Leaky bodies and boundaries: Feminism, postmodernism and (bio)ethics*. London/New York: Routledge.

Shildrick, M. (2002). *Embodying the monster: Encounters with the vulnerable self*. London: Sage Publications.

Shilling, C. (2005). *The body in culture, technology and society*. London: Sage Publications.

Shilling, C. (2008). *Changing bodies: Habit, crisis and creativity*. London: Sage Publications.

Shiva, V. (2016). *Who really feeds the world?: The failures of agribusiness and the promise of agroecology*. Berkeley: North Atlantic Books.

Stabile, C. A. (1994). *Feminism and the technological fix*. Manchester: Manchester University Press.

Tulle, E. (2007). Running to run: Embodiment, structure and agency amongst veteran elite runners. *Sociology, 41*(2), 329–346.

Turner, B. (1987). *Medical power and social knowledge*. London: Sage Publications.

Turner, B. (1991). Recent developments in the theory of the body. In M. Featherston, M. Hepworth, & B. Turner (Eds.), *The body: Social process and cultural theory* (pp. 1–35). London: Sage Publications.

Turner, B. (1992). *Regulating bodies: Essays in medical sociology*. London: Routledge.

Turner, B. (2008). *The body & society*. London: Sage. (Third Edition). First published 1984.

Urla, J., & Terry, J. (1995). Introduction: Mapping embodied deviance. In J. Terry & J. Urla (Eds.), *Deviant bodies: Critical perspectives on difference in science and popular cultures* (pp. 1–18). Bloomington: Indiana University Press.

Vågerö, D., & Illsley, R. (2004). Explaining health inequalities: Beyond Black and Barker. In M. Bury & J. Gabe (Eds.), *The sociology of health and illness* (pp. 122–133). London/Thousand Oaks/New Delhi: Sage.

Wahlert, L., & Fiester, A. (2012). Commentary: The questions we shouldn't ask. *Cambridge Quarterly of Healthcare Ethics, 21*, 281–289.

Webster, A. (2007). *Health, technology & society: A sociological critique*. Basingstoke: Palgrave Macmillan.

Wetherell, M. (2015). Trends in the turn to affect: A social psychological critique. *Body and Society, 21*(2), 139–166.

Wilkinson, R., & Pickett, K. (2009). *The Spirit level: Why more equal societies almost always do better*. London: Allen Lane.

Williams, S. J. (2003). *Medicine and the body*. London: Sage Publications.

Williams, S. J., & Bendelow, G. (1996). Emotions, health and illness: The 'missing link' in medical sociology? In *Sociology of health & illness monograph series* (pp. 25–53). Oxford: Blackwell.

Williams, S. J., & Bendelow, G. (1998). *The lived body: Sociological themes, embodied issues*. London: Routledge.

4

Production, Reproduction and Consumption

Ellen Annandale

Introduction

> Production does not simply produce man [sic] as a *commodity*, the *human commodity*, man in the role of a *commodity*; it produces him in keeping with this role as a *mentally* and physically *dehumanised* being. Karl Marx (1974 [1932]: 76, emphasis orig.) *Economic and Philosophical Manuscripts of 1844*

> Neoliberalism is the rationality through which capitalism finally swallows humanity. Wendy Brown (2015: 44) *Undoing the Demos*: *Neoliberalism's Stealth Revolution*

Karl Marx did not write in direct detail about health and illness; this was mostly the domain of his intellectual partner, Engels (1993 [1845]), whose work depicted most vividly the health consequences of

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the appalling living and working conditions—indeed, the abject misery which he described as akin to social murder—of the working class in England in the mid-nineteenth century. But Marx made clear the savage contradiction between the pursuit of profit and well-being. In the above quotation, he proposes that the capitalist mode of production not only turns 'man' into a commodity, it produces a mentally and physically dehumanised being. Most pointedly, alienation from the species-being, or humanity, estranges us from our own bodies. The malefactor, of course, is capitalism and its doppelganger, the political economy promulgated by classical economists, such as Adam Smith and David Ricardo. In *Anti-Dühring* (Engels 2001 [1877]: 186), Engels described political economy 'in the widest sense' as 'the science of the laws governing the production and exchange of the material means of subsistence in society'. Patently, twenty-first-century capitalism is distanced from the depictions of Marx and Engels not only by more than a century of time but also—and underscoring its enigmatic character and ultimate resilience (Harvey 2010)—by the metamorphosis of capital from its 'industrial' mode into a multiplicity of forms. Most notably for us there, human life itself has been drawn progressively into production and consumption, with significant health implications. The nineteenth-century worker's body, it might be said, was a tool for the extraction of profit via the production of external value through bodily labour (i.e. the production of material goods). The twenty-first-century body does this and more; it produces and reproduces (bio)value in itself. (See also the related discussion of biopower in Chap. 3.) Increasingly production is located at the genetic, microbial and cellular level as 'life becomes, literally, annexed within capitalist processes of accumulation' (Cooper 2008: 19).

Although set apart considerably in time, nineteenth- and twenty-first-century bodies share in common their positioning within distinct social relations of production, reproduction and consumption, which is the focus of this chapter. The increasingly commodified, individualised, 'neoliberal' body is realised as a form of physical and economic capital that can be moulded, changed and regenerated. In times of economic austerity, by making health a 'project' individuals in the global north in particular are exhorted to 'demonstrate to self and others that they have the entrepreneurial qualities' 'that make them more equipped than their competitors for surviving the new economic realities': health has become a 'logic of survival' (Crawford 2006: 413). Moreover, the pursuit of visible health is 'big business', witnessed by the booming fitness, diet and foodstuff, and cosmetic industries. Even though neoliberal subjects are encouraged to assume individual responsibility for health (Crawshaw 2012) the achievement of well-being also should be understood as powerfully shaped by social, cultural and economic context. (See also the discussion of neoliberalism in Chap. 6.) In a world that has become ever more mobile and globalised, the production and reproduction of the health of individuals in one part of the world is deeply imbricated with that of others, often in distant places. And, in an ever more unequal global economy and inequality, which manifests in widening disparities in morbidity and mortality (Marmot 2015), some are far more able than others to seek not only the regeneration of their own bodies from the bodies of others but also to protect their bodies from such incursions (Waldby 2002; Waldby and Mitchell 2006).

The chapter proceeds as follows. In Part 1, I address the global production of health inequalities. I begin by looking at data on life expectancies in different regions and countries and consider them in the context of neoliberal economic and social governance since the 1980s; mounting economic inequality; and the marked pulling away of the richest of the population from the rest. I then touch upon the 'double burden' of disease that has emerged in many parts of the global south; that is, the heavy weight of infectious disease, alongside the rise of non-communicable or chronic conditions, such as heart disease. Finally, as a case illustration of how swift the impact of socio-economic change can be on population health, I consider health status in Eastern Europe looking in particular at 'lifestyle behaviours'. I take this discussion of 'lifestyles' further in Part 2 as I consider health identities and the 'consumption' and 'reproduction' of health. This brings us back to the associations between health and (bio) capital as I explore the governance of health in the milieu of prevailing individual lifestyle explanations for illness and 'mHealth' (mobile health technologies). I take the very different case of the global organ trade to delve into health expectations and the achievement of positive health through consumption. In the concluding section of the chapter I focus on reproduction of human life. Paying attention to global connectivity between markets and bodies, I consider 'biogenetic trade' (Sarojini et al. 2011) and global 'reproscapes' (Inhorn 2011), taking 'egg donation' and commercial surrogacy as case examples.

Part 1: The Global Production of Health Inequality

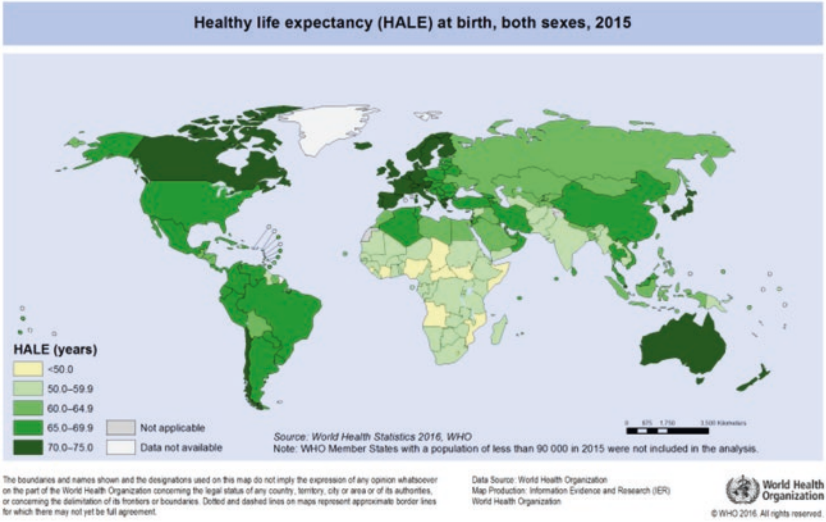
Health Inequalities

The massive and growing differences in the health status of people across the world can be considered a major form of social injustice. For Bauman (2011: ?), 'the inflammable mixture of growing social inequality and the rising volume of human suffering marginalised as "collateral" is becoming one of the most cataclysmic problems of our time'. Military in origin, collateral damage denotes the unintended and unplanned effects of armed intrusions. Applying this to globalisation, Bauman conveyed how the poor—in various ways, in various parts of the world—have become collateral damage in a profit-driven, consumer-oriented political environment. The fact that collateral damage is, by definition, unforeseen and seemingly accidental, only serves to exacerbate the invisibility or neglect of the world's poor. Although Bauman did not address matters of health, his use of this concept can be extended to suggest that health inequity often manifests as collateral damage; something which is seen as almost inevitable, even though it need not be.

In *The Health Gap*, Michael Marmot (2015) begins a discussion of the 'organisation of misery' by taking us back to the haunting words of Marx's nineteenth-century contemporary, Charles Dickens, in his novel, *A Tale of Two Cities*: 'It was the best of times, it was the worst of times, it was the age of Wisdom, it was the age of foolishness. … It was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair.' (Dickens 2008 [1859]). Bringing us to the present, Marmot relates that 'it is indeed the best of times. Health is improving globally. In many countries of the world we are much healthier and living much longer than we would have been when Dickens was writing.' Yet, as he continues, it is also the worst of times:

> [The] enjoyment of good health is most unequally spread. For some countries their health is nearly as bad as if they were still languishing in Dickensian squalor. Currently in the world the unhealthiest country has a life expectancy nearly 40 years shorter than the healthiest. That is the same as the gap between Dickensian and modern-day London. (Marmot 2015: 22)

To illustrate Marmot's point, Fig. 4.1 shows 'healthy life expectancy' (HALE[1]) across the world in 2015. We see vast differences. There was an average HALE of less than 50 years in many countries of sub-Saharan Africa, such as Mozambique, Malawi, Somalia and Nigeria, which can be compared, for example, to 70 and 75 years in the Scandinavian countries, Australia and much of Western Europe. There were also notable differences within the European Union whereby the majority of the countries



Source: World Health Statistics 2016, WHO
Note: WHO Member States with a population of less than 90 000 in 2015 were not included in the analysis.

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Information Evidence and Research (IER)
World Health Organization

Fig. 4.1 Healthy life expectancy, 2015 (WHO 2016) with average life expectancies in the 1980s were in the west (e.g. Belgium, Germany, France, Switzerland, the UK), while many of those with life expectancies in the 1970s were in the east of the Union (e.g. Bulgaria, the Czech Republic, Estonia, Lithuania, Romania) (Eurostat 2017).

Although these country-level differences are glaring, as noted, life expectancy has been rising in most countries of the world. The World Health Organisation (WHO) reports a global rise of more than three years per decade since 1950 (with the exception of the 1990s) and a notable acceleration of five years between 2000 and 2015 (WHO 2016). However, some countries of Sub-Saharan Africa (Lesotho, Swaziland and Zimbabwe) are exceptions with declines in life expectancy between 1990 and 2013 (WHO 2015). Much of the latter can be attributed to HIV-AIDS deaths (UNAIDS 2016). Global inequality has intensified over the period of the AIDS pandemic, which began in the early 1980s, heightening the risk of sickness and premature death from this disease as people living with HIV and dying from AIDS do so in situations of relative or absolute deprivation (Doyal 2013). (See also the discussions of AIDS in Chaps. 2 and 3.)

Neoliberalism

The vital question, of course, is how these differences can be accounted for. Present-day commentators increasingly turn to neoliberalism in explanation for global inequality. (See also the discussion of neoliberalism in Chap. 6.) As much rehearsed, widely associated with the economic policies of the Conservative-Republican administrations of US President Reagan and UK Prime Minister Thatcher during the 1980s, neoliberalism is now the world's dominant politico-economic policy framework, extending to Europe, Latin America, South Africa and the former Soviet Union. It can be characterised as a project of economic and social change based on the transfer of economic power and control from governments to private markets and the injection of market competition into areas such as education, housing and healthcare which, in many western countries at least, were once part of welfare states. Neoliberal economic policies have encouraged financial deregulation and the opening up of free trade and opportunities for large investments by wealthy countries in regions of the world where social conditions afford high returns. Collins and colleagues set forth that 'neoliberalism actively embraces inequality, and either refutes the concept of social justice, or equates justice with what a supposedly "free" market will produce' (Collins et al. 2016: 129). Schrecker and Bambra write that the great 'defining characteristic' of neoliberalism is that 'it redistributes income and wealth upward in a society while redistributing risk downward' (2015: 51). In 2016, the bottom half of the world's adults collectively owned less than 1 per cent of total global wealth,[2] while the top 10 per cent owned 89 per cent. In the same year, an estimated 3.5 billion individuals (73 per cent of all adults in the world) had wealth below USD 10,000 whereas the top 365 million (7.5 per cent) had between US$100,000 and one million. In the year 2000, the top 1 per cent owned 49.6 per cent of global assets, and by 2014 this had grown to 50.8 per cent (Credit Suisse 2016). Oxfam (2016: 4) characterises this as 'an economy for the 1%' and 'an inequality crisis'. Far from trickling down in the manner of classical economics, wealth is being sucked up as processes of deregulation, privatisation and globalisation associated with neoliberalism that 'have super-charged the age-old ability of the rich to use their position to further concentrate their wealth' (Oxfam 2016: 4). In accordance with the title of his book *Why We Can't Afford the Rich* (2016), Sayer argues that the explanation is found in the observation that monopolisation of wealth is unearned and involves no creation of use value. In the much discussed *Capital in the Twenty-first Century*, Piketty (2014) contends that capitalism has a 'central contradiction': when the rate of return on capital (i.e. profits and other types of income from capital) exceeds the rate of economic growth (GDP, the value of goods and services of a country), inequality tends to rise. This happens because profits and other types of income from capital tend to grow faster than wage income, the source of income for the vast majority of people. With the exception of the period from the late-nineteenth to the early twenty-first century, this is precisely what has happened, with, to paraphrase Piketty, potentially terrifying consequences for wealth distribution.

In the quote prefacing the start of his chapter, Brown (2015: 44) advances that 'neoliberalism is the rationality through which capitalism finally swallows humanity'. As *homo economicus* achieves normative reign, life becomes 'economised' as people are realised above all as actors in markets. As she so poignantly puts it, 'the neoliberal subject is granted no guarantee of life (on the contrary, in markets, some must die for others to live), and is so tethered to economic ends as to be potentially sacrificeable to them' (2015: 44, 111).

A direct connection has been drawn by researchers between health inequity and the growth of neoliberal policies. The data on regional trends in life expectancy from the onset of neoliberal globalisation in the 1980s through to 2005 seen in Fig. 4.2 show that, although there was considerable variation between countries and regions, life expectancy rose over the period. But, significantly, the former USSR and, especially sub-Saharan Africa, bucked this trend (De Vogli 2011). Neoliberalism has also been associated with spatial inequalities *within* countries, with the English 'north-south divide' being a good illustration of this.

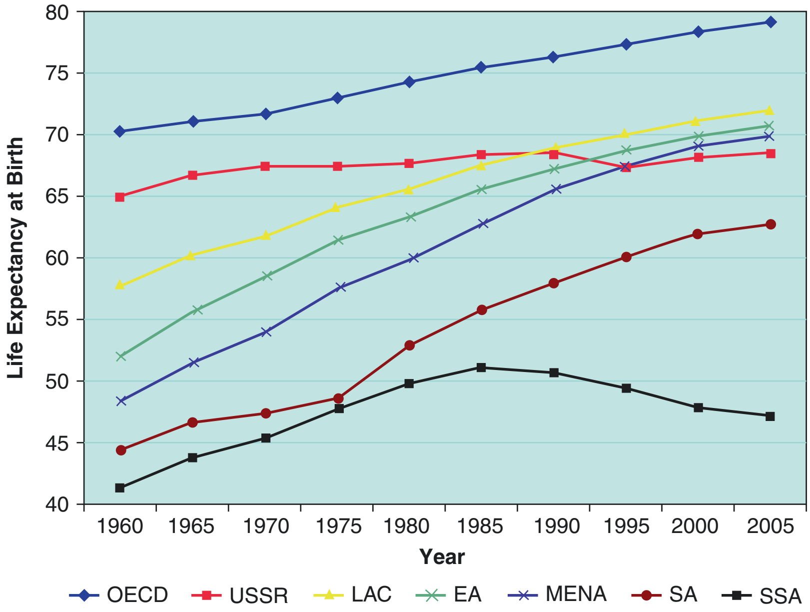


Fig. 4.2 Regional trends in life expectancy at birth (Source: De Vogli 2011: 315)

In Northern England (i.e. the North East, North West, Yorkshire and Humber regions), indicators of deprivation, for example, households with income below 60 per cent of the national medium, high levels of debt, social housing and unemployment, are far higher than in the South (Schrecker and Bambra 2015). A comparison of life expectancy data from 1999 to 2003 and 2009 to 2013 found that although the social gradient improved somewhat over the period, persistently low life expectancy was found in areas of Northern England around urban centres compared to the rest of the country (Buck and Maguire 2015).

The 'Double Burden' of Disease

Both within and between countries and regions of the world, health inequalities persist in the majority of causes of death. In most regions, deaths from communicable diseases (such as HIV/AIDS, tuberculosis and malaria) far outweigh those from non-communicable diseases (NCDs) (such as cardiovascular disease, cancers, chronic respiratory disease). The balance is more even in the African region but still overshadowed by communicable causes (WHO 2015). NCDs were responsible for 38 million (68 per cent) of the world's 56 million deaths among people aged 30–70 in 2012. Three quarters of these occurred in low- and middle-income countries and represented 82 per cent of premature deaths (below age 70) worldwide (WHO 2014). As Glasgow and Schrecker explain, NCDs do not replace communicable diseases, but the two categories combine to produce 'a double or even multiple burden of disease' (2015: 279). As these authors recount, WHO has placed considerable emphasis on rising tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol in the global south for this double burden which unintentionally replicates neoliberal notions of individual responsibilisation for health and illness (see also Part 2 of his chapter). It also overlooks risk exposure associated with trade liberalisation and the marketing activities of multinational tobacco and food companies. With reference to Latin America and the Caribbean, the Pan American Health Organisation (PAHO) reports that when national policies favour market deregulation and fiscal measures which support multinationals, the production and consumption of ultra-processed products (UPPs), that is, those high in salt, saturated fats, trans fats and sugar, increase. There is also evidence of a positive association between trade liberalisation and harmful alcohol consumption (PAHO 2016). Growth opportunities for the 'big food' US multinationals, such as the Coca-Cola Company and PespiCo, have been enormous and they have saturated the markets in many countries of the global south by mass marketing and foreign investment, in search of profit rather than the maximising of human diet. This has contributed to the 'nutritional transition' from traditional simple diets to UPPs and the seeming paradox of the coexistence of global malnutrition and obesity (Stuckler and Nestle 2012). With reference to 127 countries between 1980 and 2008, De Vogli et al. (2014) analysed the relationship between mean body mass index (BMI), economic globalisation and economic inequalities between countries. As seen in Fig. 4.3, the major increase in BMI occurred alongside an upsurge in 'economic inequalities' between countries (measured by GDP) as well as a major rise in economic globalisation. Additional statistical analysis by the authors pointed to a causal association; as globalisation and economic inequalities increase, so does BMI (although they report that the exact mechanisms involved remain to be investigated).

This suggests an association between obesity and changing social conditions of life globally. In the final illustration of the global production of health inequality, we turn to the former USSR as an illustration of how rapid the impact of social and political change on health can be. The political transition towards a market economy in the early 1990s stimulated a 'mortality crisis' of critical proportions as, by way of illustration, between 1991 and 1994, the average life expectancy of men steeply declined from 64 to 57 (Stuckler 2013). In explanation, research points to economic recession, impoverishment (official poverty levels of 40 per cent) and social dislocation. The principle casualties were middle-aged men of low socio-economic status (e.g. factory workers and technicians). This was the group most affected by the brutal market changes, who lost their employment and with it economic status and self-respect. The frequently identified contribution to reduced life expectancy of heavy alcohol consumption as a form of 'self-medication' can be understood

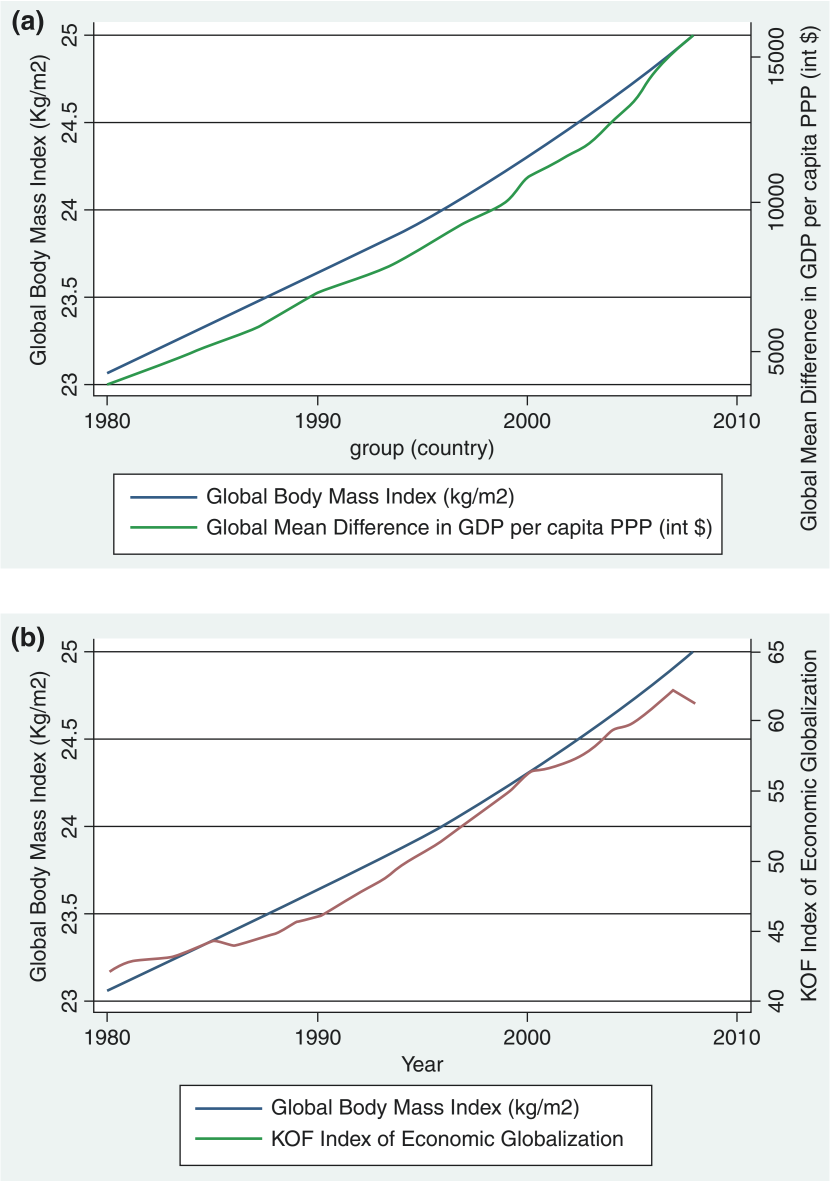


Fig. 4.3 BMI and inequality (Source: De Vogli et al. 2014)

in this context. As Stuckler (2013) identifies, it was not just alcohol, but the kind of alcohol drunk that mattered. Many factory workers turned to non-beverage alcohol known as *odekolon*; that is, alcohol-containing liquids (eau-de-cologne, aftershave, mouthwash) which, unlike vodka and other spirits, were not taxed, and therefore less costly, but far more lethal for health (Stuckler 2013).

Part 2: The Consumption and Reproduction of Health

Health and 'Lifestyle'

When reasons are sought for health differentials between people, individualised explanations prevail. In the aforementioned book *The Health Gap*, Marmot (2015: 50–51) asks the critical question: whose responsibility is health? With reference to public health messages, he takes as illustrative the 'top 10 tips for health' put forward, in 1999, by the Chief Medical Officer for England:

1. Don't smoke.
2. Follow a balanced diet with plenty of fruit and vegetables.
3. Keep physically active.
4. Manage stress by, for example, talking things through and making time to relax.
5. If you drink alcohol, do so in moderation.
6. Cover up in the sun, and protect children from sunburn.
7. Practice safer sex.
8. Take up cancer-screening opportunities.
9. Be safe on the roads: follow the Highway Code.
10. Learn the First Aid ABC: airways, breathing, circulation.

Marmot follows this with an alternative set of tips composed by David Gordon, currently Director of the Townsend Centre for International Poverty Research at the University of Bristol:

1. Don't be poor. If you can, stop. If you can't, try not to be poor for long.
2. Don't live in a deprived area. If you do, move.
3. Don't be disabled or have a disabled child.
4. Don't work in a stressful, low-paid manual job.
5. Don't live in damp, low-quality housing or be homeless.
6. Be able to afford to pay for social activities and annual holidays.
7. Don't be a lone parent.
8. Claim all the benefits to which you are entitled.
9. Be able to afford to own a car.
10. Use education to improve your socio-economic position.

The problem, as Marmot (2015) discusses, is not that the first list is wrong, but that many people simply are unable to follow the advice for the reasons in the second list. As he continues, personal responsibility is important, but 'people cannot take responsibility if they cannot control what happens to them' (2015: 51). The 'individualised behavioural explanatory model' does not necessarily conceptualise the individual outside of social context, but rather sees adverse social conditions and individual behaviour as sharing something in common: personal characteristics and the capacity to make the right choices (Bartley 2017: 76). Yet, to make the obvious point, some people, those in prosperous conditions, with high incomes, high social status and good working conditions, for example, are far more likely to have the capacity to make the 'right choices'—to follow list one, if you will, than those in deprived circumstances.

Lifestyle choice explanations for health of the type listed in the 'top 10 tips for health' not only saturate the media and public health messaging, but—and undoubtedly as a corollary—are also widely adopted by individuals themselves. As, among others, Lupton (2012: 92) has written, risk discourse is pervasive and well recognised as 'self-indulgence and lack of self-discipline are viewed as the reasons why people become ill with such diseases as coronary heart disease, stroke, diabetes, lung cancer or cirrhosis of the liver', conditions strongly linked to diet, tobacco and alcohol consumption. The more health is envisaged as something to be achieved that we are individually responsible for, the more it is embraced as a crucial part of our identity. In a prescient appraisal, Crawford (1984: 74) advanced that when 'the macro-economic conditions that affect health appear out of control, self-control over the considerable range of personal behaviours that also affect health is an only remaining option'. Under such conditions the 'overweight', 'obese' and 'fat' are observed to 'let themselves go': 'fat flesh challenges notions of propriety because of its fluidity and excessiveness. It is wobbly and jiggly, it hangs loosely, it oozes over into people's spaces, confronts them with its monstrous dimensions' (Lupton 2013a: 3, 57).

The 'Prosumption' of Health

This signifies that the 'production' and consumption of health and illness are being drawn ever more tightly together. Although Marx was aware that production always involves consumption, in the milieu of nineteenth-century capitalism, it was production that was preeminent (Ritzer and Jurgenson 2010). With the beginning of the decline in heavy industry in the 1960s, the pendulum began to swing far more towards consumption with the growth of marketing, branding and what Ritzer (2010) gathers under the conceptual umbrella of 'cathedrals of consumption', namely, shopping malls, businesses such as Walmart and, particularly of late, massive online companies such as Amazon. Ritzer and Jurgenson (2010: 18) draw on Toffler's (1980) concept of 'prosumption' to advance that the separation of production and consumption is weakening with the rise of a new wave of the 'prosumer', that is, consumers who are drawn into co-production, such as in Web 2.0, reality television and what the authors dub 'do-it-yourself medical technologies'. Prosumption, they argue, is a novel means of generating surplus value by capital, even though it is not easy to see how far this is exploitative in the manner described by Marx and how far it offers opportunities for resistance to dominant ideologies. Appadurai (1986) also highlights that we can no longer see production and consumption as linear (something is produced and then consumed); rather they are blended in a circulation of material objects.

Optimisation and mHealth

This is fertile ground for the growth of health and wellness as a commodity fetish as global cultural flows of services and products 'encourage healthcare consumers who want to preserve their capital investment in the commodity of health to purchase more commodities in the form of healthcare products and services' (Fries 2008: 357). The prosumption of health and individualised responsibility for health coalesce in bodywork. For example, respondents in Thualagant's (2016: 2000) research on sport-for-all clubs in Denmark were highly motivated by the neoliberal impetus to adopt a range of different body and performance enhancing strategies. (See Chap. 3 for a discussion of some of these strategies.) As she puts it, 'embedded in a culture of consumption' in our hypermodern times, we are 'enrolled in an economic rationale where everything is consumable, even health'. The economic 'rationale of optimisation' propels many to act not only for health, but for more health (2016: 199, 2000). Mobile, wearable technologies, encompassed by the concept of mHealth (mobile health), effortlessly fall into line with notions of the citizen as an individually responsible and 'productive consumer' (Rich and Miah 2017). Thus wristbands with motion sensors, such as *Fitbit* and *Nike+*, track daily movements, silicone bracelets monitor heart rate and sleep patterns, and smartphone apps enable people to oversee their food intake via what has become known as 'nag technology'. Apps, such as Apple's *Healthkit*, are available too to track mood and movement to share with clinicians and public health workers for health oversight. The global self-care medical devices market is forecast to reach USD 16.8 billion by 2019 (Transparency Market Research 2017). As Rich and Miah (2017) put it, mHealth has a long commercial tail as data captured by individuals and from individuals in the production of their own health become knowable to a wide range of institutions. As they continue, 'ultimately, the end point of digital health solutions may be a complete erosion of autonomy in a world where this control is assumed by intelligent machines, capable of providing the appropriate response to undesirable fluctuations in our health status' (2017: 95).

Physicist and philosopher Barad (2007) argues that matter is entangled in social and material relations that include human and non-humans. From this standpoint, bodily matter is conceived 'not as a thing but as a doing' (2003: 828). She employs the term intra-action (as distinct from inter-action) to signify the coming together of two or more separate things; the human and non-human, as co-constitutive elements in 'agential intra-actions' (2003: 822). In his analysis of posture-tracking technologies Millington (2016: 405) demonstrates that health optimisation can be envisioned as an enfolding of human and non-human 'in the pursuit of self-betterment'. He argues that bodies quite literally enjoin with technologies 'and in turn take on technical descriptions when broken down into quantified measures such as "posture hours"' (2016: 414). Conversely, haptic posture technologies—such as wearable sensors like *Lumo Lift*, *Lumo Back* and *Prana*—assume human qualities as they are 'all imagined as active agents' (2016: 414) by, for example, the wearers' coaches and trainers who act in response to body movements. Ostensibly holding out the potential of a 'perfect(ible) body', mHealth strongly enables 'techno-utopian, enhancement, and healthist discourses' (Lupton 2013b: 395, 393). These devices encourage a trust in numbers (digital data) over physical sensations and a sense of individual self-control which furthers the illusion that, by massing such data, one can prevent illness and avoid death (Lupton 2013b).

'Bioavailability': The Global Organ Trade

Developments in biotechnology not only enjoin humans and non-humans in 'health optimisation', they also facilitate the bringing together of human bodies in new ways in the avoidance of illness and death. Rose (2007) identifies a novel 'somatic' sense of self that has emerged from new, highly mobile 'circuits of vitality'. Vitality, he argues,

> can now be decomposed, stabilised, frozen, banked, stored, commoditized, accumulated, exchanged, traded across time, across space, across organs and species, across diverse contexts and enterprises in the service of both health and wealth. (Rose 2007: 3)

The illegal global sale of human organs is a stark illustration of this. Viewed in market terms, the demand for organs far outstrips the available supply. The majority of people are reluctant to donate their organs after death; for example, only about 31 per cent of people are registered as donors in the UK. On the supply side, since people are living on into much older age, their organs can be less viable for transplant upon death; improved car safety has meant less fatal road traffic accidents in healthy adults; and specialised hospital trauma units increasingly keep people alive 'at all costs'. Meanwhile, there is escalated demand associated with growing rates of chronic illnesses such as diabetes (associated with kidney disease) as well as from the rising expectations discussed earlier, especially in affluent countries, of a healthy life even with chronic illness—for example, living 'dialysis-free'.

The first successful kidney transplant (involving identical twins) took place over half a century ago in 1954. However, it was only with the development of the immunosuppressant drug Cyclosporine in the 1970s that transplant was possible without immunological matching. Importantly, this made possible a whole new category of donors: those who were willing to sell a kidney (Lock and Nguyen 2010). Certain bodies were now 'bioavailable' to others (Cohen 2009). Organ markets, first identified in Gulf States in the 1980s, soon spread. 'Organ sale' is banned in all countries excepting Iran which has a compensated programme, though only for renal transplant (see e.g. Potter 2015). Driven by a need for survival, both buyers and sellers are ripe for exploitation. As Haken (2011: 23) relates, 'organ traffickers operate in the vast chasm that exists between the world's wealthy and the world's poor. Economic stagnation and deficiencies in law enforcement combine with increasing globalisation and improved communications technology to create the perfect space for this criminal enterprise.' Criminality is widespread. People are murdered in order to harvest their organs and organs are stolen during surgery and sold after natural death (e.g. after fatal road traffic accidents) (Ambagtsheer et al. 2013). There is an extensive medical ethical debate on the question of whether legalised markets of voluntary organ sale of a kidney, liver half, and lobe of a lung would stop such abuses, make things more equitable, and benefit vendors and recipients alike, or, whether legal markets would just push illegal markets further underground. With reference to kidney transplant (the most common form of transplantation), the argument 'against' includes physical harm, coercion and exploitation of vendors, the questionable capacity for true voluntary consent, and the impairment of altruism and social solidarity which are expressed through free donation. The case for a legal market pivots on the belief that physical harm can be protected against by good conditions of care, that payment does not necessarily compromise altruism (such as when a vendor uses the income to support a family member) and that, if the predominant concern is exploitation of the poor, then minimum fees can be set to avoid unfair advantage (Ambagtsheer et al. 2013; Wilkinson 2003).

