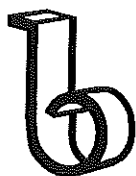


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**Rethinking Difference:  
A Feminist Reframing of Gender/Race/Class  
for the Improvement of Women's Health Research**

*K. Lisa Whittle and Marcia C. Inhorn*

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**RETHINKING DIFFERENCE: A FEMINIST REFRAMING  
OF GENDER/RACE/CLASS FOR THE IMPROVEMENT  
OF WOMEN'S HEALTH RESEARCH**

K. Lisa Whittle and Marcia C. Inhorn

In exploring the history of the social construction of gender/race/class in Western scientific discourse and examining the legacy of these persisting constructions in modern research on women's health, the authors join in a growing debate about sexism/racism/classism in women's health research—a debate being forwarded most forcefully by feminist epidemiologists. A major purpose of this article is to aid in the development of a new research paradigm for examining the relationship between gender, race, and class, one that considers the interdisciplinary theorizing of Third World feminists and European/American feminists of color. Following the examination of both historical and epistemological issues surrounding interlocking forms of oppression based on gender/race/class, the authors propose a feminist research agenda that not only is responsive to different women's health needs, but can potentially contribute to a process for understanding and answering the health needs of all persons.

INTRODUCTION

Some 25 years ago, the women's health movement began energetically and irreverently to expose the multiple aspects of sexism in medicine that permeated scientific and popular views of women's bodies and women's health. Inspired by the new analyses of feminism and the insights gained through shared knowledge and shared experience, activists of the 1960s and 1970s set about questioning everything thought to be known about women's health. They challenged the fundamental view of biology as destiny, refuted the depiction of women as mentally and physically fragile, and raised questions about hazards to women's health at home and in the paid labor force.

Elizabeth Fee and Nancy Krieger (1, p. 1)

Three decades of feminist research and activism in women's health have laid the foundation for construction of a feminist-informed research framework in the area of women's health. Yet, despite these great strides, Western biomedical and public health research on women's health continues to be shaped by attitudes toward gender/race/class that can only be described as sexist, racist, and classist. In this essay, we explore the history of the social construction of gender/race/class in Western scientific discourse in order to examine the legacy of these persisting constructions in modern research on women's health. We then go on to propose an analytical framework of gender/race/class useful for creating a research agenda that engages in the feminist task of understanding and responding to the multiple effects of interlocking oppression on women's health.

We write this essay from our admittedly privileged positions as white, American feminist academics. Our various research projects, which merge anthropological, public health, and feminist approaches, have sought to improve the health of women by revealing the voices, life experiences, suffering, and resistance of poor, marginalized women in various global locations. Yet, as feminist researchers, we acknowledge the multiple layers of "difference" that inevitably distinguish—and distance—us from those we study in our own women's health research projects.

Still, we believe it is important and worthwhile to join in the growing debate about sexism/racism/classism in women's health research being forwarded most forcefully by Western feminist epidemiologists Krieger and colleagues (2). They criticize the empirical methods and underlying constructs of Western epidemiological research and describe a newly emerging approach for investigating the relationship between racism, sexism, classism, and health "that has yet to be synthesized into a well-defined paradigm" (2, p. 99). A major purpose of this essay, then, is to aid in the development of this paradigm by considering both global dimensions and epistemological issues surrounding gender/race/class from an explicit feminist position informed by the interdisciplinary theorizing of Third World feminists and European/American feminists of color (3–6).

As we describe in greater detail later in this essay, Third World feminists and European/American feminists of color are engaged in the "*common context of struggle*" (6, p. 7) against sexist, racist, classist, and imperialist structures, even though they do not constitute a unitary group with similar interests or political histories (5, 6). Rather, through their feminist writings, they challenge us to focus on the "simultaneity of oppressions" (6, p. 10), or the interlocking, relational effects of such categories as gender, race, class, religion, sexual orientation, and citizenship in the global political and economic order, in order to understand how interlocking systems of oppression may shape the daily lives, survival strategies, and—of particular concern in this essay—health and well-being of women around the world. Thus, Third World feminists and feminists of color challenge us to move away from binary oppositional thinking (black *or* white, male *or* female, etc.) and an understanding of oppression as simply "additive" or "identical" for

women around the world, in order to explore the complex *relationality* that shapes women's social and political lives everywhere (5, 6). Moreover, pertinent to this essay, these feminist approaches suggest that we must very carefully interrogate Eurocentric, masculinist forms of knowledge production, including the ways in which terms such as "gender," "race," and "class" are understood and used in Western biomedical<sup>1</sup> and public health discourse. Ultimately, such understandings may serve to maintain the political interests, power, and dominance of elite, white men—be they colonizers or scientists—at the expense of women and people of color around the globe.