The Iranian compensated and regulated living-unrelated donor programme was instituted in the late 1980s. Pair-matched registered candidates and donors reach an agreement on an acceptable price to be paid by recipient to donor which is intended to eliminate the corruption that can enter transactions when a broker or 'middle man' are involved. The programme is purported to have eliminated the transplant list as well as organ trafficking and transplant tourism (since only Iranian citizens are eligible). However, equity concerns still remain since, even though there is evidence to suggest that recipients come from all socio-economic groups, donors appear to be drawn overwhelmingly from the economically poor who, in some instances, publicly advertise the sale of their kidney for a price, which questions voluntariness.

Although the demand-support gap is a significant issue, there is more at stake. In Scheper-Hughes' assessment, to say that distasteful and dangerous practices can be resolved by regulation rather than prohibition is an exclusively market-oriented perspective underpinned by neoliberal goals, since the very idea of a shortage itself 'suggests a basic management, market or policy failure' (2003: 213). She proposes instead that we pay attention to the role of health expectations. Demand is a highly constructed notion based on sense of entitlement and of self-regeneration (Waldby and Mitchell 2006). Scheper-Hughes (2001a) points in particular to the preference for 'real time' organs as the 'normal' and 'natural' first choice of many potential recipients. Thus she recounts the response of one of her interviewees to accepting a cadaveric kidney:

> The kidney is practically dead. It was probably pinned down under the wheels of a car for several hours and then it was put on ice for another several hours. Then you expect it to go right back to work for me? It's really a disgusting idea to think about putting that traumatized dead man's organ inside you. So I chose a better way. I was able to see my donor. My doctor pointed him out to me [it was a small town in Eastern Europe]. He was young, healthy, strong. Just what I was hoping for. (Israeli man, quoted in Scheper-Hughes 2001a: 52)

For Scheper-Hughes (2001b) this consumptive demand is a form of 'neo-cannibalism', the ultimate fetish. A new transnational space has opened up where donors and recipients follow the 'new paths of capital and medical technology in the global economy' in response to new tastes and desires for the skin, bone, blood, organs, tissue and reproductive and genetic material of others (Scheper-Hughes 2003: 197). For those in desperate economic circumstances, the sale of a kidney may seem as normal and natural as any other kind of indentured labour. But, as ethnographic research has shown, the consequences are often far from beneficial. Research in the Philippines by Yea (2015), for example, found that men selling a kidney were motivated primarily by the desire to re-establish their (currently vulnerable) positions as family 'breadwinner' (*Haligi ngTahan an*, a pillar of the family). Paradoxically, however, their aspiration was often undermined by compromised health, such as fatigue and low immunity to infection, after the surgery, something that was exacerbated by poor or non-existent post-operative care. Stigma and ridicule often followed a man's sale of a kidney: to employers he may be seen as weakened, and to a future bride he may be emasculated. As one of Yea's respondents explained, 'I can't carry heavy loads anymore. The pain lasts for days if I take work as a cargador. It's impossible for me to continue this kind of work now. I've lost everything; my house, my business and my ability to work' (2015: 132).

The Reproduction of Human Life

The increasingly commodified reproductive body lends itself to free embrace within the production-consumption nexus we have been exploring in the chapter. Perforce the concept of 'prosumption' (Ritzer and Jurgenson 2010; Toffler 1980) might be expanded to 're-prosumption'. Our consideration of the global organ trade has drawn attention to the complex intertwining of economic and health vulnerabilities. As we turn to biogenetic trade and infertility, the binaries commonly drawn upon in discussion of production and consumption, such as exploiter/exploited, powerful/powerless, are troubled by the complex relationships between women as donors and recipients in markets.

Sarojini and colleagues write that

> At the core of the 'business' of IVF is […] reproduction, increasingly seen as a professionalized and commercialized domain, wherein women's procreative capacity can be tested, stimulated, broken down, transferred, frozen, bought and sold. It is this convergence of professional, technological, and commercial 'management' of reproduction that has generated widespread public debate. (2011: 8)

Drawing on Appadurai's (1996) notions of 'scapes', Inhorn (2011) refers to the powerful set of global 'reproscapes' consisting of 'technoscapes' (reproductive technologies), 'ethnoscapes' (circulating reproductive actors) and 'bioscapes' (gametes i.e. reproductive cells, embryos) that surround 'reproductive tourism'. These are connected to powerful 'financescapes' involving large-scale global industry (e.g. pharmaceutical companies, equipment suppliers, brokers, lawyers and doctors), 'mediascapes' (images) and 'ideoscapes' (ideas) (such as images of adorable 'miracle babies'). These reproscapes create pools of 'bioavailable women' (Pfeffer 2011). For some, such as the *Hands Off Our Ovaries Campaign Group*, this is brutally exploitative of women who repeatedly sell their ova for minimum financial amounts in an effort to escape poverty in the absence of employment opportunities that pay a living wage. Others, such as Wilkinson, maintain that 'commercial surrogacy *isn't* baby selling, needn't commodify or exploit women, and *can* be validly consensual' (2003: 181, emphasis orig.).

As has been emphasised throughout, it is important to set the production, consumption and reproduction of health in context and to explore situated experience. From her interview-based research with Romanian women who sold their ova (eggs) to an Israeli egg harvesting clinic in Bucharest, Nahman (2008) argues that the complex 'nodes of desire' produced through women's yearning for economic capital and freedom on the one hand and for children on the other produce a unique choreography of buyers and sellers. Inequality is produced through these nodes of desire. Nahman interprets the women not as brutalised victims but as 'savvy participants' in a neoliberal economy. Selling their eggs can help them to gain a better life, education and mobility as well as a sense of dignity. She reaches the conclusion that although we need to draw attention to the neoliberal global forces that have situated women so that they feel the need to commodify their bodies, 'it would be a kind of feminist imperialism to tell them they are wrong to desire these neoliberal ideals' (2008: 77). Gunnarsson Payne (2015) also addresses the trans-European market, in this case focusing on couples form Sweden seeking IVF in Latvia and Estonia. She employs the concept of 'biodesirability' to capture the inequalities that can arise when some women's bodies are made bioavailable to other women and, similar to Nahman (2008), argues that the transactions need to be interpreted within the context of new healthcare markets where individualisation and marketisation make health a product like any other to be bought and sold. The pertinent question is why do Swedish couples chose the Baltic States? Part of the answer is practicality; they are geographically close. The other is that often they were looking for a close match of phenotype; plainly put, for someone 'Scandinavian' or 'European' looking to be the donor-seller. This was associated with their notion that the Baltic states are less 'eastern' and more 'western' in feel than, for example, the less valued 'Slavic' appearance of women in the Ukraine or Russia. Thus, Gunnarsson Payne (2015) concludes that the eggs of women of the Baltic States were both 'bioavailable' (affordable) and 'biodesireable' to the Swedish couples. All the same, the couples were concerned that the relationship they had with the seller was not one of exploitation. Even though they were paying the 'donor'—donor being preferred over the term seller—they interpreted the transaction as altruistic rather than monetary. This enabled them to construe the donor as a 'nice person'. Indeed, her altruism could almost be seen as a genetic trait. As one respondent put it, 'I wouldn't want capitalist children'; in other words, for her child to be born of a woman highly motivated by money (Gunnarsson Payne 2015: 9). In Gunnarsson Payne's assessment, the couples reconcile their actions by concluding that what they are engaged in is not a market and they would not want it to be one, but that, nevertheless, the donor deserves compensation. Yet, as she concludes, a tension remains between the recipient's appraisal of women as 'savvy egg seller' and 'altruistic donor'.

These two studies of IVF—one focusing on the donor/seller and the other on the recipient/person seeking eggs—show us how, for various reasons, donor/sellers and recipients alike seek or are led to construe their relationship as more than purely commercial. The complex matter of relationality in re-prosumption is thrown into strong relief with the case of transnational commercial surrogacy where there is a true 'market in life' (Rudrappa 2015: 8). The global 'surrogacy map' is complicated and not always clear. Surrogacy is banned in some countries, such as much of western Europe, and China; it is permitted only if it is 'altruistic' (non-commercial) in others, such as the UK, Canada and Australia; while other countries still, such as Russia, South Africa and some US states (e.g. California, Texas), have altruistic and commercial arrangements. India provides a thought-provoking case study since, as discussed further below, until very recently, it has had a thriving commercial surrogacy market. Indeed, Rudrappa (2015: 5) characterises it, as 'a spectacular global phenomenon'. Third-party surrogacy was legalised in 2002 and there were no laws regulating clinics or surrogate-client relationships over much of the subsequent period. The principal type of surrogacy on offer in the country has been the 'full' or 'gestational' type (where a fertilised embryo is implanted in the surrogate's womb) rather than 'partial' (involving the sperm from future father, and egg and womb of the surrogate).

Based on her ethnographic research involving interviews with intending parents (most of whom who had travelled to India), surrogates and staff in a clinic in Gujarat state, Pande (2014) argues that commercial surrogacy is a survival strategy for Indian women and, for this reason, it is wrong simply to condemn the practice and to position surrogates as victims. Rather—and underlining the tight connection between production-reproduction and consumption that is the focus of this chapter—she proposes that we conceptualise it as a form of temporary labour and view the surrogate as a contract 'mother-worker'. She considers that between western women, altruistic surrogacy often invites the metaphor of the gift, leading to the depiction of the surrogate as an angelic gift-giver. In India, however, surrogates are construed as 'needy gift givers'; 'needy' in the sense of needing the money to support their own, often very poor, families, and 'gift givers' in the sense that they treat the baby inside them as if it is their own and 'gift' it to the purchaser. She found that surrogates were encouraged by clinic staff to treat surrogacy not like a business but to consider the money they received as God's gift to help *them* help their *own* families.

Although this helps women to maintain their dignity, Pande (2014) argues that it also serves to turn them into 'cheap, docile, selfless and nurturing' women (2014: 64). A disciplinary project is in play as a new subjectivity of 'mother-worker' is produced as surrogates are turned into 'needy gift receivers'. (See also the discussions on exchange and gift in Chap. 7.) They are often led by clinic staff to develop a bond with the intended parents, especially the future mother, and to see themselves as special to them. Ironically this also dampens their bargaining power in terms of payment and receipt of goods by positioning the relationship as non-contractual. Yet, underscoring the Foucauldian proposition that biopower power is 'a multiple and mobile field of force relations where far-reaching, but never completely stable effects of domination are produced' (1980: 102), Pande (2014) points out that there are points of resistance. Surrogates typically live together in a room with iron beds and not much else. They are kept under constant surveillance, their foods and medications monitored so that they take part in modern, medical expectations of motherhood. This is a place of surveillance, but it is also a space for resistance as women are able to engage in the networking and support that promote a sense of sisterhood and question the activities of clinics and the brokers who encouraged them to become a surrogate. The tension between exploitation and empowerment is similarly highlighted by Rudrappa (2015) from her research in Bangalore where women who have been cast out of work in the declining garment industry have turned to surrogacy to support their families and recoup a sense of moral self-worth. Rudrappa (2015) is led somewhat uneasily to conclude that while she found it 'impossible to ignore that the surrogacy system in India is disrespectful to women', it was also '*not* possible to ignore what I heard again and again from the [surrogate] mothers—they maintained that their engagement in Bangalore's surrogate reproduction industry was life-affirming' (2015: 17–18, emphasis orig.). As previously noted, although over much of the period since surrogacy was legalised in India in 2002 there have been no laws on the operation of clinics, this has begun to change. In late 2015, the government ordered clinics to stop providing surrogacy for foreign women/couples. At the time of writing, the Assisted Reproductive Technologies Bill is going to the Parliament. This has occasioned considerable debate by various interested parties, such as clinic operators and brokers. Women who work as surrogates have also spoken out, notably about their potential loss of livelihood.

Conclusion

Rudrappa's conclusion that 'surrogacy has to be located in the entrenched gender and racialized ideologies prevalent in producing *and* consuming societies' (2015: 77, emphasis orig.), encapsulates the theme of this chapter; that when it comes to health and illness it is hard to separate production, consumption and reproduction. Arguably their connection has intensified since the latter part of the twentieth century as, in the contemporary bioeconomy, the body increasingly has become a source for the generation of physical and economic capital. Biotechnological developments such as mHealth combine with the now pervasive ideology of individual responsibility for health and the avoidance of illness to configure a prosumer primed to make the 'right choices' in producing their own health through visible consumption. Yet this takes place in the context of rising global inequality within and between countries which, paradoxically, makes choice illusory for many people around the world. The increased spatial mobility of people and goods that has accompanied globalisation set alongside the pulling away of the very rich from the majority and increased economic and health marginalisation of many has facilitated new markets in which the bodies of some have become a productive site for the consumption and reproduction of the health of others.

Notes

1. HALE represents the average equivalent number of years of full health that a new-born baby could expect to live if they were to pass through life subject to the age-specific death rates and average age-specific levels of health states for a given period (WHO 2016: 10).
2. Wealth is defined as financial assets plus real assets (mainly housing) owned by households, minus debts (Credit Suisse 2016).

References

Ambagtsheer, F., Zaitch, D., & Weimer, W. (2013). The battle for human organs: Organ trafficking and transplant tourism in global context. *Global Crime, 14*(1), 1–26.

Appadurai, A. (1986). Introduction: Commodities and the politics of value. In A. Appadurai (Ed.), *The social life of things* (pp. 3–63). Cambridge: Cambridge University Press.

Appadurai, A. (1996). *Modernity at large*. London: University of Minnesota Press.

Barad, K. (2003). Posthumanist performativity. *Signs, 28*(3), 801–831.

Barad, K. (2007). *Meeting the universe halfway*. Durham: Duke University Press.

Bartley, M. (2017). *Health inequality* (2nd ed.). Cambridge: Polity.

Bauman, Z. (2011). *Collateral damage*. Cambridge: Polity.

Brown, W. (2015). *Undoing the demos: Neoliberalism's stealth revolution*. New York: Zone Books.

Buck, D., & Maguire, D. (2015). *Inequalities in life expectancy: Changes over time and implications for policy*. London: King's Fund.

Cohen, L. (2009). Operability, bioavailability, and exception. In A. Ong & S. Collier (Eds.), *Global assemblages* (pp. 79–90). Oxford: Blackwell.

Collins, C., McCartney, G., & Garnham, L. (2016). Neoliberalism and health inequalities. In K. Smith, S. Hill, & C. Bambra (Eds.), *Health inequalities: Critical perspectives* (pp. 124–137). Oxford: Oxford University Press.

Cooper, M. (2008). *Life as surplus: Biotechnology and capitalism in the neoliberal era*. London: University of Washington Press.

Crawford, R. (1984). A cultural account of 'health': Control, release, and the social body. In J. McKinlay (Ed.), *Issues in the political economy of health care* (pp. 60–103). London: Tavistock.

Crawford, R. (2006). Health as meaningful social practice. *Health, 10*(4), 401–420.

Crawshaw, P. (2012). Governing at a distance: Social marketing and the (bio)politics of responsibility. *Social Science & Medicine, 75*, 200–207.

De Vogli, R. (2011). Neoliberal globalisation and health in a time of economic crisis. *Social Theory and Health, 9*(4), 311–325.

De Vogli, R., Kouvonen, A., Elovainio, M., & Marmot, M. (2014). Economic globalization, inequality and body mass index: A cross-national analysis of 127 countries. *Critical Public Health, 24*(1), 7–21.

Dickens, C. (2008 [1859]). *A tale of two cities*. Oxford: Oxford University Press.

Doyal, L. (2013). *Living with HIV and dying with AIDS*. Farnham: Ashgate.

Engels, F. (1845). *The condition of the working class in England in 1844*. Oxford: Oxford University Press.

Engels, F. (2001 [1877]). *Herr Dühring's revolution in science*. London: Lawrence. (trans: Burns, E.). London: ElectricBook Co.

Eursostat. (2017). http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Life_expectancy_at_birth,_1980%E2%80%932014_(years)_YB16.png. Accessed 9 Jan 2017.

Foucault, M. (1980). In C. Gordon (Ed.), *Michel Foucault. Power/knowledge*. Brighton: Harvester.

Fries, C. J. (2008). Governing the health of the hybrid self: Integrative medicine, neoliberalism, and the shifting biopolitics of subjectivity. *Health Sociology Review, 17*(4), 353–367.

Glasgow, S., & Schrecker, T. (2015). The double burden of neoliberalism? Noncommunicable disease policies and the global political economy of risk. *Health and Place, 34*, 279–286.

Gunnarsson Payne, J. (2015). Reproduction in transition: Cross-border egg donation, biodesirability and new reproductive subjectivities on the European fertility market. *Gender, Place and Culture, 22*(1), 107–122.

Haken, J. (2011). *Transnational crime in the developing world*. Washington, DC: Global Financial Integrity.

Harvey, D. (2010). *The enigma of capital*. London: Profile Books.

Inhorn, M. (2011). Globalization and gametes: Reproductive 'tourism,' Islamic bioethics, and Middle Eastern modernity. *Anthropology & Medicine, 18*(1), 87–103.

Lock, M., & Nguyen, V. (2010). *An anthropology of biomedicine*. Oxford: Wiley-Blackwell.

Lupton, D. (2012). *Medicine as culture* (3rd ed.). London: Sage.

Lupton, D. (2013a). *Fat*. London: Routledge.

Lupton, D. (2013b). Quantifying the body: Monitoring and measuring health in the age of mHealth technologies. *Critical Public Health, 23*(4), 393–403.

Marmot, M. (2015). *The health gap. The challenge of an unequal world*. London: Bloomsbury.

Marx, K. (1974 [1932]). *Economic and philosophical manuscripts of 1844*. Moscow: Progress Publishers.

Millington, B. (2016). 'Quantify the invisible': Notes toward a future of posture. *Critical Public Health, 26*(4), 405–417.

Nahman, M. (2008). Nodes of desire. *European Journal of Women's Studies, 15*(2), 65–82.

Oxfam. (2016). *An economy for the 1%*. Oxford: Oxfam International.

Pan American Health Association (PAHO). (2016). *Dimensions of noncommunicable diseases in Latin America and the Caribbean*. Washington, DC: PAHO.

Pande, A. (2014). *Wombs in labor: Transnational commercial surrogacy in India*. New York: Columbia University Press.

Pfeffer, N. (2011). Eggs-ploiting women. *Reproductive Biomedicine Online, 23*(5), 634–651.

Piketty, T. (2014). *Capital in the twenty-first century* (trans: Goldhammer, A.). Cambridge, MA: Harvard University Press.

Potter, J. (2015). Does the Iranian model of kidney donation compensation work as an ethical global model? *Online Journal of Health Ethics, 11*(1). doi:10.18785/ojhe.1101.11.

Rich, E., & Miah, A. (2017). Mobile, wearable and ingestible health technologies: Towards a critical research agenda. *Health Sociology Review, 26*(1), 84–97.

Ritzer, G. (2010). *Enchanting a disenchanted world*. London: Sage.

Ritzer, G., & Jurgenson, N. (2010). Production, consumption, prosumption. The nature of capitalism in the age of the digital 'prosumer'. *Journal of Consumer Culture, 10*(1), 13–36.

Rose, N. (2007). Molecular biopolitics, somatic ethics and the spirit of biocapital. *Social Theory and Health, 5*, 3–29.

Rudrappa, S. (2015). *Discounted life. The price of global surrogacy in India*. New York: New York University Press.

Sarojini, N., Marwah, V., & Shenoi, A. (2011). Globalisation of birth markets. *Globalization and Health, 7*, 27. doi:10.1186/1744-8603-7-27.

Sayer, A. (2016). *Why we can't afford the rich*. Bristol: Policy Press.

Scheper-Hughes, N. (2001a). Commodity fetishism in organ trafficking. In N. Scheper-Hughes & L. Wacquant (Eds.), *Commodifying bodies* (pp. 31–62). London: Sage.

Scheper-Hughes, N. (2001b). Neo-cannibalism: The global trade in human organs. *The Hedgehog Review, 3*(2), 79–99.

Scheper-Hughes, N. (2003). Rotten trade: Millennial capitalism, human values and global justice in organs trafficking. *Journal of Human Rights, 2*(2), 197–226.

Schrecker, T., & Bambra, C. (2015). *How politics makes us sick: Neoliberal epidemics*. London: Palgrave.

Stuckler, D. (2013). *The body economic*. London: Penguin.

Stuckler, D., & Nestle, M. (2012). Big food, food systems, and global health. *PLoS Medicine, 9*(6), e1001242.

Suisse, C. (2016). *Global wealth report 2016*. Zurich: Credit Suisse.

Thualagant, N. (2016). Body management and the quest for performative health. *Social Theory and Health, 14*(2), 189–206.

Toffler, A. (1980). *Third wave*. New York: Collins.

Transparency Market Research. (2017). http://www.transparencymarketresearch.com/pressrelease/self-care-medical-devices-market.htm

UNAIDS. (2016, November). Fact sheet. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf

Waldby, C. (2002). Stem cells, tissue cultures and the production of biovalue. *Health, 6*(3), 305–323.

Waldby, C., & Mitchell, R. (2006). *Tissue economies. Blood, organs, and cell lines in late capitalism*. Durham: Duke University Press.

WHO. (2015). *World health statistics 2015*. Geneva: WHO.

WHO. (2016). *World health statistics 2016*. Geneva: WHO.

Wilkinson, S. (2003). *Bodies for sale*. London: Routledge.

World Health Organisation (WHO). (2014). *Global status report on noncommunicable diseases*. Geneva: WHO.

Yea, S. (2015). Masculinity under the knife: Filipino men, trafficking and the black organ market in Manila, the Philippines. *Gender, Place and Culture, 22*(1), 123–142.

5

Kinship, Blood and Alliances

Ana Porroche-Escudero

Introduction

Since the beginning of anthropology there has been a long tradition of studying kinship. Its focus on marriage, family and motherhood was not accidental and coincided with a particular historical period in the West when the nuclear family was emerging, exalted by the middle classes. This understanding of the family underscores the role of femininity in sustaining marriage and reproduction.

Decades later, some sociologists and anthropologists argued that kinship studies were "dead". Kinship was thought to be irrelevant at least in the "West", where postmodern societies are supposed to be sexually progressive and free from problems such as arranged marriage, compulsory motherhood or homophobia (Jackson and Scott 1996). But it is precisely at times such as these, characterised by "sexual antinomies" (Jackson and Scott 2004) and fuelled by conservative forces, that people are more likely

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to be concerned with the purity of the family (Esteban 2008; Pichardo-Galán 2009) and womanhood (Jolly et al. 2013: 19).

Even when popular and academic discourses claim that new models of family and parenting make kinship more equal and happier than even before, feminist scholars have warned that the time is not for complacency. They argue there is a need to visualise how traditional ideologies concerning kinship continue to apply hierarchies of kinship, reflecting existing social hierarchies and having profound implications on people's lives and well-being. Indeed, one of the key arguments of this chapter is that ideologies of "who counts as family", "who is a good mother", "the selflessness of blood ties" and "the power of love to keep couples together" continue to influence common practices, laws and social and healthcare policies. Studies have shown how patriarchy and policy, through the State and its "guardians", work together to perpetuate inequalities within kinship on the basis of race, gender and social class.

I am not claiming that kinship is inherently oppressive. I recognise that there can be "alternative" kin arrangements that can be experienced as more egalitarian. Likewise, I do recognise that the same ideologies that make kinship oppressive may be performed to transgress. As Borneman (1997) argues in his insightful article, *The Ethics of Kinship*, persons are agents in the production of kinship, rather than passive subjects.

As kinship was one of the hallmarks of anthropology and sociology for decades, excellent detailed overviews of classical (Peletz 1995) and feminist works (Collier and Yanagisako 1987; Franklin 1996; Franklin and McKinnon 2001; Pichardo-Galán 2009; Tarducci 2011) exist; there is no need to repeat them here. What is important is the persistence of dated and widely contested anthropological theories on kinship, mostly related to understandings of motherhood and the family, in current West European and North American cultures. These flawed concepts ensure that anthropologists, as much as policy makers, health practitioners, lawyers and so on, fail to recognise a variety of non-conforming models of kinship that exist today.

The chapter is divided into three sections. In the first section, I present a brief overview of key classical and feminist issues around kinship. This helps the reader understand how kinship is framed by cultural understandings of sexuality, blood ties, race, class and gender roles. The second section provides contemporary examples of how understandings of kinship apply to health. The common theme running through these examples is that old ideologies of kinship show "themselves" in the ways that people are allowed to arrange their lives. In the first example, I explore the links between sexuality, kinship and economic injustice. In the second, I focus on how violence is justified by kinship in the name of love and trust. For the final example, I show how the social and biomedical emphasis on biological motherhood encourages women to undergo numerous tests and treatments. This quest for reproduction is often physiologically invasive and emotionally demanding. The final concluding section proposes new possibilities in the study of kinship.

Anthropology and Social Sciences Studies of Kinship

Classic Anthropology and the Study of Kinship

During late nineteenth and early twentieth centuries, classical anthropologists thought of kinship as the basic factor in life and cornerstone of social structure. Kinship was described as the glue that keeps individuals together and organised society. The bedrock of this thinking was the assumption that the nuclear, heterosexual, Western family was natural, something that anyone would aspire to be part of.

Malinowski, for instance, reiterated that "the tradition of individual marriage and the family has its roots in the deepest needs of human nature and of social order" (Briffault and Malinowski 1956: 28). This model of kinship came to be normalised and equated with civilisation itself. It was used as a benchmark against which to compare, judge and sanction other kinds of kinship or social arrangements which did not fit this model, domestically and abroad.

These early views of what constituted kinship were not based on issues such as lust, affection or kindred spirit, but were influenced by anthropologists' ideologies and beliefs about the true ties of kinship that derived from intercourse. In revising Schneider's work on the criticism of classic study of kinship, José Ignacio Pichardo-Galán (2008: 36) argues that "heterosexual genital coitus" occupied a central position in two of the most influential classical theories on kinship, namely "descent theory" and "alliance theory". Pichardo-Galán explains that intercourse symbolises the union of the family in two levels: a vertical level through blood (descent) and other horizontal level through law (alliance).

Central to the descent theory is the belief that kinship is intrinsically biological. It was thought that intercourse enables conception by allowing the traffic of genes and blood from a man (husband) to a woman (wife), which in turn culminates in procreation. It was thought only natural that blood is a bonding substance, creating a strong connection between mother and child. There was a conviction that blood ties are unbreakable and able to endure generations (Pichardo-Galán 2008: 36). This belief is encapsulated in the old adage, "blood is thicker than water".

Alliance theory supports the notion that intercourse between a married a man and a woman create special bonds of alliances between the couple and their families. Like in the case of descent theory, family bonds were assumed to be unbreakable. Concerning the endurance of blood and alliance kin relations, Malinoswki said:

> Why do I so confidently affirm the strength and permanence of marriage and family? Because my conviction is derived from the scientific study of the two institutions, extended over the widest compass of human experience, that embraced by anthropology. This science teaches us, that marriage and the family are rooted in the deepest needs of human nature and society; that they are associated with progress, spiritual and material. (Briffault and Malinowski 1956: 28)

At this time, Christian discourses about love between husband and wife started to gain prominence. The focus on love reflected a concern with controlling (women's) procreation and living arrangements. Paula Tabet (1987) in her ground breaking essay *Imposed reproduction: Maimed sexuality* argues that marriage served to guarantee heterosexual monogamy. It also served to ensure women's procreation through compulsory, marital intercourse since women were "regularly available for coitus" (see Beach 1974 in Tabet 1987: 132). It was not simply that marriage was the legal structure to ensure that only husbands fathered their wives' children. The definition of marriage became love, and love became a tool to domesticate female sexuality and family arrangements.

As I will illustrate in the next section, marriage's naturalised status helped to legitimate the view that it is as a private zone, free from anyone's intervention. Violence within the matrimonial home could be easily concealed or overlooked. In contrast, classical anthropologists treated the family as a conflict-free unit that operated together, in a kind of orchestrated collaboration, to maximise the benefits of the "group".

Finally, the classic study of kinship assumed that women were responsible for children and the household, while men were the breadwinners and engaged in politics. In fact, an early, large body of kinship studies was concerned with "the woman question". This hypervisibilisation of women in the home was deceptive for feminist anthropologists and sociologists. They argued that the inclusion of women in studies was merely relegated to the observation of their "natural roles as primary restricted to the private; domestic sphere" (Franklin 1996: xiv).

David Schneider, a Turning Point in Kinship Studies

David Schneider's work is often cited as a crucial turning point in kinship studies, revitalising the field. Writing in the 1960s, he helped to unpack two engrained preconceptions about family and kin relations. The first is what he termed the "Doctrine of the genealogical unit of mankind", which is still commonly encountered in everyday discourses on kinship. By this he means the presupposition that blood or genetic ties are the same in every culture. Schneider argues that this assumption derives from the anthropologists' narrow Euro American-centric imagination about kinship (Schneider 2004: 271).

Schneider (2004: 271) stresses that biogenetic identity could be understood as cultural symbols for social relationships. These symbols are not necessarily the same in every society, "and probably do not derive from, nor stand for, the biological material they purported to order functionally". Cross-cultural comparisons produced biased generalisations and the invisibilisation or pathologisation of kin diversity.

The second assumption he dismantles is the view that physiological "phenomena" such as pregnancy, breastfeeding and birth are a "given". He explains that the biological or physiological processes related to reproduction are universal. However, the experience, practice and meanings of these biological phenomena are not (Schneider 2004: 266). (See the discussions of abject bodies in Chap. 3; the reproduction of human life in Chap. 4 and the notion of "gift" in pregnancy in Chap. 7.) In other times and cultural contexts, the meaning of kinship was different. Implied in his work is an appeal to break from classical anthropologists' tendency to judge "alternative" or "non-common" models of kinship and motherhood.

However, Schneider has also been criticised. For instance, Moncó (2014: 118) states that he did not question the idea that the family is a harmonious unit. Franklin and McKinnon (2001: 14) note that his focus on criticising ethnocentricism was at the expenses of: a lack of consideration of how scientific models come to occupy a central role in defining kinship; how local understandings of biological phenomena are culturally shaped; or examining culturally specific forms of biologicism. Peletz (1995: 348) notes that a major problem in Schneider's analysis is that while he contributed to "decenter[ing] biology from the study of kinship, he has not denaturalised the study of kinship".

Feminist Killjoy: Turning the Study of Kinship Upside Down

Rich and nuanced feminist scholarship has turned the study of kinship upside down by dismantling several naturalised assumptions. These analyses have questioned the key concepts that moulded its study and influenced praxis, including "love", "family" and "motherhood".

As Jane Carsten once observed kinship is about: "people's everyday lives and the way they think about the relations that matter most to them" (Social Science Space 2016). Similarly, Giddens (1992) assumed that "pure relationship" has democratised relationships and triumphed over racial, gender, sexual and class prejudices. His term resonates with a sense of affection, trust, freedom, love, kindness, individual choice, transcendence and equality. But I argue that there are two caveats to these popular understandings of kinship. (1) What people may feel are legitimate kinship relationships, states may criminalise them (e.g. same-sex relationships) or society may deem these unacceptable such as intergenerational relationships, single motherhood, interracial marriage and queer or trans parenting (see Llopis-Navarro 2015; Rubin 1984). (2) (See the discussion of radical inclusive embodiment in Chap. 3.) The individual experience of love and kin relations is shaped by "external" and "structural" levels of power relations, including socio-political and economic contexts and institutions. In this section, it would be impossible to review all the contributions of feminist scholarship to kinship studies so I will focus on two pressing questions: the meaning of motherhood and kinship as a locus of social class, gender, ethnicity and sexuality.

Problems in the Conceptualisation of Motherhood

Walks's (2010) revision of the anthropology of mothering suggests that, aside from notable exceptions, the topic was under-researched until the mid-1990s but has expanded considerably in the last 15 years (See excellent reviews by Hanmer 1997; Nicolson 1997). However, women activists and scholars have theorised the various questions related to motherhood for decades: whether it is oppressive or empowering; who counts as a mother; what mothers do or how they should feel. Feminist anthropology and history have been invaluable to challenge myths about the links between motherhood, biology and behaviour. These analyses show that social understandings of motherhood vary over time and across cultures. That is, they show that there is no one model of being a mother. For instance, the now mainstream and pervasive ideas that women are selfless mothers, that filial love is unbreakable and that breastfeeding is the epitome of bonding are fairly recent and date back to Victorian times.

There is a strand of feminism that argues that motherhood is the primary source of women's oppression (i.e. Tabet 1987). They highlight that the hegemonic model teaches women to aspire to become mothers. A useful concept is that of "repronormativity" which acknowledges the social expectation that women will become mothers (Roberts 2012: 780). Thus, non-motherhood is portrayed as a no option and infertility as a tragedy. In some cultures childlessness is viewed as a woman's failure and she may be subjected to social isolation, invasive fertility treatments, violence and even divorce (Frigolé 1995; Inhorn 2003). Examples from two high-profile women in the USA and the UK suffice to demonstrate that the myth that cast childless women as incomplete and incompetent persists. In July 2016, British conservative politician, Andrea Leadson, said that her party rival, Theresa May, was not well equipped to run as prime minister because she does not have children which makes her "a sad woman with no stake in the future" (Williams 2016). The same week, actress Jennifer Aniston, tired of speculations about her life, wrote a letter to the *Huffington Post* rejecting the notion that married women with no children are "incomplete, unsuccessful, or unhappy" (Aniston 2016). Given this oppressive context, it is not surprising that the development and proliferation of new reproductive technologies is one of the most obvious responses to (women's and their husbands') infertility.

Other feminist scholars view motherhood as a reflection of women's power to create life (Llopis-Navarro 2015). They contend that motherhood in itself is not oppressive. What makes the experience of motherhood oppressive is the familial, social, economic and political context. (See Chap. 7 on the exchanges between midwives and reproducing women.)

Non-medicalised and empowering motherhood should be revered and "reclaimed back" (Martha Fineman 1995: 234 in Roberts 1995: 141). Along these lines, Odent (2009) and eco-feminist scholars introduced the idea that the physiological experience of mothering—giving birth, breastfeeding, nurturing—is natural and can be orgasmic.

Blázquez-Rodríguez and Muñoz (2010) remark that even if these theories on motherhood acknowledge the need to contextualise the individual experience, they often tend to be essentialist by overemphasising the empowering dimension of motherhood and the inevitable role of hormones. These authors argue that discourses about the selflessness mother, motherly happiness and filial love are mechanisms to compel women to become biological mothers and behave *in a particular way*. Dominant views about mothers' behaviour, Roberts (1995: 146) contends, "are imbued with racial imaginary". It is also imbued with classist, heteronormative and able-bodyist imaginary. Hence, those women-mothers who do not conform with this narrow set of images are regarded as "bad mothers" or "unfit mothers" (Ettorre 2007; Moncó 2014; Scheper-Hughes 1993) and are likely to be criminalised (Roberts 1999) or forcibly sterilised (Mingus and Georgians for Choice 2006; Stolcke 1988: 117–20; Welbourn 2013: 170). The behaviour of single women, young women, black and ethnic minority women, disabled women, poor women, lesbian mothers, queer parents, drug-using women or women living with HIV is more harshly scrutinised than the behaviour of heterosexual, married, middle class, white women.

Blázquez-Rodríguez and Muñoz (2010) alert us that this "biologisation" of motherhood can be problematic for several reasons. First, it naturalises motherhood and so legitimates the idea of the maternal instinct, which implies that all women desire to become mothers. This ignores the fact that the felt or lived bodily experience of motherhood is socially constructed. Second, while mothering can be a pleasurable and fulling experience, one of the major criticisms of this approach is the focus on happiness and pleasure as integral to the experience of motherhood. This contributes to an overwhelming double silence: (1) The experiences of "ordinary" women who do not find motherhood fulfilling are not only invisible in public discourses, but their voices are hardly even considered by practitioners. (2) According to politician and LGBTQI activist Beatriz Gimeno (2014), the question of motherhood is still so taboo that it is effective in crushing any anti-motherhood discourse from within feminist academia-activist circles.

Kinship as the Locus of Class, Gender and Ethnicity

The politics of kinship have been central to feminist analyses which reveal the interplay among kinship and ideologies concerning gender, caste, ethnicity, class and age, which can perpetuate harmful traditions and human rights violations. This recognition of kinship as a site of state control and, as a site of power structures within the family, runs contrary to classical universalist assumptions that kinship alliances are freely chosen, egalitarian and harmonious. Ultimately as Lowenhauot-Tsing and Yanagisako (1983: 511) observe kinship formations can only be "understood as embedded in particular economic, political and social systems", and so there is an urgency to frame these analyses in historical contexts. Examples abound and should come readily to mind: the criminalisation of interracial marriage in the South African Apartheid; anti-miscegenation laws in the USA; Canada's Indian Act and contemporary resistance to intercaste marriage in societies such as India or Senegal.

Feminist analysis of rape as a weapon of war shows how classical theories of kinship are deeply patriarchal (i.e. sexist) and implicated with racism (Brownmiller 1979). (See the discussion of differential health vulnerabilities in violent conflicts and their health effects on women and children in Chap. 2.) To understand why rape is sought to destroy whole ethnic communities, we need to understand the main ideology that sustains it: that paternity is the central social relationship, which Barbara Katz Rothman (1994: 140) calls "patriarchal kinship". From this ideology we can discern four assumptions: (1) biological fatherhood through intercourse is essential to paternal rights and pride; (2) the father's seed (genetic tie and blood) is the ultimate marker of the child's identity; (3) the woman is an object that belongs to their family and her role is to reproduce men's offspring; and (4) the woman's body is merely an "oven". Thus, she has little role in shaping the child's identity.

In societies where women's chastity is valued and where there is strong emphasis on biological fatherhood, rape is conceptualised as a form of reproductive control to clean ethnic groups. In Yugoslavia (Drakulic 2001), Rwanda (Fox 2011) or Chechnya (Rousseva 2004), women who had been raped were likely to be regarded as polluted with the "seeds" of ethnically different enemy men. Social ostracism, divorce, honour crimes or kin violence were common phenomena during conflict. For those women who were single their chances to marry were reduced drastically. Thus, reproduction of the ethnic group was halted in four ways: (1) no men wanted to have children with polluted women; (2) women's infertility was a common sequel of the brutality of rapes; (3) abortions and killing of "contaminated" babies was sometimes the only option available to women to avoid, or minimise, violence; and (4) in some cases, women were murdered for bringing shame to their husbands and families. If de Beauvoir famously asserted that "One is not born, but rather becomes, a woman", the reverse can be said for understanding kinship and rape as a weapon of war: babies do not become members of the mother's ethnic group through socialisation and nurturing, but are born polluted forever.

Kinship is not only a form of institutionalised sexism and racism but also homophobia, classism and islamophobia. Saskia Wieringa (2011) considers how lesbophobia and islamophobia are barriers to her transnational, inter-ethnic and religious marriage. She describes how the "war on terror" justifies racist and islamophobic migration laws in the Netherlands, splitting families apart. These laws make it harder for citizens from poor Arabic countries to access the country to be reunited with their families. For instance, it is required that "foreigners take a language test in the Dutch embassy of their countries" and "the Dutch partners must earn 120% of the minimum wage" (p. 791). Wieringa notes that social class converges with ethnicity, religion and sexuality to shape kinship as poorer "foreigners" who are less likely to be able to afford private tuition fees in their countries—and a minority of Dutch workers earn that much money. Additionally, in the country of her spouse, a major Asian country, same-sex marriage is not recognised and lesbophobia is common—a barrier to the couple to celebrate their feelings freely. For Wieringa in particular, this denies her access to basic rights such as residence and access to her spouses' properties bought with common money (p. 789).

Perhaps the most basic challenge that feminists have posed globally to traditional views of kinship lies in the recognition of marriage as a site of sexual violence. For much of history, the family has been described as "a strong force for social cohesion and integration, intergenerational solidarity and social development"[1] (OP6 in The Association for Women's Rights in Development 2015). Not surprisingly, the now familiar words of Olympe de Gouges in 1971: "Marriage is the grave of trust and love" (in Varela 2002: 32), and Kate Millet almost two centuries later: "women's oppression began in the bedroom" (in Jackson and Scott 1996: 17) become sort of revolutionary. Sadly, statistics from Spain show that sexual violence within marriage is still a reality. In 2005 it was estimated that 47% women that suffered sexual violence were abused by partners or ex-partners and 19% by a relative. Only a 12% were abused by strangers

(Federación de Mujeres Progresistas 2005 in Porroche-Escudero 2007: 154). Similar data applies to the USA (Kim 2012) and many countries in Asia (Wieringa 2014: 28).

The concept of domestic violence is preferred by some feminists to stress the fact that violence occurs within the family setting (Mohamad and Saskia Wieringa 2014). The sanctification of the family means that sexual violence within the home was not criminalised in many countries until the end of the twentieth century. Unfortunately, some countries still have narrow and patriarchal definitions of rape, which make it difficult for women spouses to escape violence. For instance, rape is understood as "forced intercourse *outside* marriage", "forced intercourse *with a woman other than the wife*", "it needs visible signs of *violence* and *semen*". Other feminists, however, argue that the concept of domestic violence is limited. As it is only concerned with traditional modes of marriage, it overlooks the needs of LGBTQI and persons living in non-traditional families and relationships (see Olivella 2016).

Kinship and Health

Kinship matters for health because it has tremendous impact on people's lives. It is worth remembering that the World Health Organisation (World Health Organization 1998) reminds us that health is not only the absence of illness. Physiological, psychological and social well-being are integral parts of health. People's well-being can be compromised by social or legal expectations, norms, sanctions and obligations tied to kinship. I argued somewhere else that economic well-being is also an integral part of the definition of health (Porroche-Escudero and Figueroa 2016) and I emphasise it here again. I want to focus on three examples that illustrate how traditional heteronormative models of kinship continue to be imposed on people through legal and social arrangements, causing tremendous impact on health: (1) heteronormative marriage and economic injustice; (2) the violence implicit in "amorous thinking" (Esteban 2011); (3) biological repronormativity and health.

The term heteronormativity was adopted by feminists to emphasise the social assumption and enforcement of heterosexuality as the norm.

According to Lisa Duggan (Duggan 2013) heteronormativity reduces people's behaviour and sexual orientation to their genitalia, understood in binary terms: penis/vagina. The resulting simplistic equations would be like this: (1) man = penis = male = acts masculine (i.e. dominant, breadwinner) = likes women; (2) woman = vagina = female = acts feminine (i.e. passive and caring) = likes men.

These equations reinforce the "old" views around love and marriage explained earlier because they assume that a man or woman are attracted to each other and are committed to live in legal, monogamous, reproductive and non-commercial relationships (Rubin 1984: 152). Needless to say heterosexuality, as practised in the nuclear family, is thought to be "good" and "natural". Everyone who threatens this equation is deemed sick, deviated, dangerous and untrustworthy. Their claims to legalise their relationships or claim parenthood rights are questioned, retaliated or "invisibilised". Saskia Wieringa (2014: 28) explains this well:

> heteronormativity informs the normativity of daily life, including institutions, laws and regulations that impact the sexual and reproductive lives of members of society as well as the moral imperatives that influence people's personal lives.

With such a narrow view of sexuality, it is not difficult to envisage the repressive effects on kinship in everyday life.

The Enforcement of Heteronormativity, Economic Injustice and Health

Sexual and economic justice has been a central political issue for feminists. This is perhaps because legal kinship, in particular legal marriage, still remains the most powerful institution in conferring rights and privileges, such as access to life opportunities and socio-economic resources (Tabet 1987). Those individuals who do not conform with this normative model of heterosexual social and sexual reproduction are not likely to be recognised legally. This means that they are excluded from resources, increasing their risk of being exposed to material poverties. So close is the link between economic injustice and marriage that feminists have long denounced that “decisions about intimacy are heavily influenced by resources” (Bedford and Jakobsen 2009: 4). The links between sexuality, economic hardship and ill-health have also been well established in law (Roberts 1993a, 1997, 1999) and international development (Bedford and Jakobsen 2009; Khanna 2007). The outcome of these links should not be underestimated: they increase mortality, profound psychological suffering, as well as a vast array of health problems derived of violence and deprivation, that can lead to feelings of powerlessness and also to greater use of social and health services.

In different parts of the world single women, widow women, mother sex workers, queer people, queer families, people living in “illegitimate” open, intergenerational, interracial or transnational relationships cannot claim rights to land, children and property, or cannot access basic banking services such as borrowing money for a mortgage or pursuing educational opportunities, which in turn will affect their employment and saving opportunities. As the example of Saskia Wieringa’s marriage illustrated, many of these persons may have long-term partners but, if their relationships are not legally recognised, they will not be able to benefit from their partner’s pension or inheritance in case of death (see also Borneman 1997: 577).

There are many other direct connections between the enforcement of heteronormative marriage, material poverties and health. For instance, Bedford and Jakobsen (2009: 4) note that in the USA “a major means of acquiring health insurance is to be placed on the health plan of a partner”. Writing about China, Xiaopei He (2013: 109) suggests that there are 20 million gay men, a high majority (80–90%) of which will marry a woman at some point due to social pressures or family expectations. The health effects of compulsory marriage are multiple. Gay men are tied to unsatisfying marriages and suffer in silence since homosexuality is linked to sickness and perversion. Disclosing one’s sexual orientation may threaten employment and family relationships. Fear of being caught having sex with other men may lead to rushed unprotected sexual encounters increasing the risk of HIV (Cornwall and Jolly 2006: 4). The health of these gay men’s wives is also compromised. Wives are not only exposed to HIV risks, but their awareness of their husbands’ sexual orientation may cause distress, loneliness and shame. Divorce is not always an option for economic reasons. For instance, houses are typically registered with their husband's name and wives are less likely to be in full-time employment (He 2013: 109). Economic insecurity further contributes to the spiral of affliction and tension within the household.

Something similar is happening in Spain. According to Castro-Martín et al. (2015: 46) mounting evidence shows that the economic recession of 2008 and subsequent austerity measures are having an impact on demography, particularly on declining divorce rates. Similar studies suggest that economic hardship as a consequence of unemployment, evictions and salary cuts increases tensions within the household that typically would finish marriage (see Chowdhury 2012 in Castro-Martín et al. 2015: 46). Paradoxically, the same economic hardship that breaks havoc on relationships makes divorce a no option since it is too costly because living in separate households is expensive. Many spouses, often women, are likely to be unemployed (i.e. taking care of the household and children) or underemployed. In these situations, a divorce may end health benefits and economic security. Living in unhappy relationships compounded with economic hardships places a heavy burden on health. These trends apply EU-wide and beyond (see Cohen 2014). Armour's (2009) article appeared in the media outlet *USA Today* and speaks to this trend arguing that "Love isn't all that's keeping family together today. The bruising housing market is, too".

Readings on welfare in Singapore (Teo 2013), the USA (Roberts 1993b) and on structural adjustment programmes in the Global South, Bedford and colleagues arrive at the same conclusions: marriage is used widely as a poverty policy and strategy (Bedford 2009; Bedford and Jakobsen 2009). And this is problematic. A safe bet for countries or NGOs to secure funding from donors is to design programmes that "keep the family together". As a consequence, individuals in need of support will have to perform, or conform with, the legal model of kinship to be eligible. There are several elements of unfair heteronormativity here. First, being married or having a family is a pre-condition to receive support (such as employment opportunities, conditional cash transfers). Thus, those persons in need who are outside legal marriage or kinship relationships not only are treated as "less than citizens" but also are more likely to fall into a downward spiral of poverty that leads to health problems. Second, the compulsory nature of heterosexual marriage—since other forms of social arrangement are not recognised in many countries—perpetuates dependence of vulnerable spouses. Third, these programmes do not ensure the well-being of the members of the family, particularly women's. The two assumptions behind these programmes are: (1) that the family is a happy unit where resources are equally distributed; (2) that if you invest in a woman-mother you will give her family a hand out of poverty—the development mantra of women's mothering instinct and responsible nature that will invest in family (Cornwall et al. 2007). These assumptions are deeply flawed because the household is not free from gendered and other forms of power dynamics. In fact, getting access to resources does not guarantee that women will benefit from them. As Palestinian scholar Eileen Kuttab argues "women don't only want access to resources, but also control over them" (The Pathways of Women's Empowerment Research Programme Consortium 2011: 23), challenging the idea that resources will be equally distributed within the household. Ironically, in many instances the introduction of these programmes has only served to increase women's exposure to existing violence, rather than addressing the need to consider women or individuals rights to get support regardless of kinship arrangements.[2]

Given these grim examples it is not difficult to understand why the Hausa Women of Niger cited by Tabet (1987: 7) spoke of marriage as sex exchange for economic certainty: "women have only their sex to make a living with".

Amorous Thinking and Gender Violence

In Spain more than 1378 women have been murdered since 1995 by men.[3] I noted before that an important number of murders are committed by their husbands, partners or ex-partners. Violence among adolescent and young couples is also on the rise. Conservative estimates suggest that one out of ten young couples is affected by gender violence. Other studies argue that violence affects five out of ten couples (Herranz-Bellido 2013: 12). The burden of this violence falls heavily on young women. This situation applies to Spain and beyond. In this section I want to zoom into the phenomenon of gender violence to show how the "amorous thought" is a social determinant of gender violence within a couple, whether they are married or dating.

Mainstream contemporary discourses on love are not new and are not exclusive to Western societies. What changes are its emic manifestations (e.g. attitudes, fantasies, roles, emotions, values and relationships). Yet there are some elements in common: (1) emotional dependency (Jankowiak and Fischer 1992); (2) durability, passion and freedom Enguix and Roca (2014: 2); (3) individual fulfilment, freedom and reciprocity (Giddens 1992); and (4) truth and trust (Lindholm 2006). Enguix and Roca (2015: 2) suggest that these ideals of love have "emerged as a more or less hegemonic global benchmark" against which to measure the legitimacy of social relationships. In contrast, a wealth of feminist work has exposed how these ideas about love are not only based on rancid ideas about kinship but are harmful as the above statistics confirm.

To this endeavour, Mari Luz Esteban (2011) proposes the concept of "amorous thought" because it extends well beyond traditional analysis of gendered dynamics between couples. Instead, the concept allows examination of how ideologies of love have ramifications in every single domain in life, including education, culture, health, couples' relationships or law. Hence, these ramifications affect everyone, including institutions, not just couples.

A report by the Government of Alicante, Spain, on gender violence within young couples defines these ramifications as "structural factors that increase the risk of gender violence within young couples" (Herranz-Bellido 2013: 11). The report identifies two categories. The first one is the formal and informal social structure and institutions which impact people's lives. These include: (1) the educational system that reproduces gendered stereotypes about boys' dominance and girls' submissiveness; (2) religious institutions which justify violence[4]; (3) the judiciary system that blames the victim and minimises the injury[5]; and (4) stories, books and the mass media that transmit models of relationships or courtship that glamourise and normalise violence. For instance, romance books such as Johanna Lindsay's saga about the *Malory Family* eroticise rape and perpetuate the myth that when women say no it means yes. Films *Love*

Actually and *You've Got Mail* (Beck 2016; Chatel 2016) romanticise the figure of the stalker and yet abound and are marketed as family movies. Songs that make apology of romantic violence(s) such as Rihanna's *I like the way you lie*, Lady Gaga's *Bad Romance* or Enrique Iglesias' *El perdón*[6] (Forgivenesses).

The second category comprises cultural values and beliefs that shape an individual's personality but also all the dimensions of the social structure as presented above. These values include the idea that women are objects to be possessed by men; the idea that men are dominant and aggressive by nature and women are submissive. It also includes myths about romantic love, including: "jealousy is expression of love; love can fix anything; love can do anything; endure violence from the partner is a sign of love; there is not violence with young couples; women need to be educated so they know what is their place; when the aggressor apologises, he is really sorry and he will change" (Herranz-Bellido 2013: 17).

Exposure to myths presents a paradox (Lippman 2015; Seoane-Pascual 2012). While myths do not lead to a greater endorsement of violence—few persons will openly acknowledge that gender violence is a good thing—there is an uncritical acceptance of them by young men and women. According to Herrera Gómez (2012) the internalisation of these myths not only serves to control spouses or partners but anaesthetises the effects of violence. For instance, many women and aggressors may not identify certain actions as violence.

Moreover, violence is not only physical but it operates "when it affects the emotions that impedes women to react" (Neira 2016). Unconditional trust, unconditional giving, fear to denounce the situation, feelings of shame, inability to speak out or to stop unwanted sex or to identify certain relationships as unhealthy are some forms in which myths about love anesthetises and manipulates emotions.

For Mari Luz Esteban a first step towards rewriting the social scripts about love is through educating: "no one should say 'don't fall in love' but 'take the harness', 'protect yourself'" (in Asensio-Lozano 2012). There is a wealth of inspirational examples from grass-roots organisations that are working to rewrite the scripts about love in a way that fosters equity, reciprocity and respect (Knerr and Philpott 2008).

Biological Repronormativity and Health

Spell-binding articles by Dorothy Roberts (2012), *The social context of oncofertility*, and Marcia Inhorn (2003), *Male infertility and patriarchal paradoxes in Egypt*, as well as fascinating conversations with my informants, colleagues and friends, provide the basis of this reflexive final section on the health implications of biological repronormativity.

When I started my fieldwork research on breast cancer and social inequality in Spain in 2006, and later in 2007–2008, the reproductive concerns of women facing cancer diagnosis and treatments often seemed to be ignored by biomedicine. The main goal of health professionals was to cure women from cancer, other concerns were considered as a kind of "luxury" or "secondary" to the disease. Around those years, Teresa Woodruff, a formidable expert in ovarian biology, coined the term of oncofertility and established the Oncofertility Consortium which brings together the fields of oncology and fertility. Her goal was to address this important aspect of cancer that was been neglected by "expand[ing] fertility options for cancer survivors". Ten years past and oncofertility is now a well-established and respected field in many Western countries. Similarly, in other contexts, new reproductive technologies (NRTs) have opened spaces for non-married and non-heterosexual couples to have children without a medical "diagnosis of infertility" (see Mouzo Quintáns 2016). As I alluded before, in countries where infertility "is a form of reproductive morbidity with profoundly gendered consequences", including violence, social isolation, divorce and death (Inhorn 2003: 237), NRTs have brought hope, happiness and safety to many women. (See the related discussion on global "reproscapes" in Chap. 4.)

All that glitters is not gold. Inhorn (2003) and Roberts (2012) have cautioned that the line between "expanding the range of women's choices rather than influencing what their choices should be" (Roberts 2012: 780) is a blurry one. The authors demonstrate that, often times, women's desire to become mothers can stem from deeply conservative ideologies about kinship as well as from family's pressures. Private clinics capitalise on these social anxieties. To paraphrase Jonathan Metzl (2012: 213) on biotechnologies, NRTs can be at once "life-saving" (from abuse and stigma), "generative" (create life) but they can also be "life-destroying", "cancerous" and "oppressive". Below I offer four observations of how NRTs can be detrimental to health.

1. NRTs are expensive. In countries where NRTs are not freely available through the healthcare system, individuals and couples from lower socio-economic backgrounds are less likely to be able to afford quality fertility treatments. In some instances, as reported by Inhorn (2003: 236, 247), women may resort to painful traditional remedies and biomedical "therapies that are obsolete in the West and that may create infertility problems where none existed". Thus, women from lower socio-economic backgrounds are more likely to be exposed to the gendered consequences of infertility such as stigma, abandonment and violence.

2. Many forms of NRTs are hard on the soul and hard on the body. The probability of conception is extremely low. Most women will have to undergo multiple rounds of treatments to become pregnant. But becoming pregnant does not guarantee that women will deliver a live baby. The process is long and arduous: it requires tests, treatments, successful conception and successful gestation. It is also delicate: if the probabilities of conception are low, the probabilities of carrying a child to term through these technologies are even slimmer. Significant amounts of emotional labour are required to endure the process and manage hopes and risk. Unsuccessful conception and gestation can be a painful experience of bereavement.

In many cases, as described by Inhorn and as I have seen through the years, the quest for biological motherhood can become relentless: always one more test, one more cycle. In some circumstances, it may create a host of new health problems. We do not know, however, how well informed women are about these health risks. For example, we know that some forms of breast, womb and ovarian cancer depend on oestrogen (the female hormone) to grow and reproduce itself. Some NRTs require heavy oestrogenisation of the body, which can increase the risk of developing cancer. This raises questions about NRTs' safety that are absent from public discussions. For instance, (1) how many cycles of IVF are safe for women who have a history of cancer diagnosis? (2) Are healthy women seeking fertility treatments increasing their chances of developing cancers? (3) What happens with those women who move between the private and public health sectors to seek treatments? Who is accountable for them? (4) If fertility treatments are psychologically straining and potentially hazardous, and there are safe alternatives to biological motherhood, should we not take the precautionary approach and simply presume that oncofertility treatments are dangerous until proven otherwise? (Porroche-Escudero 2016) If so, when should it be applied? As Dorothy Roberts (2012: 789) puts it:

> Given the ordinary health risks of egg harvesting, combined with additional interference with their cancer treatment, some women may prefer a less hazardous alternative, such as adoption or remaining childless.

Indeed, women may prefer alternative models of mothering if they knew the health risks. Yet, for women to be able to weight up the benefits against the risks, they need to access clear, balanced and evidence-based information. The problem is that a lot of women, and their partners, seem not to be properly informed.

3. The emphasis on biological motherhood and NRTs can mask some of the structural causes that make women childless. (1) Inhorn cites a study by the World Health Organisation that "found that men are the sole cause or a contributing factor to infertility in more than half of all couples around the globe" (Cates, Farley and Rowe 1985; Reproductive Health Outlook 1999 in Inhorn 2003: 237). (2) Environmental medicine demonstrates that most of the eight causes of male infertility cited in Inhorn's article (e.g. irregularities in the pH of the seminal fluid, absence of sperm; poor sperm motility, etc.) are linked to environmental pollution (Davis 2004 see her Chapter 5, "Save the males"). (3) Environmental health and gender medicine demonstrate the links between women's livelihoods, environmental degradation and infertility and cancer (Jacobs and Dinham 2003; Lynn 2007) (4) Finally, occupational and environmental health research shows that persons with low-income and of ethnic minority are at a higher risk of developing cancer and problems with the reproductive system as a consequence of their greater exposure to environmental hazards in the working and living conditions (see Brown

1995). And yet, women continue to be blamed and shamed for their infertility, which can make them opt for dramatic treatments and tests which may cause serious emotional and physiological harm.

4. Roberts (2012: 787) observes that women can also be infertile as a consequence of structural circumstances such as material poverties that make them “postpone[d] childbearing until an age when they have a greater risk of getting cancer”. As I have argued elsewhere, "it is not that these women develop breast cancer because they are nulliparous (do not have biological children) per se, but that cancer risk increases with age for all women, those who have biological children and those who do not." (Porroche-Escudero 2016). The case of Carmina, one of my informants, illustrates this point well (Porroche-Escudero 2012). Making a long story short, Carmina was happily married but delayed having children because she was aware she would be fired from her cleaning job and she could not afford being unemployed. By the time the couple was a bit settled economically and decided to have a child, Carmina was diagnosed with cancer in 2006. As she suspected, she lost her job. When I met her in 2008, she explained with a mix of sadness and anger that she did not have a job, she did not have a child, she had a cancer and her prospects for becoming a mother were seriously compromised by treatments.[7]

Final Thoughts

The main argument of this chapter can be summarised very briefly. I have argued that ideologies about kinship that can be traced back to the patriarchal, white, middle class nineteenth-century Victorian Era, and which have long been debunked by feminist scholars, continue to influence practices, law, policy and healthcare, causing tremendous impact on health. To thread the argument, I provided an overview of classical anthropological theories of kinship and enriching feminist debates on the topic. First I outlined two classical theories about alliance and descent. Classical anthropologists assumed that the heteronormative nuclear family was the most natural and basic unit of kinship. According to the alliance theory, intercourse between men and women spouses created unbreakable bonds and love, which created harmony in the unit and kept society together.

According to the descent theory, biological motherhood was assumed to be a given. The genetic tie between parents and their offspring, especially the mother, was assumed to be instinctual and selfless. Second, I presented David Schneider's theories which demonstrated that classic cross-cultural comparisons were biased since they used a Western-centric yardstick to pigeon-hole *any* kin arrangement. This bias created generalisations and missed the opportunity to appreciate diverse models of kinship and motherhood free from moralistic undertones. Schneider argued that the experience of physiological events such as birth and breastfeeding is not universal but is influenced by the wider socio-cultural context. Third, I showed how feminist analyses turned upside down two sacred assumptions about kinship: that the family is a happy unit and that motherhood is natural, something any woman will aspire to be. At the core, these studies revealed that definitions of kinship are not "natural" and based on free choice and love; they are profoundly constrained by ideologies concerning gender, sexuality, caste, race, class and age that perpetuate discriminatory and unhealthy practices which cause violence and suffering.

Once I laid out existing theoretical debates, I presented three contemporary examples of how traditional ideologies of kinship continue to be invoked through legal and social arrangements: (1) the enforcement of heteronormative marriage under the threat of economic injustice; (2) the violence implicit in "amorous thinking" and how it shapes unhealthy relationships; (3) how the quest for biological motherhood underlies an obsession to undergo relentless, sometimes invasive, use of new reproductive technologies. Throughout the text I argued that those persons who do not fit narrow models of kinship and motherhood (i.e. white, heterosexual, married, reproductive, etc.) not only are excluded from all the social and legal benefits granted by marriage and motherhood but their sexualities and alternative kin arrangements are marginalised and even criminalised. While most of my examples are drawn from research in the "West", particularly Spain, it should be noted that these pressures are international ones.

Despite the fact that I have focused on the oppressive aspects of kinship in this chapter, I do recognise that kinship can provide energy to resist social pressures. It can also become a source of support for individuals and their families when they are affected by health crisis or economic hardship (Porroche-Escudero 2012). For instance, a study by Pichardo-Galán (2009: 345) found that the "family of origin" continues to be central to the lives of same-sex couples in Spain. Pichardo-Galán suggests that economic and material need—(as a result of the Mediterranean model of welfare state whereby the family is the at the core of most social and health policy)—imposes "trade-offs" between family members to support each other because: "the majority of homosexual people can't manage without the support of their families of origin, and families can't afford to lose the support of their non-heterosexual members". "Necessity", and not necessarily selfless love, was key in the process of accepting homosexual relationships in the country.

In researching materials for this chapter I have been struck by how often definitions of kinship change and how often individuals perform kinship to fulfil their economic, material and emotional needs. For instance, through marriage, kinship is consciously performed to conform with traditional ideologies to access rights such as inheritance, social status or healthcare. It is also performed in a manner that transgresses heteronormative models of family, stretching the boundaries of what kinship is about. For example, the cases of gender queer parenting or transmen pregnancies challenge preconceived equations about women = conception = nurturing = motherhood. But at the same time it challenges conventional linkages between fatherhood, masculinity and emotional aloofness. Strictly speaking, transmen are both biological mothers and fathers. In raising children outside heteronormative frames the gendered roles attributed to mothers and fathers are blurred (see beautiful interviews to Del LaGrace Volcano, Erik Huma and Mad Kate by Llopis-Navarro 2015).

However, even if kinship is strategically performed to transgress, any investigation of new models of kinship should question to what extent it really does challenge social norms about parenthood. In fact, I was surprised by the dominance of an old "obsession of having 'a child of one's own'" (Stolcke 1988). Aware of my own judgments, I have come to see kinship performance as a dilemma: it can be empowering and disempowering, all at once. This line of argument is not new and has been addressed by feminist research. Yet many studies still tend to adhere to a binary framework that polarises the debate by offering only two options: enabling and constraining. Most notably, in thinking how seemingly new models of parenting still expose a degree of genetic determinism, I came to comprehend that we need to acknowledge that the desire for biological children cannot be understood outside the many variables that circumscribe people's lives. In Chap. 3, Elizabeth Ettorre reminds us that some countries reject transmen and same-sex adoption on the grounds that transpeople are mentally unfit for parenting. Similarly, Dorothy Roberts's (2012: 783–84) work on oncofertility revealed that "cancer survivors often lack information about adoption and face discrimination by adoption agencies". Instead, new studies need to be sensitive to how the biological and emotional desire to become parents is intertwined with structural constrains.

Finally, another challenge for the future of kinship studies is to engage seriously with anti-maternal discourses (Gimeno 2014). As I have already noted, in many theoretical debates and women's narratives, motherhood is often studied as either a source of women's empowerment derived from their power to create life or as a source of women's subordination that relegates women at home, entails suffering, sacrifice and unpayable emotional work. Few of the only attempts to capture anti-maternal discourses tend to reproduce traditional notions of femininity by reinforcing the notion of women as nurturing. For instance, Berrington and Honkatukia's (2002) and Easteal et al.'s (2015) analysis of media articles of women who kill found out that murder was hard to justify by the media and public opinion unless related to psychological disorders. Some other research frames women's acts of infanticide within a wide web of gendered and class power relations (Qadeer and Visvanathan 2004; Scheper-Hughes 1993). Women's economic poverties, vanity and career ambitions are also arguments to explain why women may have anti-maternal discourses (Moncó 2014: 122).

Yet, few studies discuss biological mothers' embodied experiences of feeling nothing, or disgust, shame or anger at the new-born baby. I am not suggesting that all women who do not love their babies kill, abuse or neglect them. On the contrary, we know well that maternal love is not enough to raise children in a safe environment. Conversely, lack of maternal love should not determine women's ability to actively perform the duties and obligations expected of the mother role. Only by acknowledging women's multiple experiences of motherhood, even if it makes us uncomfortable, can we contribute to denaturalising the study of motherhood.

Notes

1. The family is not oppressive for married couples. Akshay Khanna (Khanna 2007: 10) argues that: "in many parts of the world the family is usually the first site in which … [those] who fall outside of the heterosexual norm will be faced with pervasive (even if unspoken) homophobia".
2. I do not deny the importance of legislation endorsing same-sex marriage to fully incorporate "gays and lesbians" rights into policy and practice. However, I think it is important to highlight some feminists' criticisms and disappointments which argue that same-sex marriage signals the control of the state and its machinery to regulate people's experiences of kinship. As Judith Butler eloquently put it in her article *Is kinship always already heterosexual?*, while the driving force of marriage is supposedly to be determined by love and choice, the legalisation of marriage reinforces a model of family which is neoconservative because it is hierarchical: it discriminates "those who live nonmonogamously, those who live alone, those who are in whatever arrangements they are in that are not the marriage form" (2002: 17). As I have argued in this chapter, discrimination leads to exclusion from resources, making it more likely that one will experience material poverties and thus increasing the chances of developing ill-health.
3. http://marcha7nmadrid.org/en/
4. For instance, only in the 1990s the Church's Guide for Catholic Marriage Preparation in Madrid stated that "women need authority to feel secured" (Varela 2002: 163–170).
5. Expressions such as "you must have done something to deserve that" or "it is sex, not violence" are common in court rooms (see Varela 2002).
6. For a brilliant analysis of Enrique Iglesias' song *El perdón* (forgivenesses) watch the educational video of the Psico Woman (2015). The analysis points out that acts of violence, whether physical or not, are never a single incident but a systematic pattern of control. It also unpacks how apologies are a form of emotional manipulation.

7. In 2012, Carmina emailed me wishing me Merry Christmas and sharing with me the good news of her eight-month pregnancy.

References

Aniston, J. (2016). For the record. I am not pregnant. What I am is fed up. *The Huffington Post*, May 12. Retrieved July 16, 2016, from http://www.huffingtonpost.com/entry/for-the-record_us_57855586e4b03fc3ee4e626f

Armour, S. (2009). More families move in together during housing crisis. *USA Today*. Retrieved July 2, 2016, from http://usatoday30.usatoday.com/money/economy/housing/2009-02-02-housing-crisis-families-living-together_N.htm

Asensio-Lozano, M. (2012). Entrevista a Mari Luz Esteban: Se Pueden Hacer Sacrificios Por Amor, Pero Siempre Deben Ser Temporales. *Pikara Magazine*. Retrieved July 19, 2016, from http://www.pikaramagazine.com/2012/03/mari-luz-esteban-%E2%80%9Cse-pueden-hacer-sacrificios-por-amor-pero-siempre-deben-ser-temporales%E2%80%9D-la-antropologa-explica-en-su-libro-que-en-la-cultura-occidental-tanto-la-sociedad-como-las-r/

Beck, J. (2016). Romantic comedies: When stalking has a happy ending. *The Atlantic*, February 5. Retrieved July 22, 2016, from http://www.theatlantic.com/health/archive/2016/02/romantic-comedies-where-stalking-meets-love/460179/

Bedford, K. (2009). Holding it together in a crisis: Family strengthening and embedding neoliberalism. *IDS Bulletin, 39*(6), 60–66.