Following a strategy emphasized by feminist epistemology (4, 5, 7), we explore what has happened historically at the margins of Western scientific medical research on women's health to recognize and better understand the conceptual models that may actually reinforce social hierarchies of dominance/oppression and constrain our understanding of women's (ill) health and well-being. Indeed, women's health, the focus of this essay, provides a salient example of an area historically marginalized by Western biomedicine and public health via their overprivileging of men's health concerns and their narrow definition of women's health as only those issues related to reproduction (8–10). This is despite the fact that women are the major users of a broad range of health and medical services and are also the major producers of health within their families. They also constitute the great majority of professional health workers (11). In this essay, we describe a feminist research agenda that not only is responsive to different women's health needs, but can potentially contribute to a process for understanding and answering the health needs of all persons. Thus, we also consider an important contribution of a feminist-informed research agenda to be the provision of a framework for considering men's experiences of health and illness, shaped by gender roles and expectations, economic status, racial identities, the communities they live in, and other social locations.

Indeed, if the contemporary biomedical and public health establishments are to respond to the salient needs of women and men around the globe, then they must: (a) recognize and analyze relationships of power shaped by interlocking gender/race/class hierarchies; (b) acknowledge the value and ethics involved in the experiential production of scientific knowledge and the creation of research dialogues in which all parties participate in the production of scientific "truths"; (c) embrace a radical and emancipatory goal of human liberation from unequal and unjust social hierarchies; and (d) be made accountable professionally and personally for academic and health institutions that leave unchallenged and intact

<sup>1</sup> We use the terms "biomedical" and "biomedicine" to refer to Western biologically based medical practice. Commonly used synonyms include "allopathic," "cosmopolitan," or "modern." Such terms are generally used to contrast Western medicine to nonhegemonic "traditional" or "ethnomedical" forms.

oppressive structures, including those interwoven with gender (11). These are the issues to be taken up, directly and indirectly, in this essay.

### THE "LOGIC OF DIFFERENCE": SOCIAL CONSTRUCTIONS OF GENDER/RACE/CLASS IN WESTERN SCIENTIFIC DISCOURSE

To succeed in our struggle for equality, women need to understand how scientific descriptions of ourselves as biological and social organisms are generated and used to maintain sexual inequality. Although women have not had a significant part in the making of science, science has had a significant part in the making of women. Science or, rather, scientists—that relatively small group of economically and socially privileged white men with the authority derived from being scientists—have had an important share in defining what women's human, and more specifically female, nature is and then in defining what is normal for us to do and not to do, indeed what we can do and be.

Ruth Hubbard (12, p. 17)

As Hubbard's words suggest, it is imperative to understand how Western scientific research generates questions about women's health and how the process and results of this research maintain gender, racial, class and global inequalities. Women's health research resides in the intersection of Western science, biomedicine, and public health (based on models of liberal social reform) and holds similar epistemological foundations:

1. A positivist model of science based on "objective," controlled observations guiding knowledge production.
2. Cartesian binary thinking, leading to dualistic notions of self/other, male/female, white/nonwhite, mind/body, and rational/emotional, which further inform notions of the body politic.
3. Mechanistic views of the body, health, and illness that make technological solutions seem appropriate.
4. Belief in scientific and technological progress, including the desirability of social engineering.

Through the knowledge it thus produces and the policies it informs, such research plays a role in mediating our understandings of gender, racial, and class differences, thus reinforcing social stability through promotion of the status quo (13). It is important to ask, however, whose interests are being served by these mediations and who is being allowed to produce this scientific knowledge. A primary concern of feminist studies has been to unravel the myths surrounding gender and the "natural," biological destiny of women that have been embedded in and perpetuated by the scientific enterprise (12, 14–16). In this essay, we begin by tracing a

brief, critical history of scientific and biomedical constructions of gender, race, and class to show how interwoven, dichotomous constructions based on notions of difference and hierarchy shape contemporary research frameworks. To do so, we draw upon recent feminist critiques of science (13, 17–24). We then discuss how this “logic of difference” and “otherness” is embedded in contemporary research on women's health.

Even today, a “logic of difference” understood in terms of hierarchical, essential, biological inequalities continues to undergird the categories we use to collect, analyze, and interpret data on women's health. Currently, U.S. vital statistics utilize classifications that supposedly reflect biological differences affecting health and disease: specifically, age, sex, and race (25, 26). Such categorization reveals U.S. societal preoccupations with biological factors and the reluctance to acknowledge how social divisions, such as class, gender, sexual orientation, and racial identity, affect people's experiences of health and disease. These frameworks encourage biomedicine and public health more generally to focus on presumed “natural” biomedical explanations and solutions for disease, ignoring the importance of sociopolitical factors. By first describing how these categories came to be “naturalized” and rendered structurally invisible, we can then acknowledge their social construction, recognize they are part of a process of domination, and begin to develop an alternative feminist-informed framework.

The earliest formulation of this “logic of difference” can be traced to the beginnings of modern biomedicine in 18th and 19th century Europe. This was an era of profound economic and philosophical change in Europe, as many of these nations embraced industrial capitalism, imperialism, liberal political thought, and secularism. During this time, white women and men of color in Europe, the United States, and the Third World colonies engaged in struggles to gain political rights held by elite, white men (e.g., to vote, own property, pursue education and professional careers, live as free citizens rather than slaves). Faced with the contradictions between existing social inequalities and their political ideal that “every man is created equal in nature,” those possessing political rights called upon science and medicine to resolve these contradictions through discovery of “laws of nature.” Not surprisingly, the laws of nature thus discovered indicated that social inequalities were part of the unavoidable, natural order of things.

Because of their unique, scientific methods based on detached objectivity and replication, science and medicine were seen as having privileged knowledge about nature. In their efforts to establish “natural truths,” scientists and physicians began to define norms about human characteristics, behavior, and health and illness that were based on the experiences and interests of middle-class European and American males. Using a disembodied voice to give the illusion of objectivity and universal “truth” to their discoveries, scientists and doctors succeeded in creating a universe of ontological binary opposites, based on ideas of hierarchy and difference (e.g., male versus female, white versus colored, civilized versus

primitive), which supposedly governed the ways in which human beings naturally existed and lived (27).

The creation of binary opposites made oppressive relationships seem part of the stable, natural order of the world. The stability of such binary opposites, both in construction and in material reality, depended on the existence of contrastive units. Thus, the definition of white middle-class men as superior and powerful resulted from and relied on the creation of the "other" over whom these men could feel superior and maintain institutionalized power. Consequently, by focusing on descriptions of the "other," their concept of self within a white dominant culture was formed as the unmarked center or norm from which to judge all that was "different." Indeed, the racial construction of "whiteness"—or that unmarked category of people who were constructed as the "original and deserving citizens of the nation" and the norm for all that was modern, enlightened, and progressive—was dependent upon defining and marking what was black or colored, exotic, "oriental," or "other" (28). According to this 19th century "logic of difference" concerning sex, race, and class, such "others" included disempowered white women, poor white men, and women and men of color (23).

Employing this logic of difference, Western scientists and physicians went on to "solve the woman question" by developing "gynecological science" and "discovering" that white middle-class women were sickly, weak, irrational, hysterical, less intelligent than men, controlled by their reproductive physiology, unsuitable for the hardships of the public sphere, and in need of careful male supervision (by husbands, physicians, psychiatrists). As a result of their inferior biological nature, white women were deemed undeserving of the rights of "rational, adult" citizens (29). Medical discourses on "woman" and "femininity" provided a distinct contrast to what a middle-class white "masculine" man was supposed to be: namely, healthy, active, self-controlled, rational, and protective. The dichotomous framing of scientific constructions of the feminine and masculine reinforced notions that white middle-class men and women were more different than alike, and that these differences indicated natural superior and inferior positions, respectively. Thus, it came as a most pressing threat to the social order of white male privilege when large numbers of white middle-class European and American women began demanding full rights as citizens at the turn of the century.

Interestingly but not surprisingly, scientific descriptions of women's weakness were ascribed only to white middle-class American and European women, not to women of color or those of the working class (3). According to the European scientific logic of difference, racial difference superceded sexual difference; therefore, scientists did not have to generalize the "delicate" nature of white women to all women, especially women of color (22). Indeed, to have done so would have threatened the social order based on slavery and exploitation of women in the colonies. Instead, scientists constructed differences between women of color and white middle-class women by studying the sexuality of women from