Bedford, K., & Jakobsen, J. (Eds.). (2009). Introduction to towards a vision of sexual and economic justice. *The Scholar and Feminist Online, 4*(7.3), 1–49.

Berrington, E., & Honkatukia, P. (2002). An evil monster and a poor thing: Female violence in the media. *Journal of Scandinavian Studies in Criminology and Crime Prevention, 3*(1), 50–72.

Blázquez Rodríguez, M. B., & Muñoz, M. J. M. (2010). Emociones ante la maternidad: de los modelos impuestos a las contestaciones de las mujeres. *Ankulegi. Revista de Antropología Social, 14*, 81–92.

Borneman, J. (1997). Caring and being cared for: Displacing marriage, kinship, gender and sexuality. *International Social Science Journal, 49*(154), 573–584.

Briffault, R., & Malinowski, B. (1956). *Marriage, past and present: A debate between Robert Briffault and Bronislaw Malinowski*. Boston: Porter Sargent Publisher. Retrieved https://archive.org/stream/marriagepastpres00brif/marriagepastpres00brif_djvu.txt

Brown, P. (1995). Race, class, and environmental health: A review and systematization of the literature. *Environmental Research, 69*(1), 15–30.

Brownmiller, S. (1979). *Against our will: Men, women and rape*. New York: Bantam Books. Retrieved July 15, 2016, from http://psycnet.apa.org/psycinfo/2004-20005-001

Butler, J. (2002). Is kinship always already heterosexual? *Differences: A Journal of Feminist Cultural Studies, 13*(1), 14–44.

Castro-Martín, T., Martín-García, T., Abellán, A., Pujol, R., & Puga, D. (2015). Tras Las Huellas de La Crisis Económica En La Demografía Española. *Panorama Social, 22*, 43–60.

Chatel, A. (2016). 11 movie scenes that taught us stalking is romantic. *Bustle*. Retrieved July 22, 2016, from http://www.bustle.com/articles/138402-11-movie-scenes-that-taught-us-stalking-is-romantic

Cohen, P. N. (2014). Recession and divorce in the United States, 2008–2011. *Population Research and Policy Review, 33*(5), 615–628.

Collier, J. F., & Yanagisako, S. J. (1987). *Gender and kinship: Essays toward a unified analysis*. Stanford: Stanford University Press.

Cornwall, A., & Jolly, S. (2006). Introduction: Sexuality matters. *IDS Bulletin, 37*(5), 1–11.

Cornwall, A., Harrison, E., & Whitehead, A. (2007). *Feminisms in development: Contradictions, contestations and challenges*. London/New York: Zed Books.

Davis, D. L. (2004). *When smoke ran like water: Tales of environmental deception and the battle against pollution*. New York: Basic Books.

Drakulic, S. (2001). *Como Si Yo No Estuviera*. Barcelona: Anagrama.

Duggan, L. (2013). What is homonormativity? *Dismantling Homonormativity*. Retrieved March 7, 2016, from http://dismantlinghomonormativity.weebly.com/what-is-homonormativity.html

Easteal, P., et al. (2015). How are women who kill portrayed in newspaper media? Connections with social values and the legal system. In *Women's studies international forum* (Vol. 51). New York: Pergamon.

Enguix, B., & Roca (Eds.). (2015). *Rethinking romantic love. Discussions, imaginaries and practices*. Newcastle upon Tyne: Cambridge Scholars Publishing.

Esteban, M. L. (2008). El Amor Romántico Dentro Y Fuera de Occidente: Determinismos, Paradojas Y Visiones Alternativas. In L. Suárez, E. Martín, & R. Hernández (Eds.), *Feminismos en la Antropología: nuevas propuestas críticas* (pp. 154–172). Donostia: Ankulegi Antropologia Elkartea.

Esteban, M. L. (2011). *Crítica Del Pensamiento Amoroso: Temas Contemporáneos*. Barcelona: Bellaterra.

Ettorre, E. (2007). *Revisioning women and drug use*. New York: Palgrave Macmillan.

Fox, N. (2011). Oh, did the women suffer, They suffered so much: Impacts of gendered based violence on kinship networks in Rwanda. *International Journal of Sociology of the Family, 37*(2), 279–305.

Franklin, S. (Ed.). (1996). *The sociology of gender*. Cheltenham: Edward Elgar Pub.

Franklin, S., & McKinnon, S. (Eds.). (2001). *Relative values: Reconfiguring kinship studies*. Durham: Duke University Press.

Frigolé, J. (1995). *Un Etnólogo En El Teatro: Ensayo Antropológico Sobre Federico García Lorca*. Barcelona: Muchnik. Retrieved July 5, 2016, from https://dialnet.unirioja.es/servlet/libro?codigo=92361

Giddens, A. (1992). *The transformation of intimacy: Sexuality, love and eroticism*. Cambridge: Polity Press.

Gimeno, B. (2014). Construyendo Un Discurso Antimaternal. *Pikara Magazine*. Retrieved July 6, 2016, from http://www.pikaramagazine.com/2014/02/construyendo-un-discurso-antimaternal/

Hanmer, J. (1997). Women and reproduction. In V. Robinson & D. Richardson (Eds.), *Introducing women's studies* (pp. 349–374). Hampshire/New York: Palgrave.

He, X. (2013). Building a movement for sexual rights and pleasure. In S. Jolly, A. Cornwall, & K. Hawkins (Eds.), *Women, sexuality and the political power of pleasure* (pp. 93–110). London/New York: Zed Books.

Herranz-Bellido, J. (2013). *Violencia de Género En La Población Adolescente. Guía de Orientación Para La Familia*. Alicante: Diputación de Alicante, Unidad de Igualdad.

Herrera Gómez, C. (2012). La Violencia de Género Y El Amor Romántico | Pikara Magazine. *Pikara Magazine*. Retrieved July 19, 2016, from http://www.pikaramagazine.com/2012/11/la-violencia-de-genero-y-el-amor-romanticocoral-herrera-gomez-expone-que-el-romanticismo-es-el-mecanismo-cultural-mas-potente-para-perpetuar-el-patriarcado/

Inhorn, M. C. (2003). The worms are weak male infertility and patriarchal paradoxes in Egypt. *Men and Masculinities, 5*(3), 236–256.

Jackson, S., & Scott, S. (1996). Sexual skirmishes and feminist factions: Twenty-five years of debate on women and sexuality. In S. Jackson & S. Scott (Eds.), *Feminism and sexuality*. Edinburgh: Edinburgh University Press.

Jackson, S., & Scott, S. (2004). Sexual antinomies in late modernity. *Sexualities, 7*(2), 233–248.

Jacobs, M., & Dinham, B. (2003). *Silent invaders: Pesticides, livelihoods, and Women's health*. London/New York: Zed books in association with pesticide action network UK; Distributed in the USA exclusively by Palgrave.

Jankowiak, W. R., & Fischer, E. F. (1992). A cross-cultural perspective on romantic love. *Ethnology, 31*(2), 149–155.

Jolly, S., Cornwall, A., & Hawkins, K. (2013). *Women, sexuality and the political power of pleasure*. London: Zed Books.

Khanna, A. (2007). *The right to health and sexuality*. Mumbai: Centre for Enquiry into Health and Allied Themes Retrieved July 2, 2016, from http://eldis.org/vfile/upload/1/document/1311/cehat%20paper.pdf

Kim, J. (2012). Taking rape seriously: Rape as slavery. *Harvard Journal of Law & Gender, 35*, 263.

Knerr, W., & Philpott, A. (2008). *The global mapping of pleasure: A directory of organizations, media and people who eroticize safer sex*. Oxford: The Pleasure Project.

La Psico Woman. (2015). El Perdón Feat Psico Woman. Retrieved July 22, 2016, from https://www.youtube.com/watch?v=ggsz7oqMuUs

Lindholm, C. (2006). Romantic love and anthropology. *Etnofoor, 19*(1), 5–21.

Lippman, J. R. (2015). I did it because I never stopped loving you the effects of media portrayals of persistent pursuit on beliefs about stalking. *Communication Research* 93650215570653.

Llopis-Navarro, M. (Ed.). (2015). *Maternidades subversivas*. Tafalla: Txalaparta.

Lynn, H. (2007). *Politics and prevention: Linking breast cancer and our environment*. Utrecht: Women in Europe for a Common Future. Retrieved August 21, 2013, from https://www.google.co.uk/search?q=Helen+Lynn+(2007)+Politics+and+Prevention:+Linking+breast+cancer+and+our+environment.+Utrecht:+Women+in+Europe+for+a+Common+Future.&ie=utf-8&oe=utf-8&rls=org.mozilla:en-US:official&client=firefox-a&gws_rd=cr

Metzl, J. M. (2012). Structural competency. *American Quarterly, 64*(2), 213–218.

Mingus, M., & Georgians for Choice. (2006). Disabled women and reproductive choice. In Sistersong (Ed.), *Reproductive justice briefing book: A primer on reproductive justice and social change* (pp. 23–24). Atlanta: Women of Color Reproductive Health Collective.

Mohamad, M., & Saskia, W. (2014). The focus. Family ambiguity and domestic violence in Asia: Concept, law and process. *IIAS Newsletter, 67*, 21–23.

Moncó, B. (2014). Madres Y Madrastras: Modelos de Género, Heterodesignación Y Familias Reconstituidas. *Feminismo/s, 23*, 113–133.

Mouzo, Q. J. (2016). Salud Garantiza La Reproducción Asistida a Mujeres Lesbianas O Solteras. *El País*. Retrieved July 24, 2016, from http://ccaa.elpais.com/ccaa/2016/07/08/catalunya/1467994218_512486.html

Neira, M. (2016). Me Dejé Violar Por Amor. *Pikara Magazine*. Retrieved from http://www.pikaramagazine.com/2015/06/me-deje-violar-por-amor/

Nicolson, P. (1997). Motherhood and women's lives. In V. Robinson & D. Richarson (Eds.), *Introducing women's studies* (pp. 375–399). Hampshire/New York: Palgrave.

Odent, M. (2009). *The functions of the orgasms: The highways to transcendence*. London: Pinter & Martin Publishers. Retrieved July 5, 2016, from https://books.google.co.uk/books?hl=en&lr=&id=_nnrAwAAQBAJ&oi=fnd&pg=PT7&dq=odent+function+of+orgams&ots=7fBKRNxvPc&sig=CcTfgLsjdC4BGMx2xsSAy5KWDKI

Olivella, M. (2016). *Explorando Las (Im)posibilidades de Una Ley Interseccional Sobre Violencias de Género En El Estado Español*. Tarragona: Universitat Rovira i Virgili.

Peletz, M. G. (1995). Kinship studies in late twentieth-century anthropology. *Annual Review of Anthropology, 24*, 343–372.

Pichardo-Galán, J. I. (2008). Opciones Sexuales Y Nuevos Modelos de Familia. In A. Téllez-Infantes & Martínez-Guirao (Eds.), *Sexualidad, Género, Cambio de Roles y Nuevos Modelos de Familia* (pp. 35–64). España: Seminario Interdisciplinar de Estudios de Género del Vicerrectorado de Estudiantes y Extensión Universitaria de la Universidad Miguel Hernández.

Pichardo-Galán, J. I. (2009). *Entender la diversidad familiar: Relaciones homosexuales y nuevos modelos de familia*. Barcelona: Bellaterra.

Porroche-Escudero, A. (2007). (Re) Construyendo Mitos: Crítica Feminista Sobre La Construcción Social de La Sexualidad Femenina Y Sus Repercusiones En La Violencia Sexual. *Clepsydra: Revista de Estudios de Género Y Teoría Feminista, 6*, 139–158.

Porroche-Escudero, A. (2012). *Listening to women: Political narratives of breast cancer in Spain*. Ph.D., University of Sussex. Retrieved May 16, 2014, from http://sro.sussex.ac.uk/36135/

Porroche-Escudero, A. & Figueroa, B. (2016). Drets Econòmics de Les Persones Afectades de Càncer. In A. Porroche-Escudero, G. Coll-Planas, & C. Ribas (Eds.), *Cicatrius (in)visibles Perspectives feministes sobre el càncer de mama* (pp. 175–186). Vic: Eumo Editorial/UVic-UCC.

Qadeer, I., & Visvanathan, N. (2004). How healthy are health and population policies? The Indian experience. In A. Castro & M. Singer (Eds.), *Unhealthy health policy* (pp. 145–162). Oxford: AltaMira Press.

Roberts, D. E. (1993a). Motherhood and crime. *Iowa Law Review, 79*, 95.

Roberts, D. E. (1993b). Racism and patriarchy in the meaning of motherhood. *American University Journal of Gender and the Law, 1*, 1.

Roberts, D. E. (1995). The unrealized power of mother. *Columbia Journal of Gender and the Law, 5*(1), 141–151.

Roberts, D. E. (1997). *Killing the black body: Race, reproduction, and the meaning of liberty*. New York: Vintage.

Roberts, D. E. (1999). Is there justice in Children's rights: The critique of Federal Family Preservation Policy. *University of Pennsylvania Journal of Constitutional Law, 2*, 112.

Roberts, D. E. (2012). The social context of oncofertility. *DePaul Law Review, 61*, 777–798.

Rothman, B. K. (1994). Beyond mothers and fathers: Ideology in a patriarchal society. In E. Nakano-Glenn, G. Chang, & L. R. Forcey (Eds.), *Mothering: Ideology, experience, and agency* (pp. 139–157). Oxon/New York: Routledge.

Rousseva, V. (2004). Rape and sexual assault in Chechnya. *Cultura, Society and Praxis, 3*(1), 64–67.

Rubin, G. (1984). Thinking sex: Notes for a radical theory of the politics of sexuality. In C. Vance (Ed.), *Pleasure and danger. Exploring female sexuality* (pp. 267–321). Boston/London: Routledge/Kegan Paul.

Scheper-Hughes, N. (1993). *Death without weeping: The violence of everyday life in Brazil*. Berkeley/Los Angeles/London: University of California Press.

Schneider, D. (2004). what is kinship all about? In R. Parkin & Stone (Eds.), *Kinship and family: An anthropological reader* (pp. 257–274). Boston: Blackwell Publishing.

Seoane-Pascual, L. (2012). *Violencia de Pareja Hacia Las Mujeres En Población Adolescente Y Juvenil Y Sus Implicaciones En La Salud*. Madrid: Comunidad de Madrid.

Social Science Space. (2016). Janet Carsten on the kinship of anthropology. *Social Science Space*. Retrieved from http://www.socialsciencespace.com/2016/01/janet-carsten-on-the-kinship-of-anthropology/

Stolcke, V. (1988). New reproductive technologies: The old quest for fatherhood. *Reproductive and Genetic Engineering*. Citeseer. Retrieved July 24, 2016, from http://citeseerx.ist.psu.edu/viewdoc/summary?doi=10.1.1.618.8307

Tabet, P. (1987). Imposed reproduction: Maimed sexuality. *Gender Issues, 7*(2), 3–31.

Tarducci, M. (2011). La Adopción. In *Una Aproximación Desde La Antropología Del Parentesco*. Buenos Aires: Librería de Mujeres Editoras.

Teo, Y. (2013). Support for deserving families: Inventing the anti-welfare Familialist state in Singapore. *Social Politics: International Studies in Gender, State & Society, 20*(3), 387–406.

The Association for Women's Rights in Development. (2015). Submission for the human rights council report on the protection of the family. *AWID*. Retrieved July 15, 2016, from http://www.awid.org/es/node/4530

The Pathways of Women's Empowerment Research Programme Consortium. (2011). *Empowerment: A journey not a destination*. Brighton: Pathways of Women's Empowerment. Retrieved October 10, 2013, from https://www.gov.uk/government/news/dfid-research-new-publication-empowerment-a-journey-not-a-destination

Tsing, A. L., & Yanagisako, S. J. (1983). Feminism and kinship theory. *Current Anthropology, 24*(4), 511–516.

Varela, N. (2002). *Íbamos a Ser Reinas. Mentiras Y Complicidades Que Sustentan La Violencia Contra Las Mujeres*. Barcelona: Ediciones B, Grupo Z.

Walks, M. (2010). Anthropology of mothering. In A. O'Reilly (Ed.), *Encyclopedia of motherhood*. Thousand Oaks: Sage.

Welbourn, A. (2013). Desires denied: Sexual pleasure in the context of HIV. In S. Jolly, A. Cornwall, & K. Hawkins (Eds.), *Women, sexuality and the political power of pleasure* (pp. 142–160). London/New York: Zed Books.

Wieringa, S. E. (2011). Portrait of a women's marriage: Navigating between Lesbophobia and Islamophobia. *Signs, 36*(4), 785–793.

Wieringa, S. (2014). The enforcement of heteronormativity in India and Indonesia. *IIAS Newsletter, 67*, 28–29.

Williams, Z. (2016). Andrea Leadsom's motherhood insult was contemptible but the motherhood myth is persistent. *The Guardian*, July 11. Retrieved July 16, 2016, from https://www.theguardian.com/commentisfree/2016/jul/11/andrea-leadsoms-motherhood-insult-parenting-myth-theresa-may

World Health Organization, Education. (1998). Promoción de La Salud: Glosario. Division of Health Promotion. Retrieved August 2, 2015, from http://apps.who.int//iris/handle/10665/67246

6

Power, Control and Surveillance

Elizabeth Ettorre

Introduction

In tracing the conceptual framework of social scientists interested in social disorganization and social pathology, Mills (1943) wondered why most work of 'social pathologists' displayed 'low levels of abstraction' and a distinct 'failure to consider total social structures' (p. 166).

> No attempt has been made to trace specific concepts to their intellectual origins. … the aim is to grasp … perspectives and key concepts … certain elements are not so visible in given texts as in others and some elements are not evidenced in certain texts at all. (1943: 165, fn 1)

The above holds true for this chapter. My aim is 'to grasp typical perspectives and key concepts' related to the intellectual development of power as a concept and then relate these to applications in medical sociology. My explorations are not all inclusive: my tracings of the

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conceptual heritages of power are limited. Conceptualizing power has been problematic in the social sciences, generally and sociology in particular, including medical sociology. While power is a basic concept, it has had several different meanings. Extensive disparities surround these meanings. Traditionally in sociology, power has been viewed as a *personal attribute* that an autonomous subject owns, manages and employs. This view constructs power as being wielded by people or groups by way of self-governing acts of domination or force.

I detail in Part I the emergence of the concept of power. Briefly and broadly, I outline theories, focusing primarily on the work of Max Weber whose definitions are key in the heritage and contemporary application of power; look at Pierre Bourdieu who uncovered the intricate dynamics of power in social life; and discuss Michel Foucault whose ways of seeing power involved a new type of epistemology[1] in relationship to power.[2] My focus then shifts specifically to medical sociology. I look in turn, at the concepts, medicalization, professionalization and biomedicalization. I trace how power is constructed in and through these conceptualizations and their consequences. In Part II, I offer a case study in which the workings of biopolitics vis-à-vis reproductive genetics are seen as consequential in the emergence of power as social phenomenon. My early studies in this area are re-examined through the lens of biomedicalization. In Part III, I consider the consequences of working with power, for contemporary studies of health and illness.

Part I: The Foundations of Power

Theories of power include those which see power as being held by a number of groups in society (i.e. pluralist) (Weber 1978a); as being held by powerful groups competing to influence society (i.e. elitist) (Mills 1956); as emerging from those who are the owners and controllers of economic production (i.e. Marxist or ruling class theories) (Marx 1998; Althusser 1971); as being emblematic of the significance of relations between culture, social structure and action (i.e. symbolic) (Bourdieu 1984, 1990); and as designating a domain of relations of governing which exposes the ways one conducts the conduct of individuals (i.e. governmentality) (Foucault 1991, 2010).

Key themes exist in the development of pluralist theories such as Max Weber's: power in society is seen as being relatively fixed; individuals have special interests and individuals and groups do not need to be homogeneous or maintain value consensus and the state rather than a coercive power (as in Marxist conceptions[3]) is viewed as an arbitrator or mediator between various competing groups in society.

A fundamental notion in the development of Weber's work is the ideal type. An ideal type is an analytical construct, a useful tool to help researchers establish likenesses as well as dissimilarities in concrete cases. Weber (1978b: 43) developed his theory of power and stratification on three ideal types: 'The distribution of power in a community is reflected in the existence of "classes", "status groups" and "parties" and these … reflect the working of wealth, prestige and power in societies.' For Weber (1978c: 38):

> The term power will be used to refer to every possibility within a social relationship of imposing one's own will, even against opposition, without regard to the basis for this possibility. The term domination refers to the possibility of finding a specified group of people to obey a command of a determinate content; discipline means the possibility of finding a specifiable number of people who in virtue of an habitual attitude will obey a command in a prompt, automatic and unthinking manner.

'In general, power' was 'the chance of a man (sic) (See fn. 14 Chap. 3) or a number of men to realize their own will in a social action even against the resistance of others who are participating in the action' (Weber 1978a: 926). Power was envisaged as either authoritative (i.e. legitimate and manifesting itself through the ideal types of charismatic, traditional or rational-legal authority) or coercive (i.e. employed through force). Weber's[4] definition of power has become a starting point for much of contemporary sociological work.

While Weber saw power as emerging from within a stratified system and distributed through a series of ideal types, Bourdieu saw power as a producer of hierarchies, domination and distinction, in complex, legitimating fields of cultural action. Power is symbolically created and continually re-legitimized through an interplay of culture, social structure and action. For Bourdieu (1990: 66), there is an implicit 'logic of practice' of everyday action which along with bodily dispositions[5] reveal how social individuals act according to a 'feel for the game'. Two concepts are important: habitus and capital.

Bourdieu (1990: 55) defined habitus 'as an infinite capacity for generating products—thoughts, perceptions, expressions and actions whose limits are set by the historically and socially situated conditions of its production'. Skeggs (2004: 145) defines habitus simply as the 'internal organising mechanism which one learns as a result of social positioning, how to play the game'. This implies that our behaviours and social practices are guided by these socialized norms or tendencies (i.e. habitus).[6] As social individuals, we act according to our 'feel for the game', our sense of capacity for practical engagements in various 'fields' in society. The way we act is linked to knowledge of the conditions of these practical engagements which we are aware of, learn and have internalized before we act.

In contrast to Marx who saw capital only in economic terms (see Introduction and discussion on the presumption of health in Chap. 4), Bourdieu (1984: 114 and 291) referred to four main forms of capital: economic (i.e. income, wealth, etc.), cultural (i.e. existing in dispositions of the mind and body, cultural goods or institutionalized states such as educational degrees),[7] social[8] (i.e. generated through relationships with others) and symbolic (i.e. the form the different types of capital take once they are legitimated) (Skeggs 2002: 8–9).

Unpacking the complexity of Bourdieu's theory, Swartz (2012: 6) notes that Bourdieu 'advances the bold claim that all cultural symbols and practices from artistic tastes, styles in dress and eating habits to religion, science and philosophy—even language itself—embody interests and function to enhance social distinctions'. Thus, the fight for social distinction whatever its symbolic form, derived from the different types of capital, is a fundamental feature of social life. Swartz (2012: 6) explains,

> The larger issue … is one of power relations among individuals, groups and institutions … power is not a separate domain of study but stands at the heart of all social life and the successful exercise of power requires legitimation—the focus … is how cultural socialization places individuals and groups within competitive status hierarchies, how relatively autonomous fields of conflict interlock individuals and groups in struggles over shared resources.

Bourdieu (1984: 471), shows how the 'social order is progressively inscribed in people's minds' in 'objects' (especially cultural products), 'in institutions' (i.e. the educational system) or 'in language' and 'through all the judgements, verdicts, etc. imposed by institutions specially designed for this purpose' and 'the interactions of everyday life'. These processes lead 'one to exclude oneself from goods, persons, places and so forth from which one is excluded' (p. 471). Power works as a generator of hierarchies and domination as well as social distinction. As Swartz (2012: 6) suggests, 'how cultural resources, processes and institutions hold individuals and groups in competitive and self-perpetuating hierarchies of domination' was of the utmost importance.

While Bourdieu sees power symbolically created and continually re-legitimized through an interplay of culture, social structure and action, Foucault sees power as ever-present and beyond agency or structure. Foucault's (2010) notion of governmentality illustrates how 'neoliberal subjects' become obedient and conforming citizens who employ self-constituting practices.[9] In its contemporary form, governmentality shows that our relationships are governed by how 'one conducts the conduct of men' (Foucault 2010: 186). This means that we need to be aware of how power is constructed as a moral imperative as well as 'where' power comes from. Key to understanding governmentality is envisaging a notion of social control as being neither overtly coercive nor forceful. Although not a sociologist, Foucault challenged sociologists' understandings of power. The viewpoint he offered is innovative: a major departure from traditional sociological notions of power. As noted earlier, traditional views of power envisage power as an external force which acts on an individual. This view obscures a rich, alternative view which Foucault unearthed. The Foucauldian view of power sees the actions of bodies and the body's materiality (i.e. substance) as being surveyed, regulated and disciplined through the movements it exercises as a way of defining power. Power is that which forms, maintains, sustains and regulates bodies … (Butler 1993: 34). Through the repetition of specific bodily acts, bodies are reworked, reshaped and disciplined as power takes hold of them (see Introduction in Chap. 3). In the traditional view, power is personalized. In the Foucauldian (1998: 63) view, power is dispersed—all pervasive; 'power is everywhere' and 'comes from everywhere'. It is in constant fluctuation and intra-acting. Foucault (1991: 194) says,

> the individual is a reality fabricated by this specific technology of power. … I have called discipline. We must cease … to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals' … power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production.

Power Applied in Medical Sociology: Medicalization

As the 'power' of the medical profession was continually emphasized, medicalization became a fundamental concept for sociologists working in the field. Early scholars of medicalization developed their discussions in relation to the sick role (Parsons 1951), medical uncertainty (Scheff 1966), medical control (Pitts 1968), professional dominance (Freidson 1970a, b), medicine as an institution of social control (Zola 1972) and medical nemesis (Illich 1974, 1975a).

Parson's (1951) *The Social System* was influential, particularly, Chapter 10, 'Social structure and dynamic process: the case of modern medical practice'. (For a broader discussion of Parsons, see Part 1 in Chap. 2.) His discussion of the sick role and the physician's as well as the institution of medicine is classic. As Conrad (1992: 210) states, 'Parsons was … the first to conceptualize medicine as an institution of social control, especially the way in which the "sick role" could conditionally legitimate that deviance termed illness'.

Parsons knew that 'modern medicine' was a 'dramatic example of the maximization of belief in controllability of organic processes' (p. 381). On the other hand, the medical profession in establishing control should be aware that 'illness … may legitimately be regarded as a type of deviant behavior' (p. 285) which involves 'an institutionalized role', sharing certain characteristics with that of criminality (p. 312). The sick role implicated a relative legitimacy, meaning that a 'patient' agreed 'to pay the price in accepting certain disabilities and the obligation to get well' (p. 312). Indeed, Parsons spoke of an 'institutionalized expectation system relative to the sick role' (p. 436), a system involving four expectations:

> 1. The sick person has a right to 'an exemption from normal social role responsibilities which … is relative to the nature and severity of the illness'. This requires 'legitimation' by others. … the physician often serves as a 'direct legitimatizing agent';
> 2. The sick person has a right 'to be taken care of' and 'cannot be expected … to get well by an act of decision or will'. … His 'condition' must be changed. Acceptance of help is implied here;
> 3. The 'definition of the state of being ill' is 'itself undesirable' … the sick person has an obligation to 'get well'; and
> 4. The sick person has an obligation 'in proportion to the severity of the condition … to seek technically competent help … that of a physician and to cooperate with him in the process of trying to get well'. (pp. 436–437)

With an eye on the effects of social control within medical practice, Parson notes,

> It is here … that the role of the sick person as patient becomes articulated with that of the physician in a complementary role structure. … The role of motivational factors in illness immensely broadens the scope and increases the importance of the institutionalized role aspect of being sick. For then the problem of social control becomes much more than one of ascertaining facts and drawing lines. (p. 436)

While *The Social System* was revered as one of the first sociological forays into medicine, it was 'one of the most ferociously criticized books' (Turner 1991: xviii). An early critic (Segall 1976: 163) saw the sick role as 'not based on upon systematic observation of human behaviour, but upon an abstract set of "institutionalized expectations" … "more accurately described as an ideal-type model, rather than as a description of empirical reality"'. Reviewing Parson's work from 1939 to 1978, Gerhardt (1987: 110) claims that there are two main criticisms of Parson's sick role: (1) his theory does not explain 'the variability of normative experiences in health field' and 'the variety of … illness behaviours' and (2) his theory 'fails to account for chronic illness', may be refuted if Parson's conceptual stance is taken into account in its original version. She argues justifiably that any denunciations of his theory should be 'based on the knowledge of the whole of his thought' (p. 110). Regardless of the criticisms raised against Parson work,[10] it was at the same time ground breaking and 'unambiguously modernist in the acceptance of secularization, differentiation, pluralism of values, bureaucratization of administration, urban cultures and modern forms of citizenship' (Turner 1991: xxxix). All the same, his thinking was about how within medicine, power systems, value orientations and action orientations combine into given role-structures and sets of power conditions. Inevitably, power is personalized and employed by subjects 'whose disorders depend upon the classification of illness which are available within a culture and by reference to general cultural values concerning appropriate behavior' (Turner 1987: 215–216).

During the early development of medical sociology, Scheff (1966) talks about medical uncertainty in diagnosing illness and how this lack of exactitude caused unnecessary entry into the sick role and/or the propagation of the sick role in society. Scheff contended that medicalization created a type of moralizing effect—when a physician made a diagnosis[11] on the basis of insufficient information, the final decision was usually based on moral and ethical standards. For Scheff, a key rule in medical decision making was that it was less blameworthy for a physician to impose an unnecessary treatment than to gamble on leaving a pathological condition untreated. Within a sociology of knowledge perspective, Scheff (1968: 17) argued that sociologists must look at how the 'influence of the assessment itself on the phenomena to be assessed is an ubiquitous process' and that 'people go through their lives constructing reality', regardless of the power they have in any negotiation process. Medicalization implies uncertainty but an uncertainty that for physicians means exercising of a type of personalized power that is unsurpassed by the patient.

In a classic piece, Pitts (1968) contended that medical control will be the main form of social control in society. But others (Fox 1977; Strong 1979; Conrad and Schneider 1980b) questioned this approach by arguing that while medicalization grew, there were also indications of 'demedicalization'. Thus, the medical profession did not have overwhelming power. Kiger (1985: 79) argued rather than assume that medical control is here to stay, it is more useful to investigate the political economy of social control. Kiger (1985: 65) saw research on the medicalization of deviant behaviour as adopting 'an ahistorical, symbolic interactionist perspective … that fails to account for the structural bases of social control practices'. For him, structural determinants of power need to be examined, given that these factors influence the emergence as well as development of various forms of illness and/or deviant behaviour as a social problem. Again, we see the notion, 'structural basis of social control' requires a view of power as being emanating from some 'essential core' to be wielded by external, autonomous individuals.

Professionalization and Medicalization

At a memorial session for Eliot Freidson in 2006, Conrad (2007a: 142) noted,

> It was the 1970 publication of … *Profession of medicine* that gave medical sociology its critical stance and … fundamentally shifted the parameters of medical sociology … and the ways in which issues around health and illness could be sociologically examined.

Profession of Medicine (Freidson 1970a) includes three parts: Part I. The Formal Organization of a Profession, Part II. The Organization of Professional Performance and Part III. The Social Construction of Illness. (In a later edition published in 1988, Freidson added another part, Part IV. Consulting Professions in a Free Society).

In this ground breaking volume, Freidson focused on the workings of personalized power within the medical profession and as Kingdon (2009: 30) observes:

> It was Freidson who identified legitimated authority (or in other words, occupational self-control over the terms and conditions of work) as a characteristic crucial for professional status. Freidson argued that medicine, at least in the 1970s, had this to a … high degree. … Freidson (1970b) also identifies that medicine's supremacy in the healthcare division of labour is attributable to both autonomy (the ability to control its own work activities) and dominance (control over the work of others in the healthcare division of labour).

Freidson (1970a) envisaged two key problems which sociologists needed in order to understand the professions: (1) 'how the profession's self-direction or autonomy is developed, organized and maintained' and (2) 'the relation of the profession's knowledge and procedures to professional organization as such and to the lay world' (pp. xv–xvi). Freidson viewed the first as 'a problem of social organization'; the second as 'a problem of the sociology of knowledge' (p. xvi). Freidson dealt with 'the object of the work of medicine—illness' and he treated this social concept 'like crime and sin', referring 'to deviation from social and moral expectations which are embedded in an official order which the professions come to represent' (p. xviii). Explaining medical treatment as an institutional response to illness, Freidson describes how conflicts in perspective and interest are built into interactions between the patient and physician. He says, 'They are at the core of interaction … they reflect the general structural characteristics of illness and its professional treatment as a function of the relations between two distinct worlds, ordered by professional norms.' (p. 321) Here, Freidson departs from Parson's earlier structural-functionalism approach in that conflict rather than consensus takes centre stage. The professional power of the medical profession becomes observable, if not blindingly obvious. Freidson was influenced by the then up-and-coming, social constructionism,[12] characterized by Berger and Luckmann (1967) and rooted in the labelling theories of Erving Goffman and Howard Becker. For Friedson, the interactions of individuals were crucial in medical settings, given that negotiations, sometimes difficult, sometimes easy, were paramount. Of course, the physician rather than the patient tended to be more skilled at maintaining his/her own status and power. Bosk (2006: 638) aptly says that Freidson:

> describes one tactic to maintain and extend control—the power to define, diagnose and expand the domain of illness in need of expert intervention … this is the first extended application of labelling theory beyond mental illness to physical illness. … No longer described as neutral gatekeepers, physicians become active moral entrepreneurs, lobbying for an expanded jurisdiction in defining 'the pathological'. … Freidson both anticipated and animated the concern of medical sociologists who … developed the concept of *medicalization.*

Medicalization: The Continuing Discourse

Like Freidson, Zola (1972) based his ideas on social constructionism implanted in the labelling perspective. He envisaged that medicine was becoming a major institution of social control and medicalizing of society was taking place. Referring to Freidson's work on how the label of illness and anything attached to this label was under the purview of medical jurisdiction, Zola (1972) illustrated how, what he called 'this attaching process', is categorized in 'four concrete ways' through: (1) the expansion of what in life is deemed relevant to the good practice of medicine; (2) the retention of absolute control over certain technical procedures; (3) the retention of near absolute access to certain taboo areas; and (4) the expansion of what in medicine is deemed relevant to the good practice of life (p. 493). Zola (1983: 295) gave to medical sociology one of the first definitions of medicalization: 'a process whereby more and more of everyday life has come under medical dominion, influence and supervision' (quoted in Conrad 1992: 210). While Zola (1972: 502) was critical of the power and influence of medicine, his main concerns were 'how and when' an illness was dealt with and more importantly, the moral issue of 'what freedom should an individual have over his or her own body is shunted aside'. In later years, Zola's (1991: 2) interest in the body led him to reflect on a past medical sociology with its 'structured silence of personal body experiences'. Looking to the future of medical sociology, he breaks his silence on the struggles with his own body (as a disabled man) and contends that the future of medical sociology lies in an analysis of the 'unfinished paradigmatic challenge' of feminism, which will clarify the parameters of his and, hopefully others, struggles (p. 2). His was an interesting step, recognizing the importance of feminist thinking for understanding healthy and ill bodies. But, similar to Freidman's, Zola's view of power was unable to explain fully how bodies are formed, preserved, supported and governed by power.

A key person in the medicalization arena was Illich (1975a) whose book, *Medical Nemesis*, caused waves in medical sociology. He was very critical of the medical profession and wrote: 'the ritualization of stages in life is nothing new … what is new is their intense medicalization (p. 26)' and 'medicalization constitutes a prolific bureaucratic program based on the denial of each man's need to deal with pain, sickness, and death' (p. 45). Illich (1975b) believed that 'life' itself was being 'medicalized', given the rising share of national budgets spent at the behest of doctors (p. 75). He believed that society undergoes too much medical intrusion and a medical structure has been built up which is a threat to human beings and disguised as care (Illich 1974). Illich (1975a: 165) discussed iatrogenesis which is the damage done by the provider of health care—medical professionals and saw iatrogenesis as clinical (i.e. pain, sickness and health result from the provision of medical care), social (i.e. when health policies reinforce industrial organization which generates dependency and ill health) and structural (i.e. when medically sponsored behaviour and delusions restrict the vital autonomy of people by undermining their competence in growing up, caring for each other, ageing). Probably the most vehement criticisms of Illich came from Navarro (1976: 109) who contended that Illich's solution to iatrogenesis, particularly structural iatrogenesis, was 'a return to a market model of economy—an anti-trust approach with strong doses … of Friedman'—a neoliberal view of unchained capitalism and free enterprise with medical power being wielded by those with 'a healthy attitude towards sickness' (p. 77).

Crawford's (1977) interest in medicalization led him to argue that the placing of responsibility for health on individuals led to a victim blaming ideology. Crawford (1980) developed a concern for 'healthism' representing a particular way of viewing individualized health problems, while being characteristic of the new health consciousness and movements (i.e. holistic health and self-care). For Crawford, healthism was a form of medicalization as it preserves key medical notions—the problem of health and disease is situated at the level of the individual where solutions are devised. He argued that if healthism shapes popular beliefs, a strategy for health promotion is doomed at being non-political and the privatization of the struggle for universal well-being is strengthened. While opening the door to alternative medical practices, Crawford's view of power emphasized that the desire to preserve perfect health put much of the emphasis on individual operation of power vis-à-vis monolithic, prevailing, medical structures. Health was viewed increasingly as a moral obligation, linking individual autonomy with medical ethics.

Peter Conrad: El ‘Divo’ of Medicalization

Conrad appears as a major proponent of medicalization in contemporary medical sociology. His work dates back to the early 1970s when at Boston University, he completed his Ph.D., *Identifying Hyperactive Children: A Study in the Medicalization of Deviant Behaviour*, which was later published in book form in 1976 (Conrad 1976). Since then, he has shown how medicalization works in a number of areas. His ideas on medicalization have become more complex and are well-known. Conrad’s (1975: 12) initial definition of medicalization was ‘defining behavior as a medical problem or illness and mandating or licensing the medical profession to provide some type of treatment for it’. At the same time, Conrad (1975: 18–20) contended the medicalization of deviant behaviour included four ‘aspects’: (1) the problem of expert control—removing it from ‘the public domain and placing it in the medical domain’; (2) medical social control (which ‘presumes a prior definition of deviance as a medical problem’); (3) the individualization of social problems (i.e. physicians ‘rather than seeing certain deviant behaviors as symptomatic of problems in the social system’ focused ‘on the individual diagnosing and treating the illness, generally ignoring the social situation’); and (4) the ‘depoliticization’ of deviant behaviour (i.e. we ‘ignore the meaning of behavior in the context of the social system’).

Conrad’s approach was criticized as perpetuating medical and in turn, sociological ‘imperialism’ (Strong 1979). Strong contended that although there was ‘some value’, the approach was ‘both exaggerated and self-serving’ (p. 199). Conrad and Schneider (1980a: 75), responding to Strong’s critique, argued that he ‘adopted an unnecessarily narrow view of medicalization’ on ‘what doctors actually control and do’ and was ‘limited to the level of doctor-patient interaction’. Expanding the definition, they argued that medicalization is a complex phenomenon which can occur on ‘at least three levels’: ‘the conceptual’ (i.e. employment of medical vocabulary); ‘the institutional’ (i.e. physicians as formal supervisors and gate keepers in institutions), and ‘the doctor-patient level’ (i.e. when physicians give a medical diagnosis or treat a social problem as a medical one) (pp. 75–76).

In *Deviance and Medicalization: From Badness to Sickness*, Conrad and Schneider (1980b: 246–252) speak of the ‘consequences’ of medicalization rather than as earlier, 'the aspects' (Conrad 1975). They divide these 'consequences' into 'brighter' and 'darker sides'. The brighter include: (1) humanitarian trend in conception and control of deviance (i.e. alcoholics are treated rather than criminalized or imprisoned); (2) allows for the extension of the sick role to those labelled as deviant (i.e. removes 'blame' and stigma 'from individual for deviant action') as sick role is 'free of moral opprobrium'; (3) portrays 'an optimistic outcome' for the deviant (i.e. with a 'therapeutic ideology' proper treatment and a 'cure is possible'); (4) lends 'prestige of the medical profession to deviance designation and treatments' (i.e. it becomes 'a scientific way of viewing the problem'); (5) medical social control is 'more flexible and often more efficient than judicial and legal controls' (i.e. the deviant does not become criminal).

On the darker side, they listed seven 'consequences' of medicalization (pp. 248–252), including an additional three to Conrad's (1975) earlier four 'aspects':

1. the domination of expert control, earlier, the problem of expert control;
2. medical social control;
3. the individualization of social problems;
4. the depoliticization of deviant behaviour;
5. dislocation of responsibility;
6. assumption of moral neutrality of medicine and
7. the exclusion of evil from the 'imagery of modern human problems'.

While Conrad and Schneider attempted to expand the notion of medicalization, they wanted the medicalization of deviance to be recognized as a *de facto* social policy (p. 260). *Deviance and Medicalization* was revised with an 'Afterword' in 1992. Conrad and Schneider (1992: 277) argued that any new studies published since the earlier edition 'would not lead them to alter fundamentally their basic arguments and analysis'. Furthermore, Conrad (1992) carried out a review of all the literature on medicalization since the first publication of *Deviance and Medicalization*. In his review, Conrad (1992: 209) emphasizes that medicalization 'describes a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses and disorders'.

He contends that early thinkers linked their initial discussions of medicalization with medical social control (p. 209). While he considers the emergence, definition, contexts, process, degree, range, consequences, critiques, and future of medicalization and demedicalization, he envisages medicalization as a ‘rich area of sociological research and analysis’ (p. 228).

In medical sociology, Conrad is ‘the medicalization man’ and has a plethora of publications, establishing this claim. The following selection of publications gives an idea of his prolific knowledge in the area: medicalization generally (Conrad 2005, 2007b, 2011, 2013; Conrad and Waggoner 2013; Conrad and Stults 2008; Conrad and Barker 2010; Conrad et al. 2010); the medicalization of epilepsy (Conrad and Schneider 1983); genetics (Conrad 1997, 1999, 2002; Conrad and Gabe 1999; Conrad and Markens 2001; Shostak et al. 2008); hyperactive children (Conrad and Potter 2000); DTCA (direct to consumer advertising) (Conrad and Leiter 2008); menopause (Stults and Conrad 2010); mental disorder (Conrad and Slodden 2013); opiate addiction (Conrad and Mackie 2011); chronic pain (Conrad and Munoz 2010); deviance (McGann and Conrad 2007); the ageing male body (Szymczak and Conrad 2006); the globalization of ADHD (Conrad and Bergey 2014); and the list continually grows.[13]

Conrad’s and his colleagues work on medicalization is clear, scholarly, wide ranging and influential. By using the concept of levels and degrees of medicalization as well as bringing the issue of medicalization into a number of medical arenas, Conrad adds complexity to the concept. However, this work does not include fluid conceptions of power.

That power can be diffused and embodied in discourse, knowledge, ‘regimes of truth’ (Foucault 1991) and ‘everywhere’ offers an alternative analysis. It guides us away from analyses of physicians/the medical profession as actors, employing power as an instrument of domination and coercion and an emphasis on the professional structures in which physicians and health professionals operate. In an alternative analysis, power has a specific pivotal point: the body is the product of power relationships. Turner (1996: 63) contends that an excursion into power issues can be considered a materialist enquiry: this material body as an object of power is produced in order to be controlled, identified and reproduced.

(See the discussion of biopower in Chap. 3.) Simply, bodies are encircled by many disciplinary regimes and strategies of attention in a relentless, incessant endeavour to normalize them. Power is that which makes us who we are: this way of knowing operates on a different epistemological level from studies of power within medicalization.

The Era of Biomedicalization

Biomedicalization, an alternative view of medicalization, was put forward by a team of feminist sociologists in an *American Sociological Review* article (see Clarke et al. 2003). (See Introduction to Chap. 7.) The authors define 'biomedicalization' as the increasingly complex, multisited, multidirectional processes of medicalization that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific 'biomedicine' (p. 162). Informed by a Foucauldian view of power, they contend that biomedicalization is 'co-constituted through five central, overlapping and interactive processes' (p. 166):

1. 'major political economic shifts' reflected in 'the emergence of Biomedical TechnoService Complex, Inc.';
2. a new focus on 'health and risk and surveillance biomedicines';
3. 'the technoscientization of biomedicine' through the development of new medical technologies, computerization, data banking, molecularization and geneticization;
4. 'transformations of biomedical knowledge production, information management, distribution, and consumption'; and
5. 'transformations of bodies to include new properties and the production of new individual and collective technoscientific identities' (i.e. bodies are capable of being reconfigured and transformed as opposed to being static and in need of control).

For Clarke et al. (2003: 163) 'these processes operate at multiple levels as they both engender biomedicalization and are also (re) produced and transformed through biomedicalization over time'. In an attempt to establish the concept, biomedicalization, in the sociology of health, Clarke et al. (2010a) edited a book, *Biomedicalization: Technoscience, Health, and Illness in the U.S.* The editors wanted to 'ground their published theory through research projects' which demonstrate 'how and under what conditions biomedicalization theory is useful and provocative' (Clarke et al. 2010b: ix). The key to understanding is that biomedicine is being reorganized 'from the inside out'; power relies upon 'diffuse mechanisms such as discourses that promote the pursuit of happiness and healthiness through certain modes of personal conduct including self-surveillance, and self-regulation' (Clarke et al. 2003: 165 fn 8).

Biomedicalization theory moves us away from medicalization in which social control is evidenced by 'institutional expansion of professional medical jurisdiction into new domains' to a transformative view in which 'expansion is through technoscientific transformations of biomedical organizations, infrastructures, knowledges, and clinical treatments' (See Clarke et al. 2003: 168). The attractions of biomedicalization are: it has an accommodating, effervescent view of power; it moves away from the intellectual fixity of medicalization to a more flexible theory and most significantly, embodiment as a rich notion is included within its theoretical frameworks. To illustrate their attraction to biomedicalization, these scholars say:

> Significantly power is automatically 'built in' and mobile, embodied through social practices and norms rather than invested in particular individuals and institutions. Neither power nor biopower is in any way exclusively the domain of the state, mode of external social control or exclusively punitive—but also positive, productive (Clarke et al. 2010b: 5).

Medicalization employs a different definition of power (Table 6.1).

Conrad (2005: 5) questions biomedicalization as a theoretical position: Clark and her colleagues 'paint with a very broad brush and create a concept that attempts to be so comprehensive and inclusive … that the focus on medicalization is lost'. He (2005: 5) notes that biomedicalization as a concept 'loses focus on the definitional issues, which have always been a key to medicalization studies'. While Conrad may be partially correct, he neglects to mention what those 'definitional issues' are. Conrad (2005)

Table 6.1 The rise of medicine to biomedicalization, 1890–present

	Rise of medicine CA. 1890–1945	Medicalization CA. 1940–1985 ongoing	Biomedicalization CA. 1980–present
Infrastructure	Organizational	Material	Digital
Basic social process	Specification and legitimation	Control and elaboration	Enhancement and transformation
Focus of clinical gaze	Treatment of acute illnesses and communicable diseases	Medicalization of chronic illnesses and diseases	(Bio)medicalization of health and risk factors
Main mode of clinical action	Surgical success and clinical skills	Routinization of medical care and drugs	Technoscientific interventions and drugs
Main focus of biomedical sciences	Germ theory and disease classification	Biochemistry and pharmaceutical sciences	Molecular biology, genetics genomics and nanotechnologies
Main focus of biomedical technology	Amplifying bodily indicators, imaging and sedation	Imaging, tests, procedures and treatments	Imaging, devices, biotechnologies and nanotechnologies
Medical constructions of patients and identities	Patienthood as a privilege Illness and disease identities in known biographies	Passive patients/ doctor knows best Diagnostic entities	Responsible consumers Technoscientific identities and biosocialities
Main media construction of (bio)medicine	Great doctors and the need for medicine	Great doctors and hospitals	Great technoscientific innovations
Key rhetorics	Medicine 'for the benefit of all mankind'	'Healthcare for all' via Medicare, Medicaid and private insurance	Direct-to-consumer advertising and infomercials
Major 'other' medicines and health social movements	Homoeopathy Maternal and child health movement	Chiropractice New age healing and women's health	Acupuncture AIDS and other patient movements

From page 109 in Adele Clarke (2010) *From the Rise of Medicine to Biomedicalization: US Healthscapes and Iconography circa 1890–Present with Global Implications* In Clarke et al. (2010a)

Source: Used with permission from Duke University Press takes issue with the claim that the change from medicalization to biomedicalization represents a shift from modernity to postmodernity. (For him, these shifts are best conceptualized as shifts in the 'engines' driving the medicalization processes.) He implies that to make this claim one takes an interpretive stance, depending upon 'what one considers as postmodern'. To backs up his statement, he quotes from an unpublished paper by Anspach on gender and health which is so specific as to confuse the reader why it was quoted in the first place. In reality, it appears as if Conrad is talking past Clarke et al. Although Conrad (2013) repeats his earlier concern (i.e. 'the authors paint biomedicalization with such a broad brush that medicalization gets lost'), he offers a more robust critique when he says:

> Clarke et al. suggest the medicalization era was ending around 1990 giving way to the biomedicalization era. Here I disagree, as I believe that medicalization is actually more intensified and widespread in the twenty-first century than it was in the 1970s. In short, my claim is that there is an intensification of medicalization occurring, not a transformation.

While Clarke and Shim (2011: 185–186) are aware of criticisms of their work, they outline issues which have been raised by scholars in presentations of their biomedicalization work. Clarke and Shim (2011: 185–186) mention three critiques related to: how new is the concept, biomedicalization? (i.e. how much is new; how is it different from medicalization?); is it 'all encompassing'? (i.e. is it everything and everywhere?) and is the concept 'overly deterministic'? (i.e. is it inescapable?; inevitable?). In responding to these criticisms, Clarke and Shim (2011: 185–186) offer important rebuttals.

Firstly, with regard to 'How new is biomedicalization?', there exist 'qualitatively different' claims-making processes to designate phenomenon as 'medical'. These are related to biosciences, biopolitical economy, biopower and the shifting towards transformation of as well as control over life (p. 185). Secondly, Does biomedicalization include 'everything and everywhere'? They note that while there are five key processes of biomedicalization, these 'may or may not be present in any given empirical situation' and biomedicalization varies 'across sites' as it is a 'fluid' and 'ongoing process' (pp. 185–186). Thirdly, Is biomedicalization an overly deterministic concept? They contend that biomedicalization is a 'contingent, ongoing, provisional process—not an achieved outcome that remains forever stable'[14] (pp. 185–186).

Clarke and Shim (2011: 187–189) detail how biomedicalization has been taken up by scholars in the field and how it has been a rich concept for expanding sites of interest.[15] While there is no space here to review this increasing work, biomedicalization involves a movement towards a paradigm shift or as Riska (2010: 167) notes, 'a paradigmatic shift in sociological theorizing' which could usurp the traditional place that medicalization studies holds in medical sociology. This paradigm shift does not simply entail the transformation of medicalization studies. Rather a focus on biomedicalization shifts the way terminology is defined; how we in the field of sociology and anthropology view medicine; what sites of interest can be used to explicate biomedicalization processes and most importantly, what sorts of questions are viewed as compelling and legitimate. The conception of the 'still robust medicalization thesis' (Clarke and Shim 2011: 173) may become a misnomer. Biomedicalization rather than a replacement era of medicalization may come to offer completely new world views. Perhaps, the advocates of medicalization and biomedicalization are in an intractable position now.

As Kuhn (1962: 148) has said about those advocating different paradigms,

> Though each may hope to convert the other to his way of seeing science and its problems, neither may hope to prove his case. The competition between paradigms is not the sort of battle that can be resolved by proofs.

Indeed, advocates subscribing to these two paradigms may end up 'talking past one another'.

Part II: A Case Study: Revisioning Reproductive Genetics

I came to genetics 20 years ago when I was co-ordinating an empirical study on prenatal screening in Europe (see Ettorre 1999, 2000, 2001, 2002a, b, 2009). Writing up the findings, I found that there were not enough sociological concepts to describe how prenatal practices were shifting to the intensification of technoscientific modes of intervention, reorganization, transformation and the remaking of reproductive identities and subsequent procreative biosocialities—all characteristics of biomedicalization (Clarke and Shim 2011). It is understandable that my work was described as providing 'a dystopian view' (Raz 2009: 606), although it is clear that genetic technologies have failed to fulfil their promises (Steinberg 2015) and carry risks along with ethical problems (Beeson and Lippman 2006: 578). Those working in the field, including myself, knew that genetic biomedicine differed from other types of biomedicine not only because of 'its implications for family' but also and more importantly, 'its potential to reveal a spoiled or new genetic identity' (Diamond 2014: 11).

At that time of writing *Reproductive Genetics, Gender and the Body*, I defined reproductive genetics as 'a sociological concept employed to demonstrate that powerful social and cultural processes are involved in the medical organization of genetic tests for prenatal diagnosis' (Ettorre 2002a: 1). My focus was mainly on DNA based prenatal biotechnologies. However, I found that both non-DNA and DNA based biotechnologies were used in conjunction with each other in the search for foetal abnormalities. Readers need to be reminded that reproductive genetics can also include assisted conception in the form of invitro fertilization (IVF) and pre-implantation genetic diagnosis (PGD) (see e.g. Franklin 2006a, b, 2013; Franklin and Roberts 2006; Franklin and Johnson 2013; Kerr 2013).[16]

Reproductive Genetics, Gender and the Body was published a year before Clarke et al.'s (2003) now classic article. As I did my analyses to explain the transformations I was observing, I had a strong sense that a depth of insight was missing. I want to revisit my theoretical area of research with a biomedicalization lens and inject more complexity into my earlier discussions—a foray into of 'technologies of enhancement' (see Clarke et al. 2010b: 3). I use some of Rose's (2007: 5–6) work which shows that biopolitics is formed by mutations along five dimensions (i.e. molecularization, optimization, subjectification, somatic expertise and economies of vitality). Like Clarke and Shim (2011: 182), Rose's work has multiple parallels to biomedicalization in that biopolitics has manifold levels of development. Biopolitics in the prenatal arena is formed by the embodied desires of biological citizens, entangled with specialists as somatic experts in reproductive medicine—all wanting the optimal result—a healthy, normal baby—the living, embodied expectation of the biomedical process. The biomedical gaze has the authority to legitimate what can be seen as 'problematic' or not (McLaughlin and Clavering 2012: 470). As Franklin (2013: 748–750) contends, there is 'a cultural specificity to how reproductive causality is understood and modelled'—'bioscience and biomedicine have together rendered human biology a more relative condition, in part, paradoxically through the effort to facilitate new biological relations'.

Somatic experts in the neoliberal world of global biopolitics, bioethics and reproductive genetics (Gottweis et al. 2009; Wahlberg et al. 2013) bring together health and identity, wealth and sovereignty and knowledge and values. Steinberg (2015) suggests that the cultural sedimentation of the genetic discourse is of grave concern and needs to be critically de-constructed, mapping onto existing feminist, sociological, cultural and bioethical theory. Rabinow (1999: 13) argues that the biologicalization of identity, 'biosociality', is embedded in science and understood as inherently manipulable and re-formable. Older biological categories of gender, age and race are being replaced by newer knowledge of genes—genes that are viewed as determining our prime location of identity—a view which can be contested.[17] Transformations in the assemblages of reproductive genetics and the biosocialities (Rabinow 1992) surrounding these assemblages illustrate how DNA, reproductive material, foetuses, bioreproductive processes, gendered bodies and somatic experts are all entangled, contained and managed in a multiplicity of ways with the effect that pregnant women, as reproductive citizens (Lupton 2010), are compelled to recode their duties, rights and expectations in relation to their procreative power. It is through the genetics discourse that ethics, societies and bodies are in the process of reformation (Rabinow 1999: 13). For all of us, these issues become profound questions of knowing[18] (i.e. epistemology) and being (i.e. ontology). For pregnant women, the scientific quest for biosociality, the biologicalization of their identity, is shaping increasingly their reproductive experiences, whether good or bad. In this context, Katz Rothman (1998: 18) contends that genetics is not just a science, it is a way of thinking, 'an ideology of our time' and that scientists are not detached observers of nature: they produce culture.

Reproductive genetics exposes pregnant women as becoming entangled in 'new socialities and identities' that are forming around novel sites of genetic 'knowledge' and medical power (Gibbon and Novas 2008: 3). Transformations in the category of reproduction and the issues of how and what it means to reproduce life in the midst of highly emotional decisions, ethical prevarication and ambivalence (Franklin and Roberts 2006: 12, 22) locate pregnant women centrally in the midst of somatic experts who administer the biotechnologies, techniques and procedures, designed to govern the conduct of their reproductive lives. Here, women's reproductive power has consistently been grounded in the ambiguity of their wombs as well as their, at times, reproductive ambivalence (Everywoman 2013).

Seeing reproductive entanglements in the transformation and regulation of women's pregnant bodies, Rapp (2011: 706–707) refers to the 'the niche of reproduction' as being 'useful in highlighting newly routinizing technologies in individual and family life cycles' and how these biotechnologies 'fall on complex relational grounds'. She invites us to imagine that this niche itself has now 'extended into consciousness' and 'increasingly selective action throughout the life cycle, encompassing diverse and fraught moments for potential biotech interventions' (p. 706).

The niche of reproduction involves pregnant women deeply in biomedical reproductive genetics practices through which they are governed. What Rose (2007: 17) says about new reproductive technologies (i.e. when women are seen as the 'collateral damage' of the imperatives of the biosciences George 2008), can be applied to current sites of prenatal genetic practices (see the discussion on biological repronormativity and health in Chap. 5):

> These technologies 'entail much more than the craft skills of doctors using new instruments and techniques. They engender certain ways of thinking about reproduction for the subject and … the expert, certain routines and rituals, techniques of testing and practices of visualization, modes of advice giving … new biotechnologies must be understood as hybrid assemblages oriented towards the goal of optimization … not merely … technologies of health, they are technologies of life. Once one has seen the norms of female reproduction reshaped by assisted conception, the nature and limits of procreation and the space of hopes and fears around it are irrevocably changed.'

Besides links between biology, agriculture and reproductive biomedicine (Franklin 2007; Wilmont 2007; Friese and Clarke 2012) as being relatively hidden in discussions of reproductive technologies, another hidden process is 'stratified reproduction' and how 'the reproductive aspirations, practices and outcomes of one group of people are valorised, while the parenthood of another is despised and unsupported' (Rapp 2011: 703). Roberts (2009: 796) believes there is a link between contemporary reproductive genetics and eugenics which she envisages as a modern-day way of 'making the social order seem natural by casting its features as biological facts'. She contends that programmes based on such beliefs 'set up standards for reproduction that subsume childbearing under prevailing hierarchies of power' (p. 796); there exists 'a coercive nature of contemporary reproductive genetics' that 'privileges a white elite'.[19]

Intersecting with genomic governmentality are the subsequent ways that expert knowledge and scientific discourse are drawn upon in the construction of identities (Bunton and Petersen 1997: 2). The biopolitics of reproduction sets reproductive limits both upon the inner body and the outer body in our modern consumerist culture with the result that women's more than men's bodies are restrained. The science of genetics becomes an ideal way of bringing together what Turner (1992: 58–59) has referred to as external problems of representation (i.e. commodification) and regulation and the interior ones of restraint (i.e. control of desire, passion and need) and reproduction. Through reproductive genetics pregnant bodies experience self-imposed restraint through a type of reproductive asceticism.[20] As these technologies become routinized, pregnant women become engaged in a type of 'body work' (Kerr 2013) in which they accept prenatal screening under the rubric of older non- controversial medical practices and routine prenatal care (Press and Browner 1997).

The discipline of reproductive genetics aids in the biomedicalization process through the circulation of its limiting but powerful routines, values and invasive practices.[21] The image of the foetal body comes to signify endangered childhood in need of parental protection (Taylor 1993)[22] as well as a commodity … subject to quality control (Rapp 1998, 1999) – or as Franklin (2006c) suggests, 'the cyborg embryo'. Bordo (1993: 196) contends that consumer capitalism depends on the continual production of novelty and fresh images to stimulate desire. The continual deployment of biotechnologies within reproductive genetics incites pregnant women's yearning for perfect offspring. As disciplinary and consumerist practices, these biotechnologies become embedded in reproduction, stimulating pregnant bodies to perform well. Continual questions arise for any pregnant woman. ‘Is my pregnant body performing/consuming well?’ and ‘Are my genes “good enough” to deliver a fit baby?’

On the level of morality, Taylor (2000) maintains that consumption itself to a considerable extent constitutes the experience of pregnancy and is invested with a new level of moral significance. Consumption is ‘cast as an act of maternal love, an expression of a woman’s strength of character and powers of self-discipline, even as consumption is seen to literally create the foetal body’ (p. 403). Pregnant bodies are consuming bodies; pregnant women ‘consume’ prenatal biotechnologies for successful pregnancies as well as for the well-being of their foetuses, their ‘precious cargo’ (Lupton 2010). Within the disciplinary process of reproductive genetics, both maternal love and reproductive asceticism become merged. Pregnant bodies are constructed as those who should engage in ‘exemplary’ self-disciplinary and gendered consumerist practices in the biopolitical economy. Within the context of biotechnology vis a vis pregnancy, ultrasound offers ‘a vision’ for women’s embodied knowledge of their fetuses, while encoding a transformation ‘from haptic to visual hexis’ (Draper 2002: 789–90).

Part III: Implications for Contemporary Studies of Health and Illness

We saw earlier that in traditional sociology power has been viewed as a personal attribute that an autonomous subject owns, manages and employs: power is wielded by people or groups by way of self-governing acts of domination. This view ‘enforces a metaphysics of external relations’ in that ‘a subject acts on bodies as its distinct objects’ (Butler 1993: 34).

Within the biopolitical economy this ‘personal attribute’ notion of power sustains neoliberalism[23] in which ‘individual’ subjects interact with government policies, supporting economic liberalizations, free trade, open markets, privatization, individualism, deregulation and enhancing the role of the private sector. (See the discussion on globalization and health system change, Part 3 in Chap. 2.) In medicine and health care, this includes public health[24] campaigns emphasizing individual responsibility for health behaviours, and diverting policy and public attention away from structural influences on health outcomes.

The centre of the neoliberal project is the rational, autonomous, 'free', individual subject, typically a white, Western, affluent man from the global North, who appears as having the capability of wielding economic, political and social power in an atmosphere of unfettered capitalism and free enterprise. Think Donald Trump. Undeniably, the state expects this 'free individual' to be self-regulating, productive and responsible for his own well-being. Free markets and privatization become linked to policy programmes in which the private sector and civil society are viewed as more appropriate providers of health and social services than that of a nation's government.

Earlier I used Foucault's (2010) notion of governmentality to illustrate how neoliberal subjects become 'health conscious citizens, employing self-constituting practices'. The neoliberal project calls upon the individual 'to go into the process of … self-governance through processes of continuous self- examination, self-care and self-improvement' (Petersen 1997: 194). Crawshaw (2012: 201) upholds the relevance of 'governmentality theory' for 'understanding the constitution of the health society'. In its contemporary form, governmentality is characterized by an approach to political rule, neoliberalism, upholding individual freedom and rights against the excessive intervention of the state (Lupton 1999: 86). The key to governmentality is that social control is neither deemed as being overtly coercive nor forceful but rather as operating on autonomous individuals regulating themselves in the best interest of the state (Ayo 2012: 100). In this way, 'power' is both externalized and well as internalized. Viewed as a consequence of the application of neoliberal principles to health care whereby individualized, commercial and social needs have been created, 'personalized medicine has flourished' as individual citizens become responsible for their own health (Savard 2013: 197–198).

As an economic ideology, a policy paradigm and an aspect of the societal imaginary, neoliberalism is the primary driver of distribution of resources including health related ones (see Labonte and Stuckler 2015), while giving primacy to 'interactions between individuals and markets' as well as extolling 'self-reliance and sturdy individualism' (Siddiqi et al. 2013: 196). Mooney (2012: 396–397) emphasizes neoliberalism's deleterious effects on health through the individualism it promotes. He contends that 'neoliberalism kills' (p. 397). Arguing that neoliberalism was 'never a blanket laid over the world', Hall and Lamont (2013: 61) link 'systemic' inequalities in health with neoliberal thinking and demonstrate how the diffusion of neoliberalism affects self-concepts, orders of worth and criteria of evaluation central to social action. For these authors, dominant scripts of personhood shift us towards emphasizing a person's individuality and productivity. Harrison (2012: 330) emphasizes how 'correct neoliberal subjectivity' or 'the body economic' means an acceptable (i.e. slim, conforming, attractive, well-kept, etc.) body which will not pose a risk to the future economic health of societies (p. 326). Annandale and Hammarström (2010: 580–81) contend gender-specific medicine with its individualizing logic and discourse of the 'gender-specific body' dovetails with neoliberal, market driven approaches, placing emphasis on healthcare as 'a good to be consumed' (p. 580).[25] Some scholars have argued that neoliberalism is incompatible with a human rights approach (London and Schneider 2012; Schrecker 2011) and creates multiple forms of health disparities (Nkansah-Amankra et al. 2013). The fact that the UN Millennium Development Goals to eliminate suffering, disease and ill health do not put global restrictions on the 'neoliberal plundering agents' (i.e. banks, economic institutions and non-limited trading markets, etc.) is crucial for Vržina's (2011: 971) critical analysis. Furthermore, international organizations such as the International Monetary Fund, The World Bank, The World Trade Organization and United Nations often collude with global neoliberal logic, although they may use adaptive strategies to challenge this logic (Chorev 2013: 628).

In looking at the implications of power for contemporary studies of health and illness, neoliberalism is discussed as a way of contrasting the traditional notion of power, enforcing a metaphysics of external relations with a more flexible notion of power, embodying, a metaphysics of governmentality. The traditional notion may have obscured a rich, alternative one, seeing the actions of bodies or the body's materiality as being surveyed, regulated and disciplined through the movements it exercises as a way of defining power. Power is 'that which forms, maintains, sustains and regulates bodies' (Butler 1993: 34). Through the repetition of specific bodily acts, bodies are reworked, reshaped and disciplined as power takes hold of them (p. 34). In the traditional notion, power is *personalized*. In the alternative one, 'there is no power that acts', but only a 'reiterated acting that is power in its persistence and instability' (Butler 1993: 9). Power is dispersed and all pervasive—not an external force which acts on a subject: ‘Power is everywhere’ and ‘comes from everywhere’ (Foucault 1998: 63). It is in constant fluctuation and intra-acting. As Barad (2007: 235–236) notes there is only ‘a reiterated acting that is power in its stabilizing and sedimenting effects’.

In the medical context,[26] this alternative notion of power challenges the idea that the ‘power’ of the medical profession is ubiquitous in discussions of illness. The alternative governmentality view of power as dispersed and omnipresent helps to contest some of medical sociology’s fundamental, interrelated concepts such as professionalization and medicalization. These concepts may appear as central to our understanding of health and illness behaviours in advanced industrialized societies. But, in our analysis of power, these concepts conceal an awareness of how discursive practices are linked to the body—the materiality of the body—and the processes of materialization by which sick or healthy subjects are constituted. Foucault (1973) argues that the specific material configuration of the clinic enacts particular discursive practices of ill health and disease. He saw how intricacies and interrelations of medical discourses and systems of classification (i.e. nosologies, tables, pictures, positivistic ways of thinking, etc.) gathered patients’ bodies into a collective, standardized space, the hospital/clinic, where medical technology and political ideology converged and the medical gaze became embedded (Sheridan 1980: 40). Foucault’s focus on bodies in medical discourse presents an innovative way of identifying how methods of segregation, regulation and control not only discipline bodies but also provide medically useful spaces in which regularity and rhythm were applied to their movements. Within a metaphysics of governmentality, the materializing effects of medical power trumps the idea that the medical profession holds, employs and distributes power as it dominates developments in orthodox medicine.

Conclusion

I have mapped out how power has been constructed in and through a series of conceptualizations; examined theories of power, especially focusing on the works of Weber, Bourdieu and Foucault and looked at the application of power with specific reference to medicalization and its different phases of development, including its conceptual links with professionalization as well as its enduring promotion through the discipline. I contrasted medicalization with the growth of biomedicalization, influenced by a highly and increasingly technoscientific biomedicine. Reproductive genetics was offered as a case study to operationalize the consequences of biomedicalization on 'the niche of reproduction'. We saw how biopolitics, biopower, pregnant bodies and procreative biosocialities combine through reproductive genetics. In the end, I opted for a more flexible view of power than what has been offered traditionally. This view of power based on a metaphysics of governmentality is instructive—the kind of power which 'relies not upon brute coercion, but instead upon diffuse mechanisms such as discourses that promote the pursuit of happiness and healthiness through certain modes of personal conduct including self-surveillance, and self-regulation' (Clarke et al. 2003: 165). Significantly, governmentality is a key concept in understanding health, neoliberalism and power, while it connotes 'various governing rationalities based in disciplining and surveillance, biopower, and technologies of the self' (p. 165). In the field of health, an understanding of how biopolitics, biopower, biological citizens and their biosocialities coalesce informs our knowledge of what power is all about.