Africa (30). They portrayed their sexuality as bestial and promiscuous in contrast to the ideal of chaste modesty for white middle-class women. For example, Sarah Bartmann from South Africa was deemed "Venus Hottentotte" and exhibited throughout Europe, much as if she had been a wild beast, so that voyeuristic Europeans and scientists could view, even touch, her "protruding buttocks" or catch a glimpse of her genitalia. During her lifetime, she refused to let scientists study her genitalia, but after her death, scientists dissected her body, sending parts off to various museums for study and display (22). By characterizing such African and "mulatto" women as hypersexual and hyperfecund, white European and North American men justified taking women as concubines, selling them as prostitutes, enslaving them, raping them, and using them to "breed" more slaves (31). Indeed, according to the prevailing logic of difference, the powerless (enslaved or exploited) poor woman of color (i.e., of non-European ancestry) represented the "antithesis" of the white European middle-class man (30, 32-34)—an image of essentialized difference that persists in contemporary U.S. portrayals of African American women as ignorant, oversexed, and irresponsible and is echoed in the discourse surrounding women and AIDS in settings such as Haiti and countries in Africa (35, 36).

The concept of "race" and the importance of ascribing innate racial differences was and is closely linked to changing relations of power and processes of struggle. As abolitionists in the United States threatened the social order with their moral and theological arguments, the authority of science was called upon to decide controversial issues. The State of Louisiana commissioned one physician to prove the natural inferiority of African Americans (25). He catalogued every racial difference he could imagine—in texture of hair, length of bones, vulnerability to disease, and even color of the internal organs. Medical theories that portrayed Africans as inferior and less than human were used to justify dissection and medical experimentation in the antebellum U.S. South (37). For example, Gamble (37) discusses an experiment conducted from 1845 to 1849 in which three slave women were used to develop an operation to repair vesico-vaginal fistulas. Each underwent 30 painful operations because operation after operation was unsuccessful. Having finally perfected his procedure, the physician in question tried it on white women who could not and would not withstand the pain of the procedure.

Briefly following the Civil War, as African Americans gained citizens' rights, medical journals published new views on racial difference, which began to attribute black-white differences to socioeconomic position (25). Yet, after the dismantling of Reconstruction, the scientific community again treated "race" as a fundamental biological difference. White physicians repeatedly cited high mortality and morbidity figures of African Americans as evidence of biologically determined "racial" susceptibilities rather than as evidence of social conditions, economic environment, and the political realities of discrimination (38). Many public health officers—particularly those in the southern United States—agreed that public health interventions could do very little for a "race" that was inherently

"degenerate, syphilitic, and tubercular" (25, p. 268). These pervasive stereotypes of black men and women and genocidal attitudes set the 20th century stage for research abuses such as the infamous Tuskegee Syphilis Study (39).

Nineteenth century medical authorities also conceptualized class as a biological category based on a Social Darwinist perspective linking industrial-revolution-created social inequalities with the natural law of "survival of the fittest." This theory that the poor were poor because they were "less fit" developed during an era of economic depression, labor struggles, trade union organizing, and socialist movements (e.g., Marxism) challenging the social order (25). Social Darwinism naturalized poverty and poor health by reference to "lesser evolution"; any mention of "class" and class-based inequality (in health, housing, etc.) was seen as a subversive, revolutionary threat. Over time in the United States, the North American ideology of meritocracy (i.e., ideals of progress and success through individual effort) merged with Social Darwinist thinking to make the notion of fixed social "classes" seem irrelevant. Scientists understood social position as "socioeconomic status," a depoliticized term suggesting that one's ranking in society reflected individual differences rather than exploitative political and economic relationships existing between different classes (25). Unfortunately, such social class differences were then, as they are now, one of the most important predictors of morbidity and mortality (25).

The erroneous theory-making of white European and North American male scientists went unchecked by those who could tell them otherwise: namely, women, people of color, and the poor, who were barred from the production of knowledge. Women, people of color, and those without economic resources were not allowed to study at the university, become members of the scientific academy, or apply for licenses to practice medicine (22). Science and medicine were busy constructing the very "biological facts" of nature, which would let them justify their exclusion of women, the poor, and people of color on the basis of inferior intelligence and temperament. Indeed, such constructions of gender, race, and class were crucial to the construction of modern science and to the consolidation of its power as the apolitical and value-neutral authority on knowledge.

#### THE LEGACY OF GENDER/RACE/CLASS CONSTRUCTIONS IN CONTEMPORARY RESEARCH ON WOMEN'S HEALTH

The master's tools will never dismantle the master's house. They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change.

Audre Lorde (40, p. 112)

Given the inglorious history described above, it should come as no surprise that Western biomedicine and public health, with their deep roots in Western scientific thought, retain lingering attitudes toward gender/race/class that can only

be characterized as sexist, racist, and classist. Despite growing official recognition on the part of the biomedical and public health research establishments that "women's health" matters—as evidenced in the creation of the Office of Research on Women's Health in the National Institutes of Health and the Office of Women's Health in the Centers for Disease Control and Prevention (41)—biomedicine and public health remain insensitive in some important ways to the problematic history described above and to the sexist/racist/classist set of assumptions that have emerged from that history. If research on women's health is to become informed and altered by a feminist agenda, then researchers themselves must first come to recognize how persisting biases regarding gender/race/class, as well as lack of theoretical problematization of these categories, hinder the research enterprise.

First, "sex" and "gender" have been historically conflated in health research. As currently used in feminist and social science analysis, the term "sex" most often refers to a biological category, defined by biological characteristics pertaining to the ability to reproduce (2). Thus, in the United States and many other societies, sex is typically dichotomized as "male" and "female." However, "gender" is a different construct, for it is a socially (human) constructed category, regarding culturally produced conventions, roles, behaviors, and identities involving notions of "masculine" and "feminine," and "heterosexual," "homosexual," and "bisexual," which are constructed and performed in relation to each other (42). Consequently, it is not enough for health researchers to simply replace the term "sex" with "gender" in their analyses, as has been occurring in some studies since the early 1990s. Although the move to "gender" marks an important shift in awareness, understanding the implications of "gender" on health—and especially the health-demoting consequences of gender oppression—involves more than replacing "sex" with "gender" in the text of a health study. It involves understanding how sex and gender are different and gathering data that not only link women's experiences of health to their reproductive organs and physiology but also provide answers to questions such as (a) how women's daily lives are influenced by gender norms and expectations concerning femininity, masculinity, heterosexuality, and homosexuality; (b) how gendered relationships among and between men and women influence health outcomes; (c) how gender inequality perpetuated by institutional structures affects women's lives; and (d) how the effects of gender are modified by other social locations such as race, ethnicity, class, and nation.

A second related "gender problem" in biomedical and public health studies is that men's experiences of health seem to provide the implicit norm against which women's health is defined and measured. White women, as well as men and women in nonwhite racial/ethnic groups, have been excluded from clinical trials and cohort studies based on the acceptability of a white male norm for explaining health and disease (43). As Krieger and Fee (25) point out, the logic guiding this exclusion has little to do with assumptions of similarity between white men and others. Rather, historically produced notions of difference have become so firmly embedded in epidemiological research that whites and nonwhites and women and

men have rarely been studied together. Whites and nonwhites, men and women are seen as so different that it would not make sense to study them together. Therefore, white men have been used as the research subjects of choice for all health conditions other than women's reproductive health, and nonwhites' health has rarely been studied and only in order to measure degrees of racial difference.

Biomedical and public health research also maintains an antiquated and spurious notion of "race" as a biological concept—an idea that has long been challenged by social and natural scientists. As biological anthropologists have clearly shown, genetic variation within so-called "racial groups" far exceeds that across groups, and all humans share approximately 95 percent of their genetic makeup (44–47). Yet, in the *Dictionary of Epidemiology*, race is defined as "persons who are relatively homogenous with respect to biologic inheritance" (2, p. 85). As Krieger and colleagues point out, "the accumulated evidence indicates that, for virtually every racial/ethnic group, a handful of genetic diseases seems specifically associated with aspects of their geographic and biologic heritage, yet these diseases nonetheless account for only a minute percentage of each group's overall morbidity and even less of their mortality" (2, p. 85).

Certainly, biomedicine and public health have not been uncritical of this archaic perspective on race. Critics within epidemiology have documented how ambiguous concepts of race and ethnicity result in inaccurate counts, rates, and ratios that lack meaningfulness and affect our understanding of the distribution of disease among diverse populations (26, 48–50). Critical epidemiologists also wrestle with issues of how to define, measure, and validate what are often self-perceived and unstable notions of race and ethnicity. Epidemiologists understand that "measuring" race is critical to understanding and eliminating differences in health status among racial/ethnic populations. However, a shift in the methodological debates needs to occur. First, race needs to be recognized as "a social, *not* biologic, category, referring to social groups, often sharing cultural heritage and ancestry, that are forged by oppressive systems of race relations, justified by ideology, in which one group benefits from dominating other groups and defines itself and others through this domination and possession of selective and arbitrary physical characteristics (e.g., skin color)" (51, p. 253). Second, the major issue that needs to be explored is how to conceptualize and operationalize racism and race privilege (or social relations of race) in order to describe how racial relationships structure people's lives and experiences of health and disease.