Notes

1. I would also include metaphysics here.
2. For example, Foucault (2010: 186) asks, 'How does "one conduct the conduct of men"?' rather than traditional questions such as Who holds power? or How is it used to control others?
3. See R. Miliband's (1969) *The State in Capitalist Society* where he contends that maintaining State power in democracies, especially Western ones, is concentrated in the hands of a dominant class.
4. We shall see later in this chapter how Eliot Freidson (1970a, b), utilizing a neo-Weberian perspective, turned attention towards the process of professionalization vis-à-vis the medical profession. See also Weber (1978d).
5. Dispositions arise from fields (i.e. structured social spaces with their own rules such as education) to which 'one has access, knowledge and experience'. See Skeggs (2004: 145).

6. Crossley (2014) contends that sociologists 'must not conflate habitus with embodied actors'. Downey (2014) says we 'should not neglect the value of carnal immersion' and our 'key concepts' should 'emerge from close analyses of specific bicultural (sic) processes of enskilment, the kind that habitus as an empirical site invites'.
7. See Skeggs (2002: 8) for a fuller discussion of Bourdieu's four forms of capital.
8. It is important to note here that along with the work of James Coleman (1988) and Robert Putnam (1993, 1995a, b, 2000), Bourdieu's work on social capital has had a crucial influence on the study of health and its broad determinants.
9. Self-constituting practices refer to our intentional work as individuals on ourselves in order to become our own moral beings.
10. As a feminist, I see a stunning absence of a gender awareness.
11. For an excellent compendium on the sociology of diagnosis, see McGann and Hutson (2011).
12. Social constructionism is a theory of knowledge in sociology that looks at how our understandings of the world and societies are built up in relationship with other social individuals.
13. For an excellent review of the current state of medicalization, see Conrad (2013).
14. For example, see Kim's (2013: 842) work on GBR (i.e. Germinated brown rice) in Korea where the Korean government, food scientists, mass media and consumers have added 'cultural accounts to the biomedical understanding of foods'. Kim (2013: 842) shows not only how consumers have 'transformed their households and online communities into a place for surveillance medicine' but also how 'functional foods are embedded in multiple actors' perspectives on what healthy foods mean and how and where the risks of chronic diseases should be managed'. See also, Fosket's (2010) excellent work on 'Breast Cancer Risk as a Disease' and how risk is transformed into a 'treatable health problem'.
15. See, for example, Bell and Figert (2015).
16. Henn (2000) argues that prenatal technologies are ethically the most difficult applications of genetics.
17. See Roberts (2009) below.
18. How do we know who we are? How can we be who we are?—All questions within the light of genetics.
19. Simply, 'certain repro technologies are reserved for the wealthiest' (Roberts 2009: 796).

20. See Ettorre (2002a: 79) and Reed's (2009: 350) use of the identical term.
21. This is regardless of those 'doing good care' in prenatal risk assessment (Schwennesen and Koch 2012).
22. In a related context, Price (2016: 20) notes that with 'the emergence of the black fetus', African-American women are unwitting contributors to racial genocide if they decide to obtain abortions.
23. Harvey (2005: 3) contends that neoliberalism is 'hegemonic as a mode of discourse' with the effect that 'it has become incorporated into the common-sense way many … interpret, live in, and understand the world'. In health studies, critical perspectives on neoliberalism include for example, works by Petersen and Lupton (1996), Petersen and Bunton (1997), Lupton (1999), Foucault (2010), Crawshaw (2012) and Carter (2015), Schrecker and Bambra (2015), Schrecker (2016). In a supposedly critical public health context, Bell and Green (2016) complain about the utility of neoliberalism as a 'deeply compromised idea' without acknowledging the glaring evidence that neoliberalism or their preferred term, 'neoliberalization', has had global, devastating effects on men's experience and understanding of gender (Cornwall et al. 2016) as well as on perpetuating racism (Davis 2012).
24. See also Briggs and Hallin (2016).
25. As we saw above within reproductive genetics.
26. Excellent examples of alternative approaches in the medical context include Armstrong's (2002) work on the 'modern' person's identity and Nettleton's (1992) on the relationship between dental knowledge and power. For a stunning theoretical approach, see Petersen and Bunton (1997).

References

Althusser, L. (1971). *Lenin and philosophy and other essays*. New York: Monthly Review Press.

Annandale, E., & Hammarström, A. (2010). Constructing the 'gender-specific body': A critical discourse analysis of publications in the field of gender-specific medicine. *Health, 15*(6), 571–587.

Armstrong, D. (2002). *A new history of identity: A sociology of medical knowledge*. Basingstoke: Palgrave Macmillan.

Ayo, N. (2012). Understanding health promotion in a neo-liberal climate and the making of health conscious citizens. *Critical Public Health, 22*(1), 99–105.

Barad, K. (2007). *Meeting the universe halfway: Quantum physics and the entanglement of matter and meaning*. London: Duke University Press.

Beeson, D., & Lippman, A. (2006). Egg harvesting for stem cell research: Medical risks and ethical problems. *Reproductive Biomedicine Online, 13*(4), 573–579.

Bell, S. E., & Figert, A. E. (2015). *Reimagining (bio)medicalization, pharmaceuticals and genetics: Old critiques and new engagements*. New York/London: Routledge.

Bell, K., & Green, J. (2016). On the perils of invoking neoliberalism in public health critique. *Critical Public Health, 26*(3), 239–243.

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. Garden City/New York: Anchor Press.

Bordo, S. (1993). Feminism, Foucault and the politics of the body. In C. Ramazanoglu (Ed.), *Up against Foucault: Explorations of some tensions between Foucault and feminism*. London/New York: Routledge.

Bosk, C. (2006). Review essay: Avoiding conventional understandings: The enduring legacy of Eliot Freidson. *Sociology of Health and Illness, 28*(5), 637–653.

Bourdieu, P. (1984). *Distinction: A social critique of the judgement of taste*. Cambridge, MA: Harvard University Press.

Bourdieu, P. (1990). *The logic of practice*. Cambridge, UK: Polity Press.

Braidotti, R. (1994). *Nomadic subjects: Embodiment and sexual difference in contemporary feminist theory*. New York: Columbia University Press.

Briggs, C., & Hallin, D. (2016). *Making health public: How News coverage is remaking media, medicine, and contemporary life*. London: Routledge.

Bunton, R., & Petersen, A. (1997). Foucault's medicine. In A. Petersen & R. Bunton (Eds.), *Foucault and medicine* (pp. 1–11). London: Routledge.

Butler, J. (1993). *Bodies that matter: On the discursive limits of sex* (p. 9). New York/London: Routledge.

Carter, E. D. (2015). Making the blue zones: Neoliberalism and nudges in public health promotion. *Social Science & Medicine, 133*, 374–382.

Chorev, N. (2013). Restructuring neoliberalism at the World Health Organization. *Review of International Political Economy, 20*(4), 627–666.

Clarke, A. E., & Shim, J. (2011). Medicalization and biomedicalization revisited: Technoscience and transformations of health, illness and American medicine. In B. A. Pescosolido, J. K. Martin, J. D. McLeod, & A. Rogers (Eds.), *Handbook of the sociology of health, illness and healing: A blueprint for the 21st century* (pp. 173–199). New York: Springer.

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2003). Biomedicalization: Technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review, 68*, 161–194.

Clarke, A. E., Mamo, L., Fosket, J. R., Fishman, J. R., & Shim, J. K. (Eds.). (2010a). *Biomedicalization: Technoscience, health, and illness in the U.S* (pp. 104–169). Durham: Duke University Press.

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2010b). Biomedicalization: A theoretical and substantive introduction. In A. E. Clarke, L. Mamo, J. R. Fosket, J. R. Fishman, & J. K. Shim (Eds.), *Biomedicalization: Technoscience, health, and illness in the U.S* (pp. 1–43). Durham: Duke University Press.

Coleman, J. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 94*, S95–S120.

Conrad, P. (1975). The discovery of hyperkinesis: Notes on the medicalization of deviant behavior. *Social Problems, 23*(1), 12–21.

Conrad, P. (1976). *Identifying hyperactive children: The medicalization of deviant behavior*. Lexington: D.C. Heath.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology, 18*, 209–232.

Conrad, P. (1997). Public eyes and private genes: Historic frames, news constructions and social problems. *Social Problems, 44*(2), 139–154.

Conrad, P. (1999). A mirage of genes. *Sociology of Health and Illness, 21*(2), 228–241.

Conrad, P. (Ed.). (2002). *The double-edged helix: Social implications of genetics in a diverse society*. Baltimore: Johns Hopkins University Press.

Conrad, P. (2005). The shifting engines of medicalization. *Journal of Health and Social Behavior, 46*(1), 3–14.

Conrad, P. (2007a). Eliot Freidson's revolution in medical sociology. *Health, 11*(2), 141–144.

Conrad, P. (2007b). *The medicalization of society: On the transformation of human conditions into treatable disorders*. Baltimore: Johns Hopkins University Press.

Conrad, P. (2011). Medicalization. *Hastings Center Report, 41*(2), 13.

Conrad, P. (2013). Medicalization: Changing contours, characteristics and contexts. In W. Cockerham (Ed.), *Health sociology on the move: New directions in theory*. Oxford: Blackwell.

Conrad, P., & Barker, K. (2010). The social construction of illness: Key insights and policy implications. *Journal of Health and Social Behavior, 51*, S70–S79.

Conrad, P., & Bergey, M. R. (2014). The impending globalization of ADHD: Notes on the expansion and growth of a medicalized disorder. *Social Science & Medicine, 122*(2014), 31–43.

Conrad, P., & Gabe, J. (1999). *Sociological perspectives on the new genetics*. Oxford: Blackwell.

Conrad, P., & Leiter, V. (2008). From Lydia Pinkham to queen Levitra: DTCA and medicalization. *Sociology of Health and Illness, 30*, 825–838.

Conrad, P., & Mackie, T. (2011). Opiate addiction: A revival of medical involvement. In M. Milhat (Ed.), *Drugs and cultures*. Farnham: Ashgate.

Conrad, P., & Markens, S. (2001). Constructing the 'Gay Gene' in the news: optimism and skepticism in the US and British press. *Health, 5*(3), 373–400.

Conrad, P., & Munoz, V. L. (2010). The medicalization of chronic pain. *Tidsskrift for Forskning i Sygdom og Samfund, 13*, 13–24.

Conrad, P., & Potter, D. (2000). From hyperactive children to ADHD adults: Observations of the expansion of medical categories. *Social Problems, 47*(4), 559–582.

Conrad, P., & Schneider, J. (1980a). Looking at levels of medicalization: A comment on Strong's critique of the thesis of medical imperialism. *Social Science and Medicine, 14A*, 75–79.

Conrad, P., & Schneider, J. (1980b). *Deviance and medicalization: From Badness to sickness*. St. Louis: Mosby.

Conrad, P., & Schneider, J. (1983). *Having epilepsy: The experience and control of illness*. Philadelphia: Temple University Press.

Conrad, P., & Schneider, J. (1992). *Deviance and medicalization: From Badness to sickness* (Expanded ed.). Philadelphia: Temple University Press.

Conrad, P., & Slodden, C. (2013). The medicalization of mental disorder. In C. Aneshensal & J. Phelan (Eds.), *Handbook of the sociology of mental health*. New York: Springer.

Conrad, P., & Stults, C. (2008). Contestation and medicalization. In P. Moss & K. Teghtsoonian (Eds.), *Contesting illness: Processes and practices*. Toronto: University of Toronto Press.

Conrad, P., & Waggoner, M. (2013). Medicalization. In *Blackwell encyclopedia of health and society*. London: Blackwell.

Conrad, P., Mackie, T., & Mehrotra, A. (2010). Estimating the costs of medicalization. *Social Science and Medicine, 70*, 1943–1947.

Cornwall, A., Karioris, F. G., & Lindisfarne, N. (Eds.). (2016). *Masculinities under neoliberalism*. Chicago: University of Chicago.

Crawford, R. (1977). You are dangerous to your health: The ideology and politics of victim blaming. *International Journal of Health Services, 7*, 663–680.

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services, 10*(3), 365–388.

Crawshaw, P. (2012). Governing at a distance: Social marketing and the (bio) politics of responsibility. *Social Science & Medicine, 75*, 200–207.

Crossley, N. (2014). Embodied actors, sociability and the limits of reflexivity. *Body and Society, 20*(2), 106–112.

Davis, A. (2012). *The meaning of freedom and other difficult dialogues*. San Fransisco: City Lights.

Diamond, R. (2014). Negotiating identity at the intersection of paediatric and genetic medicine: The parent as a facilitator, narrator and patient. *Sociology of Health and Illness, 36*(1), 1–14.

Downey, G. (2014). 'Habitus in extremis': From embodied culture to biocultural development. *Body and Society, 20*(2), 113–117.

Draper, J. (2002). 'It was a real good show': The ultrasound scan, fathers and the power of visual knowledge. *Sociology of Health and Illness, 24*(6), 771–795.

Ettorre, E. (1999). Experts as genetic story tellers: Exploring key issues. *Sociology of Health and Illness., 21*(5), 539–559.

Ettorre, E. (2000). Reproductive genetics, gender and the body: Please doctor, may I have a normal baby? *Sociology, 34*(3), 403–420.

Ettorre, E. (Ed.). (2001). *Before birth: Understanding prenatal screening*. Aldershot: Ashgate Press.

Ettorre, E. (2002a). *Reproductive genetics, gender and the body*. London: Routledge.

Ettorre, E. (2002b). A critical look at the new genetics: Conceptualising the links between reproduction, gender and bodies. *Critical Public Health, 12*(3), 337–350.

Ettorre, E. (2009). Prenatal genetic technologies and the social control of pregnant women: Harming or helping? Special issue on disability. *Marriage & Family Review, 45*, 448–468.

Everywoman, J. (2013). Cassandra's prophecy: Why we need to tell the women of the future about age-related fertility decline and 'delayed' childbearing. *Reproductive Biomedicine Online, 27*, 4–10.

Fosket, J. R. (2010). Breast cancer risk as disease. In A. E. Clarke, L. Mamo, J. R. Fosket, J. R. Fishman, & J. K. Shim (Eds.), *Biomedicalization: Technoscience, health, and illness in the U.S* (pp. 331–352). Durham: Duke University Press.

Foucault, M. (1973). *The birth of the clinic*. London: Tavistock Publications.

Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality* (pp. 87–94). Brighton: Harvester Wheatsheaf Press.

Foucault, M. (1998). *The history of sexuality: The will to knowledge*. London: Penguin.

Foucault, M. (2010). *The birth of biopolitics*. Basingstoke: Palgrave.

Fox, R. C. (1977). The medicalization and demedicalization of American society. *Daedalus, 106*(1), 9–22.

Franklin, S. (2006a). Origin stories revisited: IVF as an anthropological project. *Culture, Medicine and Psychiatry, 30*, 547–555.

Franklin, S. (2006b). The IVF stem cell interface. *International Journal of Surgery, 4*, 86–90.

Franklin, S. (2006c). 'The cyborg embryo': Our path to transbiology. *Theory, Culture and Society, 23*(7–8), 167–187.

Franklin, S. (2007). 'Crook' pipettes: Embryonic emigrations from agriculture to reproductive biomedicine. *Studies in History and Philosophy of Biological and Biomedical Sciences, 38*, 358–373.

Franklin, S. (2013). Conception through a looking glass: The paradox of IVF. *Reproductive BioMecdicine Online, 27*, 747–755.

Franklin, S., & Johnson, M. H. (2013). Are assisted reproduction health professionals still letting down their patients? *Reproductive Biomedicine Online, 27*, 451–452.

Franklin, S., & Roberts, C. (2006). *Born and made*. Princeton: Princeton University Press.

Freidson, E. (1970a). *Profession of medicine: A study of the sociology of applied knowledge*. New York: Harper and Row.

Freidson, E. (1970b). *Professional dominance: The social structure of medical care*. New York: Atherton Press.

Friese, C., & Clarke, A. E. (2012). Transposing bodies of knowledge and technique: Animal models at work in reproductive sciences. *Social Studies of Science, 42*(1), 31–52.

George, K. (2008). Women as collateral damage: A critique of egg harvesting for cloning research. *Women's Studies International Forum, 31*, 285–292.

Gerhardt, U. (1987). Parson, role theory and health interaction. In G. Scambler (Ed.), *Sociological theory and medical sociology* (pp. 110–133). London: Tavistock Publications.

Gibbon, S., & Novas, C. (2008). Introduction: Biosocialities, genetics and the social sciences. In S. Gibbon & C. Novas (Eds.), *Biosocialities, genetics and the social sciences: Making biologies and identities* (pp. 1–18). Abingdon: Routledge.

Gottweis, H., Salter, B., & Waldby, C. (2009). *The global politics of human embryonic stem cell science: Regenerative medicine in transition*. Basingstoke: Palgrave Macmillan.

Hall, P. A., & Lamont, M. (2013). Why social relations matter for politics and successful societies. *Annual Review of Political Science, 16*, 49–71.

Harrison, E. (2012). 'The body economic': The case of childhood obesity. *Feminism & Psychology, 22*(3), 324–343.

Harvey, D. (2005). *A brief history of neoliberalism*. Oxford: Oxford University Press.

Henn, W. (2000). Consumerism in prenatal diagnosis: A challenge for ethical guidelines. *Journal of Medical Ethics, 26*, 444–446.

Illich, I. (1974). Medical nemesis. *Lancet, i*, 918–921.

Illich, I. (1975a). *Medical nemesis: The expropriation of health*. London: Calder & Boyars, Ltd..

Illich, I. (1975b). The medicalization of life. *Journal of Medical Ethics, I*, 73–77.

Katz Rothman, B. (1998). *Genetic maps and human imagination*. New York: W.W. Norton.

Kerr, A. (2013). Body work in assisted conception: Exploring public and private settings. *Sociology of Health and Illness, 35*(3), 465–478.

Kiger, G. (1985). Economic transformations and the processing of hyperactive school children. *Mid-American Review of Sociology, 10*(1), 65–85.

Kim, H. (2013). Functional foods and the biomedicalisation of everyday life: A case of germinated brown rice. *Sociology of Health & Illness, 35*(6), 842–857.

Kingdon, C. (2009). *Sociology for midwives*. London: Quay Books.

Kuhn, T. S. (1962). *The structure of scientific revolutions* (1st ed.). Chicago: University of Chicago Press.

Labonte, R., & Stuckler, D. (2015, September 30). The rise of neo-liberalism: how bad economics imperils health and what to do about it. *Journal of Epidemiology and Community Health, 0*, 1–7. doi:10.1136/jech-2015-206295.

London, L., & Schneider, H. (2012). Globalisation and health inequalities: Can a human rights paradigm create space for civil society action? *Social Science & Medicine, 74*, 6–13.

Lupton, D. (1999). *Risk*. London: Routledge.

Lupton, D. (2010). ‘Precious cargo’: Feotal subjects, risk, reproduction and reproductive citizenship. *Critical Public Health, 22*(3), 329–340.

Marx, K. (1998). *Marx and Engels collected works, volume 37: Karl Marx – Capital, volume III* (pp. 870–871). London: Lawrence & Wishart (Electric Book).

McGann, P. J., & Conrad, P. (2007). Deviance and medicalization. In G. Ritzer (Ed.), *Blackwell encyclopedia of sociology*. New York: Blackwell.

McGann, P. J., & Hutson, D. J. (Eds.). (2011). *Sociology of diagnosis: Advances in medical sociology* (Vol. 12). Bingley: Emerald Group Publishing Ltd.

McLaughlin, J., & Clavering, E. K. (2012). Visualising difference, similarity and belonging in paediatric genetics. *Sociology of Health & Illness, 34*(3), 459–474.

Miliband, R. (1969). *The state in capitalist society*. London: Weidenfeld & Nicolson.

Mills, C. W. (1943). The professional ideology of social pathologists. *American Journal of Sociology, 49*(2), 165–180.

Mills, C. W. (1956). *The power elite*. New York: Oxford University Press.

Mooney, G. (2012). Neoliberalism is bad for our health. *International Journal of Health Services, 42*(3), 383–401.

Navarro, V. (1976). *Medicine under capitalism*. New York: Prodist.

Nettleton, S. (1992). *Power, pain and dentistry*. Buckingham: Open University Press.

Nkansah-Amankra, S., Agbanu, S. K., & Miller, R. J. (2013). Disparities in health, poverty, incarceration, and social justice among racial groups in the United States: A critical review of evidence of close links with neoliberalism. *International Journal of Health Services, 43*(2), 217–240.

Parsons, T. (1951). *The social system*. New York: The Free Press.

Petersen, A. (1997). Risk, governance and the new public health. In A. Petersen & R. Bunton (Eds.), *Foucault and medicine* (pp. 189–206). London: Routledge.

Petersen, A., & Bunton, R. (1997). *Foucault and medicine*. London: Routledge.

Petersen, A., & Lupton, D. (1996). *The new public health: Health and self in the age of risk*. Thousand Oaks: Sage.

Pitts, J. (1968). Social control: The concept. In D. Sills (Ed.), *International encyclopedia of social sciences* (Vol. 14, pp. 381–396). New York: Macmillan.

Press, N., & Browner, C. H. (1997). Why women say yes to prenatal diagnosis. *Social Science and Medicine, 45*(7), 979–989.

Price, K. (2016). The emergence of the black fetus. *Contexts, 15*(1), 19–20. (Published by American Sociological Association).

Putnam, R. D. (1993). The prosperous community: Social capital and public life. *American Prospect, 13*, 35–42.

Putnam, R. D. (1995a). Bowling alone: America's declining social capital. *Journal of Democracy, 6*(1), 65–79.

Putnam, R. (1995b). *Making democracy work: Civic traditions in modern Italy*. Princeton: Princeton University Press.

Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community*. New York: Simon & Schuster.

Rabinow, P. (1992). Artificiality and enlightenment from sociality to biosociality. In J. Crary & S. Kwinter (Eds.), *Zone 6: Incorporations* (pp. 234–252). New York: Zone.

Rabinow, P. (1999). *French DNA: Trouble in purgatory*. Chicago: University of Chicago Press.

Rapp, R. (1998). Refusing prenatal diagnosis: The uneven meaning of biosciences in a multicultural world. In R. Davis-Floyd & J. Dumit (Eds.), *Cyborg babies: From techno-sex to techno-tots*. New York/London: Routledge.

Rapp, R. (1999). *Testing women, testing the fetus: The social impact of amniocentesis*. New York/London: Routledge.

Rapp, R. (2011). Reproductive entanglements: Body, state and culture in the dys/regulation of childbearing. *Social Research, 78*(3), 693–718.

Raz, A. E. (2009). Eugenic utopias/dystopias, reprogenetics, and community genetics. *Sociology of Health and Illness, 31*(4), 602–616.

Reed, K. (2009). 'It's them faulty genes again': Women, men and the gendered nature of genetic responsibility in prenatal blood screening. *Sociology of Health and Illness, 31*(3), 343–359.

Riska, E. (2010). Gender and medicalization and biomedicalization theories. In A. E. Clarke, L. Mamo, J. R. Fosket, J. R. Fishman, & J. K. Shim (Eds.), *Biomedicalization: Technoscience, health, and illness in the U.S* (pp. 147–170). Durham: Duke University Press.

Roberts, D. E. (2009). Race, gender and genetic technologies. *Signs, 34*, 783–804.

Rose, N. (2007). *The politics of life itself: Biomedicine, power and subjectivity in the twenty-first century*. Princeton: Princeton University Press.

Savard, J. (2013). Personalised medicine: A critique of the future of health care. *Bioethical Inquiry, 10*, 197–203.

Segall, A. (1976, June). The sick role concept: Understanding illness behavior. *Journal of Health and Social Behavior, 17*(2), 162–169.

Scheff, T. J. (1966). *Being mentally Ill*. Chicago: Aldine Publishing Company.

Scheff, T. J. (1968). Negotiating reality: Notes on power in the assessment of responsibility. *Social Problems, 16*(1), 3–17.

Schrecker, T. (2011). The health case for economic and social rights against the global marketplace. *Journal of Human Rights, 10*, 151–177.

Schrecker, T. (Ed.). (2016). *Surviving globalism: The social and environmental challenges*. Springer.

Schrecker, T., & Bambra, C. (2015). *How politics makes us sick: Neoliberal epidemics*. Springer.

Schwennesen, N., & Koch, L. (2012). Representing and intervening: 'Doing' good care in first trimester prenatal knowledge production and decision-making. *Sociology of Health and Illness, 34*(2), 283–298.

Sheridan, A. (1980). *Michel Foucault the will to truth*. London: Tavistock Publications.

Shostak, S., Conrad, P., & Horwitz, A. (2008). Sequencing and its consequences: Path dependence and the relationship between genetics and medicalization. *American Journal of Sociology, 114*(S1), S287–S316.

Siddiqi, A., Kawachi, I., Keating, D., & Hertzman, C. (2013). A comparative study of population health in the United States and Canada during the neoliberal era, 1980–2008. *International Journal of Health Services, 43*(2), 193–216.

Skeggs, B. (2002). *Formations of class & gender*. London: Sage.

Skeggs, B. (2004). *Class, self and culture*. London: Routledge.

Steinberg, D. (2015). *Genes and the bioimaginary: Science, spectacle and culture*. Farnham/Surrey: Ashgate.

Strong, P. M. (1979). Sociological imperialism and the profession of medicine: A critical examination of the thesis of medical imperialism. *Social Science and Medicine, 13*, 199–215.

Stults, C., & Conrad, P. (2010). Medicalization and risk scares: The case of menopause and HRT. In D. Light (Ed.), *The risks of prescription drugs* (pp. 120–142). New York: Columbia University Press.

Swartz, D. (2012). *Culture and power: The sociology of Pierre Bourdieu*. Chicago: University of Chicago Press.

Szymczak, J., & Conrad, P. (2006). Medicalizing the aging male body: Baldness and andropause. In D. Rosenfeld & C. Faircloth (Eds.), *Medicalized masculinities*. Philadelphia: Temple University Press.

Taylor, J. S. (1993). The public foetus and the family car. *Science as Culture, 3*(17), 601–618.

Taylor, J. S. (2000). Of sonograms and baby prams: Prenatal diagnosis, pregnancy and consumption. *Feminist Studies, 26*(2), 391–418.

Turner, B. (1987). *Medical power and social knowledge*. London: Sage.

Turner, B. (1991). Preface to the new edition. In T. Parsons (Ed.), *The social system* (New ed., pp. xviii–xvxlv). Abingdon/Oxford: Routledge.

Turner, B. (1992). *Regulating bodies: Essays in medical sociology*. London/New York: Routledge.

Turner, B. (1996). *The body and society* (2nd ed.). London: Sage.

Vržina, Š., & Sanja, M. (2011). Talking culture, crying health, hoping for nothing: Surviving the many flyers above the human rights global cuckoo's nests. *Collegium Antropologicum, 35*(4), 969–978.

Wahlberg, A., Rehmann-Sutter, C., Sleeboom-Faulkner, M., Guangxiu, L., Döring, O., Cong, Y., Laska-Formejster, A., Jing, H., Haidan, C., Gottweis, H., & Rose, N. (2013). From global bioethics to ethical governance of biomedical research collaborations. *Social Science & Medicine, 98*, 293–300.

Weber, M. (1978a). In G. Roth & C. Wittich (Eds.), *Economy and society: An outline of interpretive sociology* (trans: Fischoff, E., Kolegar, F., Parsons, T., Rheinstein, M., Roth, G., & Wittich, C.). Berkeley: University of California Press.

Weber, M. (1978b). Chapter 3: Class, status groups and parties. In W. G. Runciman (Ed.), *Max Weber: Selections in translation* (pp. 43–56). Cambridge: Cambridge University Press.

Weber, M. (1978c). Chapter 2: Basic categories of social organisation. In W. G. Runciman (Ed.), *Max Weber: Selections in translation* (pp. 33–42). Cambridge: Cambridge University Press.

Weber, M. (1978d). In W. G. Runciman (Ed.), *Max Weber: Selections in translation*. Cambridge: Cambridge University Press.

Wilmont, S. (2007). Between the farm and the clinic: Agriculture and reproductive technology in the twentieth century. *Studies in History and Philosophy of Biological and Biomedical Sciences, 38*, 303–315.

Zola, I. K. (1972). Medicine as an institution of social control. *The Sociological Review, 20*, 487–504.

Zola, I. K. (1983). *Socio-medical inquiries: Recollections, reflections, and reconsiderations*. Philadelphia: Temple University Press.

Zola, I. K. (1991, March). Bringing our bodies and ourselves back in: Reflections on a past, present, and future "medical sociology". *Journal of Health and Social Behavior*, *32*, 1–16.

7

Gift Giving, Reciprocity, and Exchange

Vanessa M. Hildebrand

A great deal can be learned about the successes and failures of health care interventions by examining the exchanges or transactions between health care provider and targeted patient. This is a key place where power is enacted, conflicting motivations meet, and expressions of social status can be found. It is difficult to analyze these transactions as they happen over time, move geographically, and engage multiple parties. The practice of medicine, medical treatments, and the understandings of medical encounters continue to change dramatically over the years and are increasingly individualistic and technological in focus through a process of biomedicalization (Clarke et al. 2003). (See the discussion on biomedicalization in Chap. 6.) Much of the health encounter writ large is an exchange not just between the individuals in the clinical encounter but also between cultures and social worlds. It is a moment where social hierarchies and inequity are displayed, often highlighting the stark contrast between different life experiences and opportunities.

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For example, in the empirical case that will be examined in this chapter, the continued low levels of uptake of biomedical, maternal health care in a population of rural poor women in Indonesia who are a great risk for maternal mortality, morbidity, and infant death can be better understood by examining the exchange between the health care practitioner and the patient.

The fields of sociology and anthropology have robust and intertwined histories in examining exchange. This chapter examines a key enduring concept that is foundational for much of this scholarship: exchange in terms of gift giving and reciprocity. This concept was introduced by Marcel Mauss in *The Gift: Forms and Functions of Exchange in Archaic Societies* (1925, 1967, 1990, 2016). Simply put, this idea is: the exchange of gifts and services may be understood as a social system of transactions that is shaped by motivation on the part of the giver to create social relationships and obligations on the part of the receiver to reciprocate. This concept, which has been consistently discussed and contested since its introduction, will be explored and used to help understand the treatment of health and illness in interaction with cultural values, social practices, and perceptions. While most analyses of exchange examine objects moving between parties, this chapter looks at the provision and reception of health care in contemporary societies. In particular, I will examine the dynamics of power, status, social cohesion, and repulsion between the giver and recipient. First, the concept and trajectory introduced in *The Gift* will be explored. Then the concept will be used to analyze ethnographic data from long-term research in maternal mortality programs in Indonesia.

An Enduring Concept in Sociology and Anthropology: The Exchange of Prestations

It is remarkable how the ideas introduced in *The Gift* have instigated continual debate but never left scholarly conversation. These ideas have had profound impact across many fields of social inquiry. A review of the scholarly analyses that use the concepts introduced by Mauss reveals use in the fields of history, political science, psychology, social work, health sciences and practice, public policy and administration, business, law, literature, and medicine, among others. All of this is above the heavy use of the concepts in the fields of sociology and anthropology, in which Mauss himself was involved. Mauss's essay was translated from the original French into English three separate times: by Ian Cunnison (Mauss 1954), W. D. Halls (Mauss 1990), and Jane Guyer (Mauss 2016). While there are years of particular flurries of interest in the original idea (based on the frequency of citations of *The Gift*), the interest is long standing, from the time of first publication to the present time. This is truly an enduring concept.

Mauss, a student and nephew of Emile Durkheim, conducted research based on ethnographic data in which he sought to understand some of the most basic interactions between humans, namely how exchange of all kinds works. He systematically examined the records of social scientists, explorers, and missionaries who wrote on what he called "archaic" social systems to examine what it is that humans are doing when they exchange goods, services, and people (e.g. through marriage, adoption, slavery). He used ethnological reporting from North America, Polynesia, Southeast Asia, Melanesia, and ancient Europe (in contemporary geopolitical terms) to discover patterns of exchange of "prestations" among humans. He broke from what was then scholarly norm and used ethnographical data to derive social understanding rather than finding data in support of a theory.

In his essay, Mauss famously asked, "what power resides in the object given that causes its recipient to pay it back" (1967: 3). The answer is essentially that gift exchange brings into relationship the honor of the giver and recipient of the gift. Mauss found that in these transactions the gift is not necessarily an object but an almost non-material or ethereal part of the giver. The bond between giver and the object of the gift can never truly be severed. Because this bond between giver and recipient must be reciprocated in a culturally prescribed manner, great social and perhaps, physical peril might befall the recipient who does not reciprocate appropriately. Prestige can be gained or lost in the transaction. The honor of both the giver and receiver is at stake. An element of this type of exchange that helps develop social relationships is that these exchanges happen over time; there is delayed reciprocity. In this way, the gift exchange becomes part of what creates political order in society.

In order to describe this obligatory gift, Mauss used a French term with no direct translation into English: "prestation." He intended this to mean the obligatory gifts and services, both of which were widely defined by Mauss and the many scholars who have used the ideas since. Mauss was particularly concerned with what he called "total prestations" which were those prestations that involved not just a whole social group but something that comes to bear on the entirety of cultural and social organization and institutions including religion, economics, politics, legal, moral, ethical systems, esthetics, and so on. This idea of the total prestation builds on Durkheim's concept of the total social fact. It is argued that in Mauss's description and use of the "total prestation," Durkheim's concept of the total social fact is described clearly and value proven resolutely (Valeri 2013: 277). (See a related discussion of Durkheim's ideas on organic solidarity as a process internal to a society in the Introduction to Chap. 2). In this chapter the words "prestation" and "gift" will be used interchangeably; the word "gift" is always meant as a technical term as defined by Mauss.