If race is viewed as a social construction, then clearly "racial" differences in disease—such as hypertension and low birthweight—require nongenetic explanations that health researchers have hardly begun to fathom. Indeed, the simple replacement of the term "race" with "ethnicity," as has become the fashion in some health studies, is again inadequate, for "ethnicity" is also a problematic term that is rarely defined. According to Krieger and Fee, "ethnicity" is apparently being used as "a polite way of referring to what are still conceptualized as 'racial'/biological differences" (25, p. 271). Or it may represent a new form of "cultural determinism"

in health research, in which "ethnic differences" in "lifestyle" are seen as autonomous, unchangeable "givens" rather than as products of social locations (e.g., class and gender) in society. "This cultural determinism makes discrimination invisible and can feed into explanations of health status as reductionist and individualistic as those of biological determinism" (25, p. 271).

Finally, with respect to "class," health studies invariably gloss this category—when they consider it at all—as the imprecise variable "socioeconomic status" (SES). Yet, the collection of personal attributes that constitutes SES remains unclear; as a result, no regular method of collecting data on socioeconomic position and health has been developed (2). Even if such data were regularly collected in health studies, however, their applicability to *women's* health would remain in question, for measures of SES are generally conceived upon sexist and heterosexist assumptions that male heads of households and male patterns of employment are more important determinants of SES than women's employment. Thus, the class positions of women—if "class" is to be understood as "a social category referring to social groups forged by interdependent economic and legal relationships, premised on people's structural location within the economy" (51, p. 253)—remain unspecified. The problem with this significant lacuna on women and class is that strong social class gradients appear in almost every form of morbidity and mortality (25). In the case of women and AIDS, for example, social class is perhaps the major risk factor in the epidemic (52).

Women's diverse social locations influence how they will experience being a woman—experiences that are differentiated by social class and race/ethnicity. The risks and benefits of being poor, wealthy, a person of color, a white person, homosexual, heterosexual, man, woman, and so forth, will be experienced differently, depending upon how they are combined. For example, in her pathbreaking epidemiological study of the effects of racial and gender discrimination on hypertension, Krieger (53) showed that black women who responded actively to unfair treatment were less likely to report high blood pressure than women who internalized their responses, and that black women at highest risk were those who reported no experiences of gender or racial discrimination. Among white women, gender discrimination was not associated with hypertension. In other words, African American women exposed to the risks of racist-induced stress and gender discrimination may have a higher risk of hypertension than those who experience only one of these factors (53). Similarly, other studies have shown that African American women subjected to both racism and poverty may have a higher risk of giving birth to babies who will die as infants than do African American women who are exposed to either racism or poverty, but not both of these harmful situations (54). Thus, Krieger and Fee (25) ask us to consider how racism shapes people's environment; how people's experiences of and responses to discrimination may influence their health; how diversity may occur within racial/ethnic groups; and how similar patterns may or may not occur across the social lines of gender/race/class. This kind of research emphasizes the importance of looking at

social inequalities from multiple locations, in order to make obvious not only how they constitute harmful risks, but also how they confer privileges and benefits that may be protective against disease and ill-health.

Unfortunately, the statistical modeling techniques currently employed in modern biomedical research make difficult such complex analyses of patterns, connections, and interactions between varying levels. Turshen (55), for one, has argued that multifactorial models currently used in epidemiology treat all factors of income, race, and class only as personal characteristics; they have no way of assessing group characteristics or social structures and conceptual systems. Indeed, epidemiology, as the statistical discipline that intersects biomedicine and public health, must develop highly refined ways of conceptualizing the overlapping effects of racism, poverty, and gender inequality in order to document and make visible the synergistic effects of these interlocking forms of oppression on health and illness, especially as they affect women (56). As Krieger and Zierler point out, this means "more than simply adding one-dimensional terms like *race/ethnicity* or *social class* to a long list of other variables in a multivariate analysis and looking for additive or multiplicative effects. It instead requires asking questions about deprivation, privilege, discrimination, and aspirations, to permit characterizing people more fully, and as more than the sum or product of their parts" (51, p. 253).

#### CREATING A FEMINIST RESEARCH AGENDA: UNDERSTANDING THE MULTIPLE EFFECTS OF GENDER/RACE/CLASS OPPRESSION ON WOMEN'S HEALTH

Given the legacy of these sexist/racist/classist biases in studies of women's health, it seems worthwhile to consider a theoretical framework for a feminist research agenda that is perceptive of and responsive to the multiple effects of gender/race/class oppression on women's health. Calls such as this one for a feminist-informed approach immediately raise the questions: "Whose feminism?" "Who determines what women want?" and "Is there a unified concept of 'women' that we can talk about?" (57). We recognize that there are many feminist standpoints and kinds of feminism originating from specific historical and political locations. Examples would include middle-class white European/American women's versions of liberal feminism; lesbians' radical feminism; Marxist women's socialist feminism (58); and recent developments in postmodern feminism (59).

As noted in the Introduction, the theorizing of European/American women of color (a.k.a. black feminists) (4, 5) and that of Third World feminists living in "developing" countries shaped by colonial legacies (6) informs our feminist approach in this proposed reconfiguration. To reiterate briefly, the terms "women of color" and "Third World women" are often used interchangeably to designate a group not unified by racial identifications, but rather constituted by "a common context of political struggle against class, race, gender and imperialist hierarchies"

(6, p. 57). Given their shared resistance to multiple forms of social hierarchy, both European/American feminists of color and Third World feminists have urged the recognition of the "simultaneity of oppressions" as "fundamental to the experience of social and political marginality and the grounding of feminist politics in the histories of racism and imperialism" (6, p. 10). In other words, European/American black feminists and Third World feminists, perhaps more than other types of feminists, have been particularly concerned with overcoming the multiple, interlocking, and simultaneous forms of oppression based on gender, race, class (as well as nation) which many women face worldwide (5, 6) and which, as we have shown above, have been perpetuated both ideologically and in practice by the Western scientific, biomedical, and public health establishments.

Furthermore, European/American black feminists have challenged the Eurocentric, masculinist knowledge-validation process described in the earlier parts of this essay. They argue for the development of an "Afrocentric feminist epistemology" (5, p. 201), which recognizes that "because elite white men and their representatives control structures of knowledge validation, white male interests pervade the thematic content of traditional scholarship," including scholarship in science, biomedicine, and public health. Through critique of mainstream forms of knowledge production, such an epistemological approach may lead to a significantly enriched understanding of "how subordinate groups create knowledge that fosters resistance" (5, p. 207). In particular, black feminism calls for new forms of knowledge creation capitalizing on four important elements.

1. *Valuing of women's experiential knowledge and wisdom*: "Living life as Black women requires wisdom because knowledge about the dynamics of race, gender, and class oppression has been essential to Black women's survival. African-American women give such wisdom high credence in assessing knowledge" (5, p. 208).

2. *Using dialogue in assessing knowledge claims*: "For Black women new knowledge claims are rarely worked out in isolation from other individuals and are usually developed through dialogues with other members of a community" (5, p. 212). The widespread use of the call-and-response discourse mode among African Americans represents an illustration of the importance placed on dialogue (5).

3. *Implementing an ethic of caring*: "The ethic of caring suggests that personal expressiveness, emotions, and empathy are central to the knowledge validation process" (5, p. 215).

4. *Implementing an ethic of personal accountability*: "African-Americans consider it essential for individuals to have personal positions on issues and assume full responsibility for arguing their validity" (5, p. 218). Thus, instead of severing the scholar from his or her context in order to dissect the rationality of a truth-claim, a scholar's personal biography and politics are considered highly relevant, affecting as they do the production of knowledge.

We draw from these theoretical frameworks to argue for a new feminist approach to women's health research—one that ultimately advances the radical, emancipatory goal of transforming global inequalities based on gender, race, and class. This feminist research agenda involves a number of important assumptions.

1. Feminist-informed women's health research involves a political commitment to identify and end gender oppression. It arises from the understanding that women everywhere, as gendered beings, face some form of oppression and exploitation, which may be deleterious to their health. The fact of nearly universal gender inequalities does not imply that gender oppression is more oppressive than racism, classism, heterosexism, ethnocentrism, or exploitative global economic conditions. Nonetheless, gender oppression is the practice of domination of men over women that most people experience and are socialized to accept, as either discriminator or discriminated, often before they even know other forms of oppression exist (4). Thus, gender oppression involves relations of relative power and authority of males over females, which are (a) learned through early gender socialization, often in the family; (b) manifested in both inter- and intragender interactions within the family and other interpersonal milieus; (c) legitimized through deeply engrained, pervasive ideologies of inherent male superiority and heterosexual privilege; and (d) institutionalized on many societal levels (medical, legal, political, economic, educational, religious, and so on) (60).