In order to investigate exchange among humans Mauss closely examined ethnographics data concerning excahnge practices in many societies. The most well discussed in his writings were the examples of the Kula exchange[1] of the Trobriand Islanders (Malinowski 1922) and the Potlatch[2] as found among several native groups in North America (Piddocke 1965). Mauss defined the gift exchange by isolating what he called the three questions: the obligation to give, to receive, and to reciprocate. This type of exchange becomes part of what creates political order in a society (Strathern and Stewart 2005). This structure has been thoroughly discussed, developed, and critiqued, notably by Firth (1936), Polanyi (1944), Gouldner (1960), Levi-Strauss (1987), Sahlins (1965), A. Strathern (1971), M. Strathern (1988), Weiner (1992), Hart (2007), Scheper-Hughes (2007), and many other scholars. Their analyses were focused mostly on the obligation to reciprocate. Gift exchange is a contract entwined with morality and social engagement. There are implications in this contract that determine to whom to give, how much to give, how to receive, and how to reciprocate.

The serious critique made of this idea centers on the accuracy of the original analysis and the extent of the universality of the concept. Raymond Firth (1967), for example, dissected Mauss's idea based on data from a field site that was close to the location where Malinowski did his research (Mauss was particularly taken with the work of Malinowski). Firth was most concerned that Mauss was basing his concept on a faulty interpretation of ethnographic data. In Firth's analysis, he found that reciprocity as a result of gift exchange is due to wanting to avoid witchcraft or economic costs of defaulting on the exchange. He added that the exchange happens between individuals and does not set off a continual relationship. (See a discussion of Engel's similar idea of exchange in the Introduction to Chap. 4.) Alain Testart (2013), for example, does not see the Kula ring as a gift exchange at all, but merely as a commodity exchange (i.e. a service rendered to receive a payment without expectation for further interaction).

Many other scholars have tested the idea and found it to be a sound analytical tool. Research from all over the world and in many different settings has found that the gift economy produces solidarity (Bohannan 1955; Borbieva 2010); creates and maintains social relationships (Atipkis et al. 2011; Godoy et al. 2007; Schwartz 1967); is imbued with relationships and identities (Battaglia 1992); can be a tool to negotiate difficult social situations (Borbieva 2010; Andaya 2009; Godoy et al. 2007); and a method of dealing with risk (Cashdan 1985; Mortiz 2013). Similarly, this chapter will use the concept of gift exchange applied to understanding maternal health service provision.

Using the Gift Exchange as an Analytical Tool to Understand the Low Uptake of Maternal Health Services in Rural Indonesia: Unmet Need, Global Maternal Health Programming, and Ethnographic Evidence

Unmet Need

Throughout the world a great deal of effort, across governments and insitutions, goes into addressing what it termed as "unmet need" for health treatments, interventions, and services. In the contemporary era that privileges community-based problem identification rather than top-down approaches, unmet need is most favorably defined as a problem that the target population recognizes and wishes to change (there are notable exceptions to this). This unmet need can be categorized in two ways. In some cases, unmet need exists because the care to address the presenting problems is not available locally. Two examples are: first, women suffering from vaginal fistulas in rural areas of Sub-Saharan Africa are sometimes days or weeks of travel away from a facility where they can get help (Maheu-Giroux et al. 2015); and second, women all over the world who want but are not able to obtain reliable contraceptive methods (Sedgh et al. 2016). Clear paths to rectifying these unmet needs exist, although the provision of care is complicated and replete with service delivery problems. There is, as in the case with treating vaginal fistulas or obtaining contraception, a continual stream of women going to great lengths to get the treatments. A second way to categorize unmet need is when treatments are available for a condition recognized as a problem by those suffering from it, yet when treatment is offered, it is not sought by the target patients. Importantly, this type of unmet need refers to services identified as a need by the target patient population. This is different from people in a target population not selecting treatment because it addresses problems that the local group of people in question do not find to be of concern. This issue is an area of great consternation to people who work in health care provision. This is the type of unmet need that will be investigated in this chapter in the context of the low uptake of maternal health services in rural Indonesia.

The following presents a proposition that one of the layers of complication that inhibit the uptake of clinic-based, biomedical midwifery services in rural Indonesia is the social interaction and relationships between the government, biomedically trained midwives, and targeted patients. This proposition is based on ethnographic data that I collected in several rural Indonesian villages over the last decade. Interviews and long-term participant observation methods were used to understand the relationships between government midwives, traditional midwives, and women in the villages as they seek to care for pregnancies in an area with high infant and maternal mortality. All names used in this chapter have been changed to protect the identity of the women interviewed as some of what they say could jeopardize their employment status.

There are many analyses of medical colonization in developing regions of the world that are similar in important ways to the case of Indonesia. For example, Warwick Anderson describes the imposition of sanitation intervention programs by the American colonial government in the Philippines (2006). Anderson's analysis, similar to that presented in this chapter, investigates the socially complicated nature of implementing care based on a particular knowledge system when care based on local knowledge systems is already available. Anderson finds that the colonizers and colonized involved in the colonial encounter were impacted in related and unexpected ways. This impact and change could neither be predicted nor was the change unidirectional; both the people of the Philippines and the colonizers exhibited change. This is not to say that there were not negative impacts on the people of the Philippines (there were) this is mentioned only to highlight what a great deal of research in medical anthropology has found, that biomedical interventions are not entirely homogenizing. Of the many results were that novel solutions to health problems and cultural patterns were created.

The attempted replacement of the local Indonesian midwifery practices with biomedical forms of midwifery can rightly be seen as a form of medical colonization. I am aware that some, including Rothman in Chap. 8, may see this as a "theft" rather than an interaction between agents with different access to a variety of types of social, economic, and political power. Theft is indeed what best describes what has happened in many historical and cultural contexts, such as the case of midwives in the USA in the nineteenth and twentieth centuries. At that time and place physicians, through a variety of methods, stripped midwives of both their social power and their means of making a living. I contend that a feminist perspective on prestations exposes that the exchanges between skilled birth attendants (SBAs), traditional birth attendants (TBAs), and pregnant women, reflects social positions and relations of power. These exchanges reveal a rigid cultural, social, and patriarchal regulatory regime that surrounds birth in Indonesian society. By using Mauss's concept of the prestation, or the gift, we see that an entire social group of women is controlled in the rules surrounding these exchange relationships. Although biomedical obstetrics is medically colonizing, the result is not that which was expected by national and global health organizations that sought to change behaviors and beliefs through the implementation of maternal health services in rural Indonesia.

Maternal Health Programs in Rural Indonesia

Throughout developing regions of the world the problem with the most seemingly intractable health care benchmark is that of maternal mortality (Ronsmans and Graham 2006). (See also the Introduction to Chap. 2.) In 2010, approximately 287,000 women across the world died of causes related to pregnancy and childbirth; the vast majority of those deaths occurred in poor countries (Viera et al. 2012). Making biomedical treatment available to women across the world is a key human rights issue as there are biomedical interventions and treatments that effectively improve the life chances of the women at risk for suffering from complicated pregnancies. Many organizations and governments, including the Indonesian Ministry of Health, have sought to address this problem on multiple levels. Central to these programs is making "skilled birth attendants" (referred to as SBA midwives in this chapter) available to all women across the world to improve maternal health (WHO 2004; Ministry of Health 2008).

The SBA midwives are professional, biomedically trained, nurse-midwives who receive their educations in national universities directly out of high school. They represent a professional category created by global reproductive health programs and deployed by national health systems. The SBA midwives are framed as the keystone position in implementing global reproductive health programs. An expectation of those implementing these programs is that SBA midwives will replace the local midwives who use systems of knowledge about pregnancy and birth that predate biomedicine. In the parlance of global health, these local midwives are collectively known as traditional birth attendants, referred to as TBA midwives in this chapter. Since the mid-2000s, programs have been in place to encourage SBA midwives to work with TBA midwives by finding a new role for them as emotional support for the birthing women (Viera et al. 2012). SBA midwives hold a great deal of political, economic, and broad social capital, while the TBA midwives hold a great deal of local social capital (Hildebrand 2012).

As has been well described elsewhere (Barkin and Hildebrand 2014; Brunson 2010; Pigg 1997; Pinto 2008) the nomenclature assigned to various categories of "midwife" by global health apparatuses is highly problematic. Three examples of the many problems are the following. The idea that all locations have a position of a birth specialist is faulty (Brunson 2010; Pigg 1997). The value-laden term "traditional" downgrades the highly skilled women who manage reproductive health in many areas of the world to a relic (Pigg 1997). The term "skilled", or even using the word "midwife" in reference to a biomedically trained midwife, in relation to "traditional" implies skill lies in one of those midwifery categories but not in the other. Yet, these are names, categories, and concepts in play in the settings in which all the categories of midwife participate. These midwives are not only aware of these terms but, as demonstrated in numerous ethnographic accounts, will on occasion use the terms themselves in particular ways to describe specific actions, events, or relationships. A more detailed discussion of this is beyond the scope of this chapter.

Nonetheless it is complicated to apply terminology to describe the various categories of midwives in the scholarly literature. This chapter does employ the terms "TBA" and "SBA" for several reasons. First, it represents the continual presence, interaction, and influence of global structures of power that both the SBA and the TBA are in conversation with. Second, it is a continual reminder that the midwives of these two categories must contend with the relationship with each other as initially shaped by the global health apparatus. Third, in much scholarly writing that includes versions of these two categories the biomedically trained midwife is often termed "midwife" while the local midwife is termed using the local name. I wonder if this practice is inadvertently replicating the "modern" versus "traditional" colonialist dichotomy. For these reasons, and for the ease of the reader, with acknowledgment of the inherent problems, this chapter uses the terms "TBA" and "SBA."

In the time that these programs have existed, there has been a decrease in infant mortality globally, but improvements in maternal mortality and morbidity are smaller than have been hoped. The key moment that these programs work toward is for women to give birth with a SBA midwife in attendance, ideally in a biomedical facility (WHO 2004). The number of women seeking antenatal care has increased globally but not to the extent expected. There is much less change in the number of women who give birth in the presence of an SBA midwife (WHO 2004).

It is well recognized that there are "social determinants" of the causes of morbidity and mortality or the "causes of the causes" (Bhutta and

Black 2013; Filippi et al. 2006; Titaley et al. 2010; Marmot 2009). Yet, when examining reasons for why many programs are not as successful as hoped, the analyses tend to focus on the individual level. For example, many analyses that find the problems in the uptake of maternal health care rest with characteristics of either the SBA midwives or those of the targeted reproducing women. Reasons for the low uptake of maternal health care often include faulting the SBA midwives for their lack of quality of care (Harvey et al. 2004; Van den Broek and Graham 2009). Some research finds that there is a disconnect between programming and the local social and cultural contexts (Finlayson and Downe 2013; Barkin and Hildebrand 2014). There are many analyses that locate a need to "raise awareness" among women (Kyomuhendo 2003; Mpembeni et al. 2007; Anwar et al. 2008). Similarly, medical and program staff in rural Indonesian clinics see the need to "decrease ignorance" among women, revealing a similar idea but also a judgment of the women by clinic staff (Hildebrand 2012). Interestingly, the relationship between the SBA midwives and the women are less frequently mentioned. This chapter presents an argument that the relationships between SBA midwife and patient is in need of greater examination.

The SBA Midwives of Rural Indonesia and the Target Patient Population

In rural Indonesia, the SBA midwives find themselves frustrated by their moderate success with enticing target patients to use their clinic-based services rather than that of the TBA midwives. For three decades, a clinic-based village midwife national program, offering free or nearly free biomedical care, has been available throughout much of Indonesia. Many women reported that they sought maternal health care "sometimes" which is reflected in the Indonesian usage statistics (BPS 2011). While 82% of women deliver their infants with an SBA midwife in attendance countywide, among the poorest quintile (i.e. urban and rural) this percentage is only 43.8%, even though basic obstetric care is free of charge (BPS 2011). In rural areas of all economic strata across Indonesia, 62.7% of women give birth with the assistance of an SBA midwife (BPS 2011). Further, 30% or rural women do not have a postnatal examination and 53.4% do not register the birth (BPS 2011). The women in the rural villages who are the target patients generally seek the care of the SBA at some point in a pregnancy; around 73% of the women in the poorest quintile in the rural areas seek at least one antenatal visit with a SBA midwife (BPS 2011). These data reveal that there is a social process yet to be well understood involving women's usage of the SBA midwives.

Women and their families in the villages express great concern for the outcomes of pregnancy. Problems occur in the reproductive process regularly. Even though the usage statistics are lower than hoped, when asked, women and their families identify having a SBA midwife present in the village as a positive change. They see possibilities for decreasing the risks associated with the reproductive process. They also express curiosity in the comparatively worldly manner in which these SBA midwives live. At the same time, the women find many of the behaviors of the SBA to be personally off-putting, questionable, and are concerned about the SBA midwives' apparent lack engagement with the spirit world (Hildebrand 2012). It is found by many researchers across Indonesia that the women remain socially tied to the TBA midwives who have assisted their families in the reproductive process for decades (e.g., Agus et al. 2012). Generally, the rural women are demographically quite distinct from the SBA midwives, as they tend to have lower levels of education, have not traveled beyond the island of their birth, and have fewer resources available to them.

The Obligation to Give: Perspectives from the SBA Midwives

Mauss suggested that the obligation to give a gift is socially constraining as there are culturally defined motivations and responsibilities associated with the act. Data from extensive interviewing demonstrate that the SBA midwives feel compelled to offer their care for reasons beyond the simple fact that it is their job. They see the midwifery knowledge that they have as a gift that was given to them and as something that they must then offer to the women in need. Interview data from four of the total 37 SBA midwives interviewed are presented here. These responses are representative of those offered by the remainder of the group of primary informants.

The SBA midwives were clear and resolute in their perception that biomedical obstetric care was an important gift to be given to the local women. Bidan[3] Hati, a SBA midwife, connected offering the services that she and her colleagues could provide as a gift. She said, "We are taught at the midwifery academy that it is a human right … a person must have [biomedical] health care. Once we have been trained to be midwives the skills are now ours to offer these women who need it. It is something that I can give to the women. It is my contribution." Similarly, SBA midwife Bidan Nopi responded in the following way; "My talents and abilities are a gift from God. I learned the skill of midwifery at the midwifery academy, but there is a great deal of intuition (*gerak hati)* involved in being a midwife. My successes I believe are a gift from God. In order to give thanks, I must offer my abilities to women." SBA midwife Bidan Yanti, added, "It is *wajib* (compulsory) that a person chooses what is best for the family and their community. This is what I tell women in the village, 'it is wajib to go the clinic to give birth.'" In these statements the SBA midwives evoked a sense held by many that biomedical midwifery knowledge is a gift to her that she must repay by offering care to women in need. Further, they added that the midwives see accepting the gift as compulsory as it is an act that impacts more than just the women. The SBA midwives understood that their job in regions of the country where uptake of clinic care was low and mortality rates were high was to treat those needing help in the most primal and elemental of ways, in offering safe entry for a new human into the world. The SBA midwives interviewed felt it was of the greatest honor for them to be able to give this care to women in need.

In offering a gift, Mauss suggested an "alliance and communion" would be developed (Mauss 2016: 74). SBA midwives saw the importance of developing relationships with the women as part of the nationalistic attempts to "modernize" the country. Bidan Yanti described the critical task of developing relationships with the target patient population in this way. "One by one I will have a relationship with the women. When a [SBA midwife] has a relationship with the women, she has a relationship with the whole village." Further Bidan Yanti described that it was through the personal relationship with women that change can be made in how the women and their families live. "Every midwife makes the new theory [biomedical obstetric knowledge] her own. She must believe in herself and her training and then figure out how to meet the women." In this statement, Bidan Yanti evokes a central tenant of Indonesian nationalist and development sentiment that the key to making any change is through the women in the household. Further, the best time to do this is during the reproductive process (Brenner 1998, 2011). The reasoning is metaphorical and literal: it is in the emergence of new life that a new version of Indonesia will be created. Offering the gift of maternal health care is not without an agenda. The SBA midwives, and indeed, the program officers who develop the programs see the opportunity in engaging the women to make changes in hopes of meeting government and global health programing goals.

Mauss suggested that in presenting a gift a person is giving something of his or her self (Mauss 2016: 73). The hope in offering maternal health care was to make change in the way that the women and their families live both in their engagement with biomedicine but also in other social, political, and economic manners of things. As mentioned earlier, the SBA midwives sent to the villages were different from the women who they were sent to treat: they were educated, connected to global cultural flows and economies, and had access to resources not available to the women they sought to treat. Part of their mission was to, in a sense, give themselves as a model to women, "who want to progress and take advantage of what Indonesia can be in this era" (SBA midwife, Bidan Hati). Bidan Dewi supported this sentiment in saying, "[The women] die in ways that they should not. I can help them. They live in ways that they do not need to, like in eras passed. I can help them move to a new way." SBA midwife, Bidan Yanti, said: "I must behave while I am wearing my uniform, but also when I am wearing a sarong washing and hanging my laundry. I have to be a proper modern woman. I must do as I want the women to do." The SBA midwives took their charge to be a model of a national citizen for the women seriously.

The Obligation to Receive: Perspectives from the Target Patient Population and the SBA Midwives

Mauss suggested that, "One does not have the right to refuse a gift or a potlatch. To do so would show fear of having to repay, and of being abased in default. One would 'lose the weight' of one's name by admitting defeat in advance" (Mauss 1967: 39). Mauss gives the example that among the Kwakiutl, a native group of Northwest USA, one must attend the whale feast associated with potlatch even though whale oil might make the person sick (FN 159 1967: 107). Interestingly, in Mauss's analysis he also pointed to data from the Dayak people of what is now Indonesia and Malaysia as an example of a particularly strong obligation to accept a gift. This obligation to receive gifts and services is a key part of developing social relationships that tie groups of people together and can promote change. Further, Mauss found that both the obligation to reciprocate a gift and how a gift is properly reciprocated are expected to be implicit. This is where problems emerge, as will be discussed below, as there are no explicit directions about how to go through the process correctly by local social standards. If the reception or reciprocity of this gift is not carried out properly, then the exchange becomes something else or, as Smart (1993: 393) suggests, "a failed gift performance." The low uptake of maternal health care in rural Indonesia has hallmarks of being a failed gift performance. In the case here, women feel ashamed and this shame becomes a barrier to service. Interview data from six of the reproducing women in three rural Indonesian villages are presented here. It is representative of the total of 48 women who qualify as "poor" in the group of primary informants.

As reported by the global reproductive health literature, the most common reasons for the lack of uptake, or reception, of maternal health care are related to issues of access (i.e. economic, geographical, logistical) (Thaddeus and Maine 1994). As of the mid-1990s, these issues of access to basic biomedical obstetric care were no longer a problem in the three villages represented in this study. As described above, the women in the research sites had access to maternal health care, most of which was offered free of charge for antenatal, delivery, and postnatal care offered in the clinic. Clinics were easily within reach for all the neighborhoods included in the study. All the clinics had SBA midwives available. Local women identified maternal health care as something that was critical to be offered in village clinics as they similarly identified maternal and infant mortality as one of the greatest problems faced in their region. These same women regularly sought care from the clinics where maternal health services were offered but for health issues not related to pregnancy and childbirth or to seek contraception (BPS 2011).[4] While usage of the clinics by these women was regular for other issues, this was not the case for reproductive health care.

Women demonstrated a marked hesitancy to engage with the SBA midwives for the care that they offer. "I am very lazy to go to the clinic for a [prenatal] check-up. I feel nervous around the [SBA midwives]" said Ibu Yulia, a pregnant woman. Further, her friend Ibu Sartana, who had recently delivered a baby attended by a TBA midwife, was not sure what it would mean to engage in the exchange that would begin should she accept care from the SBA midwife. Ibu Sartana added, "It isn't clear what I am supposed to do if I go [to the clinic], or what they expect me to do. Information was given to me by Bidan Yanti at an exam. I don't know what it means to change to clinic instead of [the TBA midwife]."

In describing this hesitancy many women invoked the feeling of shame or embarrassment, the majority of the time using the word *malu* to describe this feeling. The feeling of *malu* is complex and is poorly translated into English as "shame" or "embarrassed" (Boellsdorf 2004). In the Indonesian use, it has a broader reach in shaping motivations than simple embarrassment in the English usage. Ibu Kadek, an older woman with several children, stated, "The [SBA midwives] are different than us and I feel *malu* when I am at the clinic. It is better if I stay with [the TBA midwife]. With [the TBA midwife] I know what to do and I know what to ask for." Regarding feeling *malu*, Ibu Yulia responded in a fashion that represents responses from the majority of women included in this research. "It is clear that the SBA midwives want to help but I feel *malu* when around them. I worry that I will do the wrong thing. I will feel *malu* so I do not go." Responses from women throughout the research site similarly revealed that they were concerned about not understanding what was expected of them in the exchange and felt an increasing level of shame in interactions with the SBA midwives, so they concluded that it was best that they not receive care from the SBA midwives.

There is an important difference in the transactions that Mauss used as data and the transactions that are described in the current chapter. Mauss was describing exchange between men who exist in a similar social world. Instead, in this case, the exchange participants are women that inhabit separate social worlds: the reproducing women and the SBA midwives. The reproducing women represent local village environment and as individual people are seen as internal to the family structure. Women are not understood as the public representative of the family. Rather the category of *kepala keluarga*, or "head of the household," a role held by the senior male in the house, is the official and the symbolic public contact node for the family. In meeting the SBA midwives the reproducing women are engaging with other women, not across gender boundaries. Even so the SBA midwives operate in a social arena officially and symbolically external to that in which the women exist. The SBA midwives represent a system of understanding and operating that is foreign to the women. Additionally, in their daily lives, the SBA midwives exhibit behaviors that continually mark their experience in places outside of the local village life (e.g. manner of dress, way of speaking, languages spoken).

The Obligation to Reciprocate: How Would the Gift of Biomedical Obstetric Care Be Repaid?

The return gift, or the act of reciprocity, is the climax of the three-step social process Mauss (1967: 5) described; steps one (i.e. offering the gift) and two (i.e. receiving the gift) work to create the obligation to reciprocate. The honor of all people involved in the exchange is at stake. The assumption, Mauss found, is that the giver has superior social status to the recipient and the return gift must mark a recognition of that hierarchy. Further, when the recipient properly engages with the giver by reciprocating in the appropriate manner there is a transference of status and protection. The two parties are socially marked as belonging together. The recipient can borrow some of the status of the giver and the giver has bolstered her social status by being socially recognized as a person in a position to give. It is in discussion with the SBA midwives and the women that the stoppage of the exchange process reveals the differences in social power and status between giver and recipient in a health care setting. This results in vulnerabilities experienced by the women being offered this care.

The descriptors used among global health institutions can be conflicting; both that health care is a "gift," and a "right." The language of gift giving is common in describing global health endeavors: for example, "gift," "donation," "the gift of life." (See the discussion of "needy gift givers" with regard to commercial surrogacy in the Gujarat state in Chap. 4.) This is also paired with the idea that health care is a human right: for example, the phrase "the right to health" is commonly used. In either case, if health care is a right or an altruistic gift then what are the expectations of the patient? Mauss suggested that there is no such thing as a "free" or "pure" gift. Mauss (1967) suggested that a gift without obligation to reciprocate does not create social relationships as the obligations and connections between people would be absent. Part of the goal of global health endeavors is to develop an ongoing relationship with groups of people identified as needing care. The idea of a "free gift" has caused the greatest amount of contestation from Mauss's work.[5] Scholars investigating the development industry have demonstrated that giving aid creates an obligation of the recipient to reciprocate by becoming an ideal patient, all the while presenting the aid offered as a "pure gift" (Bornstein 2012; Hattori 2003; Stirrat and Henkel 1997). Other scholars have found that the country of origin of the development agency determines the presentation of whether or not it is expected that the recipients are obligated to return the favor (Mawdsley 2012; Watanabe 2015).

In the Indonesian case, there is a strong expectation among people working in the national health care programs that there will be a reciprocation for a gift or service offered. Women and SBA midwives alike indicated that proper reciprocity in this setting would be to become an ideal patient as defined by receiving regular biomedical maternal health care. However, the way that their frustrations and concerns diverge reveals what they feel is at stake in the exchange and the ramifications of engaging in the relationship. Their reflections revealed tensions concerning transformation, hierarchy, inequality, and vulnerabilities. The remainder of this section will discuss three points of tension concerning becoming an ideal patient. First, the SBA expressed frustration over the lack of response to their years of service and blamed women for their inability to gain status both in the village and with the larger national midwifery program. Second, the women expressed concerns and confusion about how to behave in the clinical encounter as well as what the engagement with the SBA midwife would mean for their relationship with the TBA midwife. Third, recognition that becoming an ideal patient would entail a transformation on the part of the women to become "modern" Indonesian woman as modeled by the SBA midwives.

The SBA midwives express great frustration, fatigue, and bewilderment in their inability to fill their patient rosters after almost three decades of service to the area. Bidan Yanti compared the work that she and her "sister" SBA midwives did to that of mother hens keeping a careful eye on the chicks and trying to teach them how to live well, but finding that the chicks kept running in the other direction. As a result, she said, "I am tired. I think that I will retire soon. We work very hard to bring the women to the clinic. I tell them why they should come, but they do not come. They ignore me." The SBA midwives point to personal and professional sacrifice in bringing care to the village and feel that their efforts should be recognized by the women accepting what the SBA midwives have to offer. SBA midwife Bidan Dewi, stated "We have given up a great deal to come to this small village instead of an easier job in the city. We want the best for the women of the village yet they reject our care." In this way, the SBA midwives placed the responsibility of lower-than-expected patient rosters on the women, rather than being at fault themselves.

The SBA midwives felt that their supervisors and program officials placed some of the blame for the low levels of uptake of maternal health services at the clinic. Bidan Dewi voiced this commonly expressed sentiment by responding, "because women do not come to our clinic, our supervisors in Jakarta think that we are unsuccessful because we are not working the right way." Bidan Yanti added, "They think the quality of our care is deficient! We work hard, with few supplies or equipment. We cannot perform best practice. We do the best with what we have." Bidan Dewi continued, "We are here to help the women. The least they could do is to come to our clinic to help us." The SBA midwives place the blame for disappointing results on the women. They are not following the expected course of gift exchange and thus are dishonoring the status of the SBA midwives.

The women find themselves confused about the specific manner to engage with the SBA midwives. The women recognize the reproductive process as a unique time that requires social relationships to build and introduce a new human into the community and larger world. Women understand the abilities of the TBA midwife as a God-given gift that is then offered, as a gift, to the women. They do not recognize that this is the case with the abilities of the SBA midwives.[6] In exchange for obstetric care, the women and their families offer the TBA midwives culturally defined payment by gifting at ritually important times of the reproductive process and throughout the future life of the child produced. The relationship between TBA midwife and a family continues through the life-course of the human produced from conception to death. In this way, the lives of the TBA midwives and the families they serve become intricately socially intertwined and last over several generations. This is different from the interaction with the SBA midwife that is defined as beginning at conception and ending when the postpartum period has concluded.

The care offered by the TBA midwives is reciprocated by an extensive and complicated schedule of return gifts and devotion by the women's family to the TBA midwife. Through the global health TBA programs, the local village TBA midwives were taught that they must charge for their services. Since this time it became normal to present the TBA midwife some sort of monetary offering. Generally, there is a payment equivalent to around $10 (USA dollars) at the time of the delivery that is referred to by many women as a gift, but this is never described as fee. Women commonly say, as Ibu Kadek did, "We give [the TBA midwife] something that she would like or that she can use." The payment is flexible in content as well as the schedule of payment. Sometimes these payments are made in consumable goods such as rice, chickens, or eggs and often over a period of time as the family can afford it. Further gifts are offered to the TBA midwife throughout the infant's life at ritually significant times (i.e. birthdays, coming of age ceremonies, marriage, or in sickness). It is recognized by women and their families that these gifts cost more in absolute monetary terms than would payment be to the SBA midwives. The TBA midwife responds by offering her continued blessings, protection, and assistance with the reproductive process as the infant grows to be a reproducing adult him or herself. These gifts are given with profound gratitude. In a setting where maternal and infant mortality is a real and regular threat, the families feel in debt to the person who helped with a difficult and uncertain process.

At first glance the modes of reciprocity to the TBA midwives from the women and their families might look like payments for a commodity, but in fact they act like a gift. C.A. Gregory (2015) was particularly interested in the relationship between a commodity and a gift economy. Building on Mauss's proposition, he found that gifts and commodities create different types of debt; gifts are reciprocal and socially binding. A commodity economy includes ideas about personal private property in which ownership rights are transferred in full from one person to another. With this idea, ownership of an object is alienated from the original owner, and there is no essence of the original owner upon the transfer of ownership. This is opposed to the gift economy whereby objects never really change ownership; they are inalienable from the givers. The object is still bound to the essence of the giver, which creates a debt between recipient and giver that must be honored or the honor of the people involved will be impacted. In this exchange, the expectation is created for future relationships, which creates social cohesion. Gifts create social bonds.

The experience with the TBA midwives leaves the women and their families uncertain about how to reciprocate to the SBA midwives on two levels. First, how would a relationship with the SBA midwife impact the ongoing relationship with the TBA? Ibu Titik expressed this clearly when she said, "[Our TBA midwife] is part of our life. We want her to always be part of our life. If I go to the [SBA midwife] what will Dadong [the TBA midwife] think?" Second, how does the woman and her family reciprocate with someone who lives in what is understood to be a social field (Bourdieu 1993) that only narrowly overlaps with the women? (See Chaps. 3 and 6 for related discussions of Bourdieu's work.) "I don't know if I also should give the [SBA midwife] eggs when we have extras. Dadong [the TBA midwife] likes to get eggs. I feel embarrassed (i.e. malu) because Bidan Dewi is rich, would she want my eggs?" At that, Ibu Delis laughed and added, “I wouldn’t know when to offer her something, what to say, or what to give. I just feel stupid.” The women are unsure what it would mean exactly to have an ongoing relationship with a person such as the SBA midwife who assists them through a significant life event.

Both the SBA midwives and the women sense that a transformation is expected of the women if she accepts biomedical, maternal health care. For the SBA midwives, the women who are the target patients should take the role of an Indonesian woman wanting “to progress” (Li 2007). In accepting maternal care she would accept the symbolic key to becoming a modern Indonesian woman. In this way, she would be an important part of the transformation of the nation through her desire to progress or her “will to improve” (Li 2007). To the SBA midwives, the women needed to change their behavior and accept what they had to offer given the risks inherent in pregnancy, childbirth, and postpartum care in the region. Bidan Yanti responded, “After so many years, they do not hear, they do not understand. It seems that maybe, they are ignorant, or selfish, or just too lazy. They will harm their children and families by not following these directions. This is what makes a weak Indonesia.” In this way, the SBA midwives perceive of women who do not become regular patients as ignorant at best and at worst actively choosing a path of diminished well-being for the family and the nation.

The SBA midwives’ frame of understanding the women’s low uptake of clinic services as being a result of negative characteristics exposes women to vulnerabilities in treatment. Bidan Dewi expressed this vulnerability when she commented, “I feel lazy to tend to an emergency delivery when I know it is a woman who never came for a prenatal examination. I find myself being slow to arrive to help.” Bidan Yanti agreed, “The emergencies seem to be the women who we have not met in the clinic before. I feel lazy to go to the clinic to tend to the emergency like they felt lazy to come to the clinic for an examination.” Years of frustration on the part of the SBA midwives led to perceptions that can result in a dangerous delay in care.

The women also understand that a change in use patterns of obstetrical practitioner (from TBA to SBA midwife) would result in a transformation of their identity, but are unsure of what this would mean. Ibu Titik eloquently expressed her concern about what it would mean to engage in the world of the SBA midwife during this ritually important time of life. She responded, "I do not know what I am supposed to do to become a person who always goes to the clinic as is told to us [by the SBA midwives]." There is an existential quality to this statement. Although Ibu Titik continues to express the opinion that she is not sure that she would want to be a person who always goes to the clinic, she is examining what it would mean to embody that type of existence.

Ibu Wayan, interestingly a neighbor of both SBA midwife, Bidan Dewi and a TBA midwife, chose to give birth with the assistance of Bidan Dewi for her fifth delivery that resulted in her third living child. The first four deliveries were assisted by the neighboring, TBA midwife. Ibu Wayan related a story of transformation. She described not understanding Bidan Dewi for many years. "Bidan Dewi was frightening to me. I lived next to her. I started seeing what she did every day. I started wanting to do some things the way she does them. I decided to have this baby at her clinic." Of Ibu Wayan, Bidan Dewi said, "Wayan had two babies die in childbirth. Finally, she came to the clinic for care for her fifth baby and it was a success. If she had chosen to come for the third and fourth deliveries maybe those babies would be alive." In these responses, two sentiments are clear: first, Ibu Wayan combined being interested in the way that Bidan Dewi lived with deciding to give birth with her assistance; and second, Bidan Dewi assigned at least partial responsibility to the death of two babies to the choices that Ibu Wayan made about obstetric care. In the months after the delivery, Ibu Wayan mentioned several times that she was one of Bidan Dewi's patients now and was learning the "new theories." Likewise, Bidan Dewi often made mention of her interactions with Ibu Wayan when she was in the presence of other women.

Clashing Motivations and Goals in the Transactions Between SBA Midwives and Reproducing Women

A great deal of effort from global health operatives and social scientists has gone into investigating the many barriers to treatment in various geographical and illness contexts (EG Nichter 2008). It is well understood that there are multiple confounding issues at play in these situations, including the right to simply not want treatment that is offered. In some cases, there are not clear answers as to why treatment or intervention programs are not more successful in places where the practitioner shares the treatment objectives and other barriers to treatment have been removed. Understanding this process remains a dilemma in health care provision.

A focus on individual reasons for slow changes in maternal health misses an important space in the provision of care where problems exist. The transaction between the SBA midwives, as the agent of global maternal health programs, and the rural women, as the intended audience, is not examined to the extent that it should be, as this analysis has demonstrated.

In these transactions, we see efforts to shape and transform the rural women into a modernized version promoted by the Indonesian development agencies. Global reproductive health efforts to improve the life chances of women and children are profoundly necessary in many regions of the world. But with these programs comes knowledge systems created by experts imposing specific agendas and goals for foreign bodies (Rothman 1998). In this way, the knowledge and product carries with it a particular view of how the world ought to be and how people should behave (Hahn and Gaines 1985). The services are gifts imbued with an agenda to replicate social and cultural ways of being that are native to the experts. Mauss (1990: 13) described the gifts of the Maori (called *taonga)* as being a “vehicle for its mana, its magical, religious, and spiritual force.” The person who engages with the gift accepts the “spiritual essence,” “soul,” and identity of the giver and signals a desire to join their way of being. When the rural Indonesian women seek the care of the TBA midwife they are maintaining those social ties and existence in their social world of origin rather that transforming, as the SBA midwives are meant to facilitate.