2. Feminist-informed women's health research does not consider gender oppression as an isolated axis of domination but as part of interlocking structures formed by destructive social divisions and hierarchies, which include race, ethnicity, class, religion, sexual orientation, age, physical abilities, and national location in the global order (6). These hierarchies construct and maintain each other, supported by similar institutional structures and shared notions of difference, superiority, and the right to dominate (40). Thus, the feminist commitment to end gender oppression also involves understanding and overcoming the oppressive forces of interlocking systems of oppression.

3. Feminist-informed women's health research recognizes that, within complex webs of interlocking structures, women occupy simultaneously diverse locations and identities, which will shape their experiences, their struggles, their resistance strategies, and their power and strengths (5). From this perspective there can be no universal category of "women" who are oppressed by the same patriarchal institutions and who share identical experiences, interests, and desires (6). Although most women share similar biological events (e.g., menstruation, childbirth, lactation, menopause) that affect their health and well-being, women will often differ dramatically in how they experience and create meaning from these events, which is highly dependent on their social locations in space and time (61). Thus, women's health research must recognize and begin to study the multiplicity of women's identities, interests, and experiences as both reproductive and nonreproductive human beings.



4. Feminist-informed women's health research recognizes that, although women share processes of struggle and resistance to unjust social hierarchies, including those occurring within the institution of biomedicine and its accompanying practices, their feminist struggles occur in specific historical and local cultural contexts. Third World feminists insist that we acknowledge the specificity of women's oppressions, defining power, influence, and status from women's particular social locations (62). Thus, Third World feminists have challenged us to rethink power, foregrounding "relations of ruling," or the specific practices of ruling, as an analytical category. This makes it possible to analyze various forms of power, oppression, and resistance without posing universal definitions of them (6).

5. Feminist-informed women's health research is concerned with actively listening to women, documenting women's diverse experiences, understanding the everyday lives of women, and connecting women's local lived experiences of health and illness to larger political and economic forces (63), including global processes of (de)colonization and transnational movements of health technologies and diseases themselves (64, 65). Valuing experience as knowledge has epistemological implications for how we produce knowledge; conceptualize agency, subjectivity, and authority; test truth claims; and create social policies, including those directly related to women's health. Embedding women's experiences within broader political-economic structures and processes helps to reveal how women's agency and authority may be undermined or ultimately curtailed in ways that are deleterious to their health and well-being.

6. Feminist-informed women's health research requires a personal commitment from those of us engaged in the production of knowledge and policy to unmask relationships of domination in our own professional and private lives as part of our life's work (66). This means examining how we as scholars and our research institutions are implicated in relations of domination, and accepting responsibility for the way gender/race/class/nation shape our social locations. It also requires us to create new structures and relationships to replace the hierarchical ones in which we may participate.

The tools forged by the experiences and epistemological thinking of Third World feminists and feminists of color provide an appropriate base for constructing an alternative framework capable of examining gendered experiences of health and illness within racist, classist, and capitalist histories. Third World feminists, in particular, have emerged at the center of women's health politics and debates as they have struggled against the effects of late 20th century globalization, including recessions, structural adjustment policies, new divisions of labor, and environmental degradation. Their struggles are, in part, a response to multinational threats against women's health, such as dangerous reproductive technologies and the exporting of environmental and occupational hazards (67). But, through their efforts, there have been growing international collaborations and networks on topics such as violence against women and reproductive politics and population control, as evidenced by the significant number of international

conferences held since the mid-1980s (68). Indeed, the 1995 Fourth World Conference on Women, held in Beijing, came close to defining a global feminist public health agenda by regarding inequalities in income, rights, resources, and power as the basis for inequalities in health (69).

If we are to take the aforementioned set of assumptions and the work of Third World and black feminist theorists and activists seriously, then feminist-informed women's health research is about creating (a) alternative research structures; (b) new theoretical frameworks that analyze historically and globally important gender, race, and class relations; and (c) activist agendas for examining and solving problems of women's health. Ultimately, feminist-informed women's health research would go beyond addressing long-neglected issues in women's health by articulating a new process for studying and addressing the health needs of *all* persons. An explicit part of this new agenda would include liberating societies from the unequal and unjust gender/race/class hierarchies that serve to diminish the health of all citizens. However, in order for such liberation to be achieved, there must first be a critical rethinking of the historically produced logic of "difference" that currently underlies—and undermines—scientific, biomedical, and public health research on women's health.

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