In these transactions, we also see the ways that global structures of hierarchy and inequality are expressed in places far from their origins (Maternowska 2006). Offering health services to women has been demonstrated to be complicated as a result of multiple vulnerabilities that are often conflicting (Clarke and Olesen 1999; Ettorre 2002). The reproductive process is marked with particular social and economic vulnerabilities as is well recognized within the fields of sociology and anthropology (Basalmo 1999; Ettorre 2002; Davis-Floyd 2003) as well as those fields associated with global health (Filippi et al. 2006). It is during this time that women are most forcefully met with politically and socially shaped practices meant to control their bodies (Manderson and Whiteford 2000). It is when physical reproduction happens that social reproduction is thoroughly examined (Brenner 2011). Powerful political and social structures are continually acting on and shaping women's reproducing bodies. The expectation that a woman would need to turn into something else leaves her vulnerable as in the case of the rural Indonesian women, potentially separated from her current social system.

Mauss suggested that those who default on the exchange system lose status and possibly punishment. "To refuse to give, to neglect to invite, as to refuse to take, it is equivalent to declaring war; it is to refuse alliance and communion" (Mauss 2016: 74). Women who do not accept maternal health care are defined as lazy and ignorant by the SBA midwives. Feeling this critique, women are less likely to seek care that has potential to save lives.

Conclusion

Nearly 100 years ago Mauss suggested that even his analysis was based on what he termed "archaic society," his findings told us something about forces at play in contemporary societies. The ideas presented in his essay inspired several generations of scholars to examine exchange. Whether scholars supported or critiqued his findings, the discussion about exchange was advanced and set into motion the subfields of economic sociology and anthropology. Ultimately, the central argument, that exchange represents power and social structures as well as being constitutive of social order holds today. Mauss stressed that gift exchange was significant in the way that it influenced social order and events, suggesting that even peace and war could be altered in these symbolic transactions. In the post–World War I era when Mauss conducted his research and wrote *The Gift*, he was concerned about the well-being of society, the ability of diverse social groups to find a way to get along, while also caring for the members of society. He hoped to help Europeans learn "to confront one another without massacring each other" (2016: 197). Similarly, Mauss's ideas offer insight into a confrontation of another kind: the health care encounter both at the program and intervention levels.

The case of the SBA midwives offering global reproductive health programs to women in rural Indonesia and the women's selective reception of the care at much lower rates than expected was described to accomplish three things: first, to demonstrate the importance of focusing on the social transactions rather than individual level analyses; second, to demonstrate the analytical power of examining health care transactions in the form of gift exchange; and third, to demonstrate how power and status are expressed through health care transactions.

The SBA midwives expected that the women in the rural villages were supposed to accept the care that they had to offer. The SBA midwives saw this care as a gift for the women, their families, and the nation that would improve the life chances of women and infants through the inherently risky physiological process of pregnancy and childbirth. As the gift giver, the SBA midwives inhabited a position symbolically superior to the intended recipient, the rural reproducing woman. They were surprised, frustrated, and sometimes offended to find that the women were circumspect in their interaction with the maternal health services offered to them and reticent to change their patterns of using the TBA midwives for the birth process. The rural women expressed interest in the care that might save lives but hesitance to engage in a relationship with the SBA midwives as well as to curtail the relationship with the TBA midwives. The ramifications for aligning themselves with the SBA midwives were not clear to the women so they limited their involvement with the biomedical maternal health care. If the women became patients of the clinic, would this fundamentally change their identities and relationships with their neighbors, each other, and the way that they lived? And very explicitly, how would they express their gratitude to the SBA midwives? Surely, they said, this would be different from the multitude of ways that the women reciprocated with the TBA for the services offered, a process that lasted the lifetime of the child produced.

This chapter started by describing the individualistic understandings of health status that are woven into the structure of biomedicine and global health care interventions. This individualistic perspective is used in determining the reasons for health and wellness as well as shaping evaluations conducted of interventions such as the global maternal health programs described. Individuals are seen as making healthy or unhealthy choices; institutions offer employees incentives for exhibiting healthy behavior. Those who do present with behaviors unwanted or deemed unhealthy by society are marked as morally suspect and undeserving. Poor health is understood as a personal choice or an unfortunate genetic composition.

While expenditures to advance pharmaceutical, surgical, and various other technological treatments are important in the overall effort to advance health and wellness for all, it is short-sighted to allow it to overshadow investments in making treatments and interventions effective and responsive to what the local people want. Ideas such as health belief models work to understand the particular context of the health care recipient, but they replicate a focus on the individual, leaving the interaction between the health care practitioner and patient unanalyzed.

It is in transactions and exchanges that we can locate how powerful systems of knowledge, comparatively replete with resources, move across the globe. These transactions reveal unequal power distributions whereby global systems are created by a minority but impact a majority. How is it that we determine who is “in need” and who is “deserving” of health care investment? We see that those who follow the moral codes of the powerful receive investment and those who exhibit characteristics that are not appreciated by the powerful are punished through lack of investment. These systems have a far from homogenizing impact on social worlds. It is in these transactions that we can see some of the bidirectional shaping of practice that happens as knowledge systems travel. This demonstrates the power of looking carefully at the social exchange. This is something we pass by too quickly in many analyses. It reveals tensions and miscommunications based on class, race, gender, and social and cultural issues that are otherwise silenced in searches for technological fixes. It reveals hierarchy, inequality, paths for connections, points of tension, and possible convergences.

Notes

1. The Kula exchange is sometimes also referred to as the Kula ring. This is a ceremonial exchange system found in a Melanesian archipelago off the east coast of Papua New Guinea. While it was noticed and recorded by Western missionaries and colonizers earlier, it was first described in detail by Malinowski in his study of exchange in the Trobriand Islands (1922).
2. "Potlatch" is a term to describe ceremonial feasts where gift giving is the central feature of the event. The gift giving is extensive, described as competitive, and is a central feature to the local social system. This cultural practice, like the Kula ring, was frequently mentioned by various Western explorers, missionaries, and colonizers and was seen as an obstacle to assimilating Northwestern native populations into Western and Christian ways of life. Anthropologist Franz Boas (among others) wrote extensively on this practice and the failure of colonizing bodies to ban it.
3. *Bidan* is the Indonesian word for the Skilled Birth Attendant.
4. Nearly 85% of women report having used some sort of clinic provided health care in the last year (BPS 2011).
5. There is a great amount written on the debate about whether there is such a thing as a "free gift." See the following for good examples of this debate: Panoff 1970; Titmus 1971; Parry 1986; Laidlaw 2000; Tharakan 2007; Gregory 2015.
6. This is sometimes a reason for women to choose to seek care from a TBA midwife rather than a SBA midwife. If the etiology of a problem is seen to be originating in the spirit world, then the care of a TBA would be sought sometimes rather than the care of the SBA midwife and sometimes in compliment to care from the SBA midwife.

References

Agus, Y., Horiuchi, S., & Porter, S. (2012). Rural Indonesian women's traditional beliefs about antenatal care. *BMC Research Notes, 5*, 589–596.

Aktipis, C. A., Lee, C., & De Aguiar, R. (2011). Risk-pooling and herd survival: An agent-based model of a Maasai gift-giving system. *Human Ecology, 39*(2), 131–140.

Andaya, E. (2009). The gift of health: Socialist medical practice and shifting material and moral economies in post-Soviet Cuba. *Medical Anthropology Quarterly, 23*(4), 357–374.

Anderson, W. (2006). *Colonial pathologies: American tropical medicine, race, and hygiene in the Philippines*. Durham: Duke University Press.

Anwar, I., Sami, M., Chowdhury, M. E., Salma, U., Rahman, M., & Koblinsky, M. (2008). Inequity in maternal health-care services: Evidence from home-based skilled-birth-attendant programmes in Bangladesh. *Bulletin of the World Health Organization, 86*, 252–259.

Barkin, G., & Hildebrand, V. M. (2014). Midwife radio: The entangled trajectories of global health programming, broadcast media, and the Indonesian state. *Anthroplogical Quarterly, 87*(4), 1105–1136.

Basalmo, A. (1999). Public pregnancies and cultural narratives of surveillance. In A. E. Clarke & V. Olesen (Eds.), *Revisioning women, health, and healing: Feminist, cultural, and technoscientific perspectives*. New York/London: Routledge.

Battaglia, D. (1992). The body in the gift: Memory and forgetting in Sabarl mortuary exchange. *American Ethnologist, 19*(1), 3–18.

Bhutta, Z. A., & Black, R. E. (2013). Global maternal, newborn, and child health: So near and yet so far. *New England Journal of Medicine, 369*(23), 2226–2235.

Boellsdorf, T. (2004). The emergence of political homophobia in Indonesia: Masculinity and national belonging. *Ethnos, 69*(4), 465–486.

Bohannan, P. (1955). Some principles of exchange and investment among the Tiv. *American Anthropologist, 57*(1), 60–70.

Borbieva, N. O.'. N. (2010). Troubled relations: Mobility and exchange in post-soviet Kyrgyzstan. *Ethnology, 49*(3), 167–184.

Bornstein, E. (2012). *Disquieting gifts: Humanitarianism in New Delhi*. Stanford: Stanford University Press.

Bourdieu, P. (1993). *The field of culture production*. Cambridge: Polity Press.

BPS-Statistics Indonesia. (2011). *SUSENAS 2010: National socio-economic survey*. Jakarta: BPS.

Brenner, S. A. (1998). *The domestication of desire: Women, wealth, and modernity in Java*. Princeton: Princeton University Press.

Brenner, S. A. (2011). Private moralities in the public sector: Democratization, Islam, and gender in Indonesia. *American Anthropologist, 113*(3), 478–490.

Brunson. (2010). Confronting maternal mortality, controlling birth in Nepal: The gendered politics of receiving biomedical care at birth. *Social Science and Medicine, 71*(10), 1719–1727.

Cashdan, E. A. (1985). Coping with risk: Reciprocity among the Basarwa of Northern Botswana. *Man, 20*(3), 454–474.

Clarke, A. E., & Olesen, V. (1999). *Revisioning women, health, and healing: Feminist, cultural, and technoscientific perspectives*. New York/London: Routledge.

Clarke, A. E., Shim, J., Mamo, L., Fosket, J. R., & Fishman, J. R. (2003). Biomedicalization: Technoscientific transformations of health, illness, and U.S. biomedicine. *Americal Sociological Review, 68*(2), 161–194.

Davis-Floyd, R. (2003). *Birth as an American rite of passage*. Berkeley: University of California Press.

Ettore, E. (2002). *Reproductive genetics, gender and the body*. London/New York: Routledge.

Filippi, V., Ronsmans, C., Campbell, O. M. R., Graham, W. J., Mills, A., Borghi, J., Koblinsky, M., & Osrin, D. (2006). Maternal health in poor countries: The broader context and a call for action. *Lancet, 368*, 1535–1541.

Finlayson, K., & Downe, S. (2013). Why do women not use antenatal services in low- and middle-income countries? A meta-synthesis of qualitative studies. *PLoS Medicine, 10*(1), e1001373.

Firth, R. (1967). *We, the Tikopia*. London: Routledge.

Godoy, R., Reyes-Garcia, V., Huanca, T., Leonard, W. R., Olivara, R. G., Bauchet, J., Ma, Z., St. John, J., Miodowski, M., Rios, O. Z., Vadez, V., & Seyfreid, C. (2007). The role of community and individuals in the formation of social capital. *Human Ecology, 35*(6), 709–721.

Gouldner, A. W. (1960). The norm of reciprocity: A preliminary statement. *American Sociological Review, 25*, 176–177.

Gregory, C. A. (2015 [1982]). *Gifts and commodities*. Chicago: Hau Books.

Hahn, R. A., & Gaines, A. D. (1985). *Physicians of Western medicine: Anthropological approaches to theory and practice*. Boston: D. Reidel Publishing Company.

Hart, K. (2007). Marcel Mauss: In pursuit of the whole. *Comparative Studies in Society and History, 49*(2), 1–13.

Harvey, S. A., Ayabaca, P., Burcagu, M., Djibrina, S., Edson, W. N., Gbangbade, S., McCaw-Binns, A., & Burkhalter, B. R. (2004). Skilled birth attendant competence: An initial assessment in four countries, and implications for the safe motherhood movement. *International Journal of Gynecology & Obstetrics, 87*, 203–210.

Hattori, T. (2003). The moral politics of foreign aid. *Review of International Studies, 29*(2), 229–247.

Hildebrand, V. M. (2012). Scissors as symbols: Disputed ownership of the tools of biomedical obstetrics in rural Indonesia. *Culture, Medicine, and Psychiatry, 36*(3), 557–570.

Kyomuhendo, G. B. (2003). Low use of rural maternity services in Uganda: Impact of women's status, traditional beliefs and limited resources. *Reproductive Health Matters, 11*(21), 16–26.

Laidlaw, J. (2000). A free gift makes no friends. *Journal of the Royal Anthroplogical Institute, 6*(4), 617–634.

Levi-Strauss, C. (1987 [1950]). *Introduction to the work of Marcel Mauss* (trans: Felicity, B.). London: Routledge.

Li, T. M. (2007). *The will to improve: Governmentality, development, and the practice of politics*. Durham: Duke University Press.

Maheu-Giroux, M., Filippi, V., Samadoulougou, S., Castro, M. C., Maulet, N., Meda, N., & Kirakoya-Samadoulougou, F. (2015). Prevalence of symptoms of vaginal fistula in 19 sub-Saharan Africa countries: A meta-analysis of national household survey data. *The Lancet Global Health, 3*, e271–e278.

Malinowski, B. (1922). *Argonauts of the Western Pacific: An account of native enterprise and adventure in the archipelagoes of Melanesian new Guinea*. London: Routledge.

Manderson, L., & Whiteford, L. M. (2000). Introduction: Health, globalization, and the fallacy of the level playing field. In L. M. Whiteford & L. Manderson (Eds.), *Global health policy, local realities: The fallacy of the level playing field*. Boulder: Lynne Rienner.

Marmot, M. (2009). Closing the health gap in a generation: The work of the commission on social determinants of health and its recommendations. *Global Health Promotion, 16*(S1), 23–27.

Maternowska, M. C. (2006). *Reproducing inequities: Poverty and the politics of population in Haiti*. New Brunswick: Rutgers University Press.

Mauss, M. (1925). Essai sur Le Don: Forme et Raison de l'Échange dans Les Sociétés Archaïque. *Année Sociologiqe, New Series, 1*, 30–186.

Mauss, M. (1967). *The gift: Forms and functions of exchange in archaic societies*. Translated by Ian Cunnison with an Introduction by E. E. Evans-Pritchard. New York: W. W. Norton and Company.

Mauss, M. (1990). *The gift: The form and reason for exchange in archaic societies*. Translated by W.D. Halls with an Introduction by Mary Douglas. London and New York: Routledge Classics.

Mauss, M. (2016). The gift: Expanded edition. Selected, annotated, and translated by Jane I. Guyer. Chicago, Illinois: Hau Books.

Mawdsley, E. (2012). The changing geographies of foreign aid and development cooperation: Contributions from gift theory. *Transactions of the Institute of British Geographers, 37*(2), 256–272.

Ministry of Health, Republic of Indonesia. (2008). *The directorate general of community health: Technical guidelines for health insurance scheme for the population in health centres and its networks, year 2008*. Jakarta: Ministry of Health, Republic of Indonesia, The Directorate of Community Health.

Mortiz, M. (2013). Livestock transfers, risk management, and human careers in a West African pastoral system. *Human Ecology, 41*, 205–219.

Mpembeni, R. N. M., Killewo, J. Z., Leshabari, M. T., Massawe, S. N., Jahn, A., Mushi, D., & Mwakipa, H. (2007). Use patterns of maternal health services and determinants of skilled care during delivery in Southern Tanzania: Implications for achievement of MDG-5 targets. *BMC Pregnancy and Birth, 7*, 29.

Nichter, M. (2008). *Global health: Why cultural perceptions, social representations, and biopolitics matter*. Tucson: The University of Arizona Press.

Panoff, M. (1970). Marcel Mauss's *The Gift* revisited. *Man, 5*(1), 60–70.

Parry, J. (1986). The gift, the Indian gift and the 'Indian gift.'. *Man, 21*(3), 453–473.

Piddocke, S. (1965). The potlatch system of the southern Kwakitul: A new perspective. *Southwestern Journal of Anthropology, 21*(3), 244–264.

Pigg, S. L. (1997). Authority in translation: Finding knowing, naming and training 'traditional birth attendants' in Nepal. In R. Davis-Floyd & C. Sargent (Eds.), *Childbirth and authoritative knowledge: Cross-cultural perspectives* (pp. 233–262). Berkeley: University of California Press.

Pinto, S. (2008). *Where there is no midwife: Birth and loss in rural India*. New York: Berghan Books.

Polanyi, K. (1944). *The great transformation: The political and economic origins of our time*. New York: Penguin.

Ronsmans, C., & Graham, W. J. (2006). Maternal mortality: Who, when, where, and why. *The Lancet, 368*(9542), 1189–1200.

Rothman, B. K. (1998). *Genetic maps and human imaginations*. New York: W.W. Norton.

Sahlins, M. D. (1965). On the sociology of primitive exchange. In M. Glockmand & F. Eggan (Eds.), *The relevance of models for social anthropology, Association of social anthropology monograph* (Vol. 1, 9th ed.). London: Tavistock Publications.

Scheper-Hughes, N. (2007). The tyranny of gift: Sacrificial violence in living donor transplants. *American Journal of Transplantation, 7*, 507–511.

Sedgh, G., Ashford, L. S., & Hussain, R. (2016). *Unmet need for contraception in developing countries: Examining women's reasons for not using a method*. New York: Guttmacher Institute.

Smart, A. (1993). Gifts, bribes, and Guanxi: A reconsideration of Bourdieu's social capital. *Cultural Anthropology, 8*(3), 388–408.

Stirrat, R. L., & Henkel, H. (1997). The development gift: The problem of reciprocity in the NGO world. *The Annals of the American Academy of Political and Social Science, 554*, 66–80.

Strathern, A. J. (1971). *The rape of Moka: Big-men and ceremonial exchange in Mont Hagan, New Guinea*. Cambridge: Cambridge University Press.

Strathern, M. (1988). *The gender of the gift: Problems with women and problems with society in Melanesia*. Berkeley: University of California Press.

Strathern, A., & Stewart, P. J. (2005). Ceremonial exchange. In J. G. Carrier (Ed.), *A handbook of economic anthropology*. Northampton: Edward Elgar.

Testart, A. (2013). What is a gift? *Hau: Journal of Ethnographic Theory, 3*(1), 249–261.

Thaddeus, S., & Maine, D. (1994). Too far to walk: Maternal mortality in context. *Social Science and Medicine, 38*(8), 1091–1110.

Tharakan, G. C. (2007). Gift and commodity: On the nature of Muduga transaction. *Anthropos, 102*(2), 441–454.

Titaley, C. R., Hunter, C. L., Dibley, M. J., & Heywood, P. (2010). Why do some women still prefer traditional birth attendants and home delivery?: A qualitative study on delivery care services in West Java Province, Indonesia. *BMC Pregnancy and Childbirth, 10*(43), 1–14.

Titmuss, R. M. (1971). *The gift relationship from human blood to social policy*. New York: Pantheon Books.

Valeri, V. (2013). Marcel Mauss and the new anthropology. *HAU: Journal of Ethnographic Theory, 3*(1), 262–286.

Van den Broek, N. R., & Graham, W. J. (2009). Quality of care for maternal and newborn health: The neglected agenda. *BJOG, 116*(s1), 18–21.

Viera, C., Portela, A., Miller, T., Coast, E., Leone, T., & Marston, C. (2012). Increasing the use of skilled health personnel where traditional birth attendants were providers of childbirth care: A systematic review. *PloS One, 7*(10), e47946.

Watanabe, C. (2015). Commitments of debt: Temporality and the meanings of aid work in a Japanese NGO in Myanmar. *American Anthropologist, 117*(3), 468–479.

Weiner, A. (1992). *Inalienable possessions: The paradox of keeping while giving*. Berkeley: University of California Press.

World Health Organization. (2004). *Making pregnancy safer: The critical role of the skilled birth attendant: A joint statement by WHO, ICM, and FIGO*. Geneva: World Health Organization.

8

Afterword

Barbara Katz Rothman

It is an honor to be asked to write this Afterword—and as is often the case with honors, quite a difficult task. I come at this as very much the outsider. I am an American—the only country that thinks of itself as a developed country, a part of the 'first world,' that does not guarantee access to needed medical services for all of its citizens. And I come from the world of midwifery, am the person who coined the term 'midwifery model of care,' (Rothman 1982) a term adopted by American midwives themselves, to distinguish how midwives work from the way medicine does. I am a 'medical sociologist,' who works entirely outside of biomedical spheres. Most of my interests and research have been in life arenas that have only recently been colonized by medicine, issues of health and procreation, and most of my work has been about reclaiming those things from medical domination (see e.g. Rothman 2016; Simonds and Rothman 2007).

I cannot tell you how carefully and thoughtfully I had to think about each word while writing that simple paragraph. The book has the word

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'health' in its title and uses phrases such as 'health research,' 'health care' and 'health care systems' throughout (starting in Chap. 1). I never use the word 'health' now unless I really mean it. I have been making rather a nuisance of myself with this lately: the students in my doctoral seminar this semester on 'Biomedical Imperialism' now catch themselves, start to say 'health care' and pause, smile, nod and say 'medical services.' I carefully say 'procreation' rather than 'reproduction,' because as feminist biologist Ruth Hubbard taught me, we do not reproduce ourselves—we come together and procreate a new one of us.

Defining 'health' is yet more complicated, and rather like that old bad line about pornography—I cannot define it but I do know it when I see it. I would say that health is a state of being in which the body is not causing one much trouble, and in which the body is sometimes giving one some joy.

Health is always and inevitably contextual. A person who cannot sit up, cannot eat solids, cannot coordinate hand and eye movement, and cannot effectively process words may be quite healthy: if they are two months old. A person who can only walk slowly, has some visual and some hearing loss, and needs very frequent bathroom access for urinary incontinence may also be quite healthy: if they are 92 years old. Health in some ways is about a body that meets standardized expectations; and ill health means a body that cannot meet those expectations. And our expectations involve race, sex, disability—every divisive bodily concept. I mean 'divisive' both ways here—we divide people by those hard-to-define, socially contentious categories, and then we use them politically and socially to treat people differently and create divisiveness, as Ettorre demonstrates with regard to transbodies seen as non-procreative (see Chap. 3).

While this book—and so very much of the national discussion in the United States as in the United Kingdom and Europe—claims to be about 'health' and 'health care,' its real focus is on medical services. People are forever talking about 'access to health care' when what they mean is an ability to get screenings, treatments and medical services of all kinds. But this has little to do with either health or care. By 'access' they are talking about insurance of one sort or another to pay for medical services. What access to health care as a right actually means in our contemporary world is ‘affordable medical services.’ Medical services can indeed restore health sometimes; they can even occasionally preserve health. But health is not a product of medical services, and those services very rarely look or feel like ‘care.’

There is a difference, a world of difference between what is called ‘access to health care’ and what that would really mean. Health has most certainly been medicalized, turned into a series of appropriate numbers on screening tests and fitbits, but we—as sociologists and anthropologists, as social observers and thinkers—must be clear on what health means and what it does not mean.

When people—my friends and neighbors or my colleagues in this book—talk about rapidly changing health care systems, they are rarely talking about the social infrastructure and the personal interactions that really would make up a health-focused system. Clean air and water; safe walking and biking paths; a friend to encourage walking rather than driving to the store when you’re a bit stiff with aging joints, even going along with you; cheap healthy food and friends to share it with; a warm clean place to sleep—those are health care services. A diabetes screen and a prescription for pills to manage one’s blood sugar levels is a medical service.

The place that this distinction is most central to my own work is in the care of pregnant and birthing women. In the world of medicine and biomedicine, this is called ‘obstetric care,’ or more accurately, ‘obstetric services.’ Pregnant women are expected to show up regularly and frequently at medical offices and be weighed, measured, have fetal heart tones evaluated, have fetal images scanned and observed. In the world of obstetrics, women are the ‘maternal barrier’ between the physician and the fetal patient. There are literal and actual discussions of that pregnant woman as the ‘maternal barrier,’ or in cases where a high-risk fetus is to be moved to a tertiary care center, the pregnant woman is the ‘site,’ as the fetus is moved ‘in situ.’

This is in deep contrast to the history of midwifery care, a form of care that was and is deeply woman-centered, connecting a woman’s birth to her life and her community, and very much focused on health. And here too being an American puts me very much on the outside: The United States is one of the few countries that attempted to completely abolish midwifery and grant a total monopoly over pregnancy and birth management to the medical profession. Most other countries absorbed midwifery care into biomedical management, although using midwives sometimes in a more nurse-like role, often in what we today would call a 'nurse-practitioner' position. Physicians set the limits to what midwives could do, but they could practice some version of midwifery. I believe that looking at the history of American midwifery and the medical colonization that occurred, we can better understand what Hildebrand (see Chap. 7) sees in rural Indonesia as a 'gift,' but I—along with many other historians and sociologists of birth—see it more as a theft.

By the nineteenth and early twentieth centuries, midwives and physicians in the United States were in direct competition for patients, and not only for their fees. Newer, more clinically oriented medical training demanded 'teaching material,' so that even immigrant and poor women were desired as patients. The only midwives that were spared were those that were in geographically undesirable places. African-American midwives continued to practice in the deep, rural south long enough so that the new midwifery movement of the 1970s could 'rediscover' them, rename them from the disparaging 'Grannies' (or what would now be called the equally disparaging 'traditional birth attendants' [TBAs]) to the honorific 'Grand Midwives.' But in the urban areas, doctors used everything in their power to stop the midwives from practicing. They advertised, using racist pictures of 'drunken, dirty' Irish midwives, and of hooked-nose, witch-like Jewish midwives. They played on immigrant women's desire to 'become American,' linking the midwives with 'old country' ways of doing things. The displacement of the midwife—now as then I believe—can be better understood in terms of this competition than as an ideological struggle or as 'scientific advancement.' Physicians, unlike the unorganized, disenfranchised midwives, had and have access to the power of the state through their professional associations. They were thus able to draw women in with their advertising, but also to control licensing legislation, in state after state restricting the midwives' sphere of activity and imposing legal sanctions against them.

While Hildebrand refers to obstetrically, biomedically trained nurse-midwives as 'Skilled Birth Attendants' and uses the now-standard medical language to call the midwives they are displacing 'TBAs,' the question of 'skill' is very much unresolved (see Chap. 7). To become a nurse-midwife in the United States now, for example, one has to be the primary provider at 40 births, up from 25 a few years back. Some of the midwives they are displacing have attended hundreds, even thousands. One of the 'training' films made for the Department of Health in Georgia in the 1950s, "*All My Babies*" (http://www.der.org/films/all-my-babies.html), shows a nurse teaching the supposedly unskilled grannies how to tie knots, literally knot-tying lessons for umbilical cord management—nodding approvingly at a knot tied by a midwife who had worked in her community and attended over a thousand births. She is also taught to require the birthing woman to lie flat on her back to give birth—a decidedly unphysiological position introduced by physicians.

What did the medical takeover of birth mean for women and babies? Medicine would have us believe that it meant above all a safer birth. The profession of medicine claims that the decline in maternal and infant mortality that we experienced in the twentieth century was a result not so much of women's hard-won control over their own fertility, or even of better nutrition and sanitation, but rather of medical management. Medical expansion into the area of childbirth began, however, before the development of any of what are now considered to be the contributions of modern obstetrics: before asepsis, surgical technique, antibiotics and anesthesia. At the time when physicians were taking over control of childbirth in the United States, the non-interventionist, supportive techniques of the midwife were safer for both the birthing woman and her baby (for a fuller discussion, see Rothman 2016).

In Washington, DC, as the percentage of births reported by midwives shrank from 50% in 1903 to 15% in 1912, infant mortality on the first day, first week and first month of life all increased. New York's dwindling corps of midwives did significantly better than did New York doctors in preventing both stillborns and puerperal sepsis (postpartum infection). And in Newark a midwifery program in 1914–1916 achieved maternal mortality rates as low as 1.7 per thousand, while in Boston, in many ways a comparable city but where midwives were banned, the rates were 6.5 per thousand. Infant mortality rates in Newark were 8.5 per thousand, contrasted with 36.4 in Boston (Kobrin 1966). The situation was similar in England, where an analysis of the records of the Queen's Institute for Midwives for the years 1905–1925 found that the death rate rose in step with the proportion of cases to which midwives called the doctors (Donnison 1977). One obvious, if overlooked, explanation for some of this increase in morbidity is hospitalization and the nosocomial infections which follow: bringing people into institutional care increases, not decreases, the spread of infection. This is still true in the rural Indonesian settings Hildebrand discusses in which all women are being asked to leave their homes and go into clinics for births.

By the end of the Second World War, American birth safety numbers had recovered from medicalization. Partly that has been the result of improved medical techniques and technologies, and partly by larger health and population shifts—eighth, ninth, tenth babies are at greater risk, and you hardly ever see those any more. The dangerous conditions of early urbanization, like rickets and TB, are largely conquered. The infections which are always a problem in any institutionalized setting largely (though not completely) yielded to antibiotics. The women coming in are much 'lower risk' than women were in the 1800s and early 1900s. That is, not only were *practices* different but *populations* were different. It doesn't make sense to compare outcomes on 32 year olds having their eighth baby with 32 year olds having their second; doesn't make sense to compare birth outcomes in populations with rickets with those without; doesn't really make sense to compare women living with poor sanitation, no running water, with those living in contemporary suburbs. Again, always, it's not only about clinical care, it's also about public health.

That is the history and vision which I, as the outsider, bring to a discussion of the ongoing displacement of the midwife by biomedical power: not a gift, but a theft.

We—as Europeans, Americans, as citizens of the world—are so trained to think of medicine as our savior, as something we 'believe in,' and as a scientific endeavor, entirely based on thoughtful careful research, that it is small wonder we think of it as a gift. Medicine is also though very much a product of global capitalism, an industry as much as anything else. As the outsider, as the American, I am undoubtedly far more aware of that because I am made to function more directly as a consumer. In the rest of the developed world, governments act as consumers on behalf of individual citizens so that the industrial profit-making aspect is less obtrusive. Medicine and pharmaceuticals have branded themselves as purveyors of health, and that encourages us to say things, such as are said in this book, that people have a 'right to health.' But what could that possibly mean? A baby born with an incurable painful fatal disorder has had its rights violated? By whom? God? Or the parents who didn't do proper prenatal surveillance and terminate the pregnancy? Surely that is not what was intended when the authors here speak of a 'right to health.' What is meant is a right to a world order which makes health possible, probable, as likely as it can be made—a world order which Annandale and Ettorre see as being swallowed up by neoliberal, economic and social governance (see Chaps. 4 and 6).

Most often we think of that as happening at the individual level—individuals taking good and proper care of their own bodies, and—perhaps most directly when we speak of a 'right to health'—seeking and having access to all needed medical services. But health happens not only at that individual level but as I have been pointing out, at the public level. That was of course the basis for the establishment of an entire field of research and practice known as Public Health. In the United States, many of us are very aware of the ways in which that field of Public Health has moved from addressing public and political issues to 'public service announcements' encouraging individual conformity with best health practices.

When we focus on access to medical services and on individual behavior, we look at things like the loss of the migrant health advantage as being about an adaption to the norms of the new community, as Annandale does, rather than opening our vision to the changing structures (see Chap. 2). Similar issues are raised by Porroche-Escudero in Chap. 5 about norms versus structure in our understanding of family violence. We see individuals who fail to take care of themselves, rather than an environment that fails to provide a structure conducive to health. What are the transportation systems, the housing conditions, the inexpensive and available foods? Does one adapt to the 'norms' when one switches from the plants grown in one's yard to the food available in the corner bodega? Does one adapt to the 'norms' when a neighborhood is not safe for an evening stroll? Or is one adapting to different structural conditions?

None of this is to deny the agency of individuals—as feminists in particular, we are so accustomed to the agency and power of women being ignored in research that we often tend to almost glorify that agency, appreciating the creativity and ingenuity of individual actors, the way they use their environment and its limitations without properly critiquing that environment. I have seen that controversy, that contentious discussion, on every issue involving women's use of biomedical services, from so-called surrogacy to cosmetic surgery. Surrogacy grows out of the deeply patriarchal notion that the meaningful relationship between parent and child is the genetic tie, first the seed of man and now encompassing the egg, the seed of women, both valued as making a child 'of one's own,' while pregnancy is reduced to cheap housing, outsourced to places where the bodies of women are even less valuable than in our own countries. Women interned as 'surrogate mothers' in medical clinics in India for the duration of their pregnancies, restricted, monitored, knowing that they have no control over their bodies or the babies they are bearing, form wonderful relationships with each other, create a sisterhood and a community. And some feminist scholars focus on that, the creativity of those women, without paying attention to the larger structure. But the women of Terezin concentration camp wrote a cookbook, celebrating their culture, their womanly experiences and their sisterhood. As powerful, beautiful, impressive as that creation is, it tells us nothing to make us more comfortable with the Nazis. I am not comparing surrogate brokers to Nazis, no—but I am saying that both worked with a eugenic model, used the bodies of women, and women resisted and resist today and some of that resistance is an inspiring sisterhood. Women, looking at the constraints and restrictions placed on women as they age, may well make intelligent, thoughtful, sometimes creative, clever and inspired use of cosmetic surgery—we can admire the women without accepting anything about the constraints. From the most enormous and awful of things to the most trivial, from the Holocaust to Botox, feminists can celebrate what women can and do accomplish in all kinds of resistance. But we must never let that blind us to the circumstances in which that resistance comes forth.

There is much in this book that helps us to understand better the shifting terrain of biomedical power and the way that women, in particular, are affected by those changes. And we have much more to continue thinking about.

References

Donnison, J. (1977). *Midwives and medical men: A history of inter- professional social rivalries and women's rights*. New York: Schocken.

Kobrin, F. (1966). The American midwife controversy: A crisis in professionalization. *Bulletin of the History of Medicine, 40*, 350–363.

Rothman, B. K. (1982). *In labor: Women and power in the birthplace*. New York: W.W. Norton and Company.

Rothman, B. K. (2016). *A bun in the oven: How the food and birth movements resist industrialization*. New York: New York University Press.

Simonds, W., & Rothman, B. K. (2007). *Laboring on: Birth in transition in the United States*. New York: Routledge.

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[1] Note: Locators followed by 'n' refer to notes

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