Changes in Women’s Health Activism as observed in *Our Bodies, Ourselves*

by

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Changes in Women’s Health Activism as observed in *Our Bodies, Ourselves*

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Abstract

Using data from feminist health advocacy books, I have identified the key changes within women’s health activism and the approach to women’s empowerment over the last 40 years. I conducted content analysis on a total of six chapters selected from two editions of *Our Bodies Ourselves* (1973, 2011) in order to trace key changes. My findings show three distinct developments in the approaches to activism. The first was a transformation from a critique of the medical system to an acceptance of the capitalist control of medicine. Next, I observed a change in focus from the free choice over whether to use birth control to a moral obligation to use one of many available forms of birth control. Finally, I determined that feminism has abandoned its focus on shared responsibility for health care, and instead focuses on patient-led responsibility. This in turn reflects a shift in empowerment from a focus on broad social change to individualistic solutions. I determined that these changes have been informed by a broad change in feminism to a more neoliberally informed feminism. By identifying sites of potential inequality, these findings can be employed in order to create policy that aims to build a more equitable health care experience for marginalized populations in the United States.
Lay Summary

This thesis aims to explore the changes which have occurred in the way that feminists approach activism focused on health and healthcare of women. A comparison of 6 chapters from two editions of *Our Bodies, Ourselves* (1973, 2011) was undertaken in order to investigate the changes that have occurred over the last 40 years. The findings of this thesis indicate that over the last 40 years, feminist health activism has changed from being focused on advocating for social change brought about by changing doctors’ behaviours, ensuring access to freely choose birth control methods, and shared responsibility for safety, to a focus on less accountability for doctors, reduced choice and personal responsibility. These findings suggest that an increased societal focus on the individual as well as increasingly conservative political values have inspired the change.
Preface

I am the sole author and contributor to this thesis. This project did not require ethics approval. It has not been published in part or in full.
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Dedication

I would like to dedicate this thesis to Kelsea Perry.

Kelsea, your unwavering commitment to bettering the discipline of Sociology, through your teaching, writing and by providing endless support to your peers has inspired me to complete this project even during the darkest of times.
Chapter 1: Introduction

The book *Our Bodies, Ourselves* has great personal meaning to me. First introduced as a textbook in a women’s studies class titled ‘Women and Aging’ it has continued to inspire me, educate me, and provide answers to difficult questions about women’s health that both my friends and I have had but could not find a trustworthy doctor to answer for us. When reading through the 2011 edition of this book for this undergraduate class, I was often struck by how revolutionary the text seemed compared to all other medical advice I had received in my life. Curiously, my professor felt differently. She told us she assigned the text because she found it revolutionary when it was first introduced to her in the 1970s, but this newer edition was lacking and, because of that, she often supplemented our edition of the text with photocopies of her original 1973 edition. This allowed for a comparison of two editions, drawing attention to dramatic differences. It also inspired me to dive deeper into its history and impact. If a text can mean something so significant to me, my mentors, and my friends, I felt it was worthy of deeper inquiry. The dramatic differences in the feminist approach between the first and most recent editions inspired me to look deeper into the contents of the text, and to consider the impact of the text.

This text is not only personally significant but holds great potential for academic inquiry. Its unique history, role in the Women’s Health Movement, and widespread distribution position the multiple editions of the text as an ideal area of exploration and source of data for research projects. I aim to explore the differences between two editions in terms of their approaches to empowerment. The history of *Our Bodies, Ourselves*, including its supporting organization, the Boston Women’s Health Book Collective, provides academics with a specific example of organized women’s health activism with measurable impact, evidenced by its circulation rates and multiple editions. Further, because the collective and text were borne of a key branch of the
feminist movement called the Women’s Health Movement, they provide concrete examples of many core concepts of the women’s movement, including examples of consciousness raising, and a focus on empowering women in order to reduce inequality. Finally, *Our Body, Ourselves* has been and continues to be widely circulated. The text has been translated into 31 languages internationally and a total of 4 million copies of the English edition were sold by 2011 (Our Bodies, Ourselves 2018). This broad distribution to diverse populations ensures that *Our Bodies, Ourselves* provides researchers with a source of information pertaining to second wave feminist discourse that was clearly foundational to the activism efforts.

The exploration of the Women’s Health Movement and *Our Bodies, Ourselves* is as significant now as it has ever been. In the United States, as both the healthcare industry and feminism rapidly change, it is of paramount importance to understand the Women’s Heath Movement in today’s climate. There have been dramatic changes to the American healthcare system within the last forty years. These changes include the introduction of the Affordable Care Act, changes in political leadership, the passing of Roe vs Wade and more restrictive abortion regulations. These upheavals have forced women across the United States to navigate new laws, regulations, and insurance policies, at a time when marginalized women continue to face inequality economically, socially, and politically. For example, in the United States there is pressure to restrict abortion access. In 2017, “The Pain-Capable Unborn Child Protection Act” which calls for banning abortion after 20 weeks, passed in the House of Representatives (Franks 2017). Within this context, the work of feminist health activists is shifting in an effort to adapt and become more accessible to a wider population.

In the western world feminism is changing into a more public role in the lives of women, particularly young women, due to a significant presence in media, as well as a commercialized one through female-focused advertising campaigns (Banet-Weiser and Portwood-Stacer 2017).
For example, popular musical artist Beyoncé often features a prominent video display of the word ‘Feminist’ during her live televised performances, encouraging fans to identify with the concept (Bennett 2014). Additionally, advertisements are approaching female-focused products from a sexually empowered perspective, with the aim of creating a feeling of freedom, choice and liberation among younger women. At a time when feminism is a feature of marketing campaigns, popular entertainment, and more critical activism work, it is important to reflect on the actions that feminists are taking to empower women and reduce gender inequality, as well as how their approach is changing over time.

*Our Bodies, Ourselves* serves as an accessible example of the work of American feminists attempting to change the experiences women face in healthcare through their empowerment. Within the Women’s Health Movement, empowerment refers to the collective power of women to reject paternalistic control and male subjugation in favor of personal and group autonomy regarding women’s bodies, sexuality and health (Arendt 1970; Hartsock 1996). The historical context of *Our Bodies, Ourselves*, including a focus on consciousness raising, education, and broad social change has maintained and strengthened the feminist focus on women’s empowerment. The collective which wrote *Our Bodies, Ourselves* grew directly from the Women’s Health Movement, which was clear in their goal of empowering women, particularly in regard to healthcare. As feminism changes, understanding the way that feminist activists approach the key goal of female empowerment is important to understand in order to maximize the impact of activism in general.

The historical impact of the Women’s Health Movement, along with its increasing importance in the wake of continued attacks on women’s reproductive care, makes it an important movement to examine. By understanding the changing approach to women’s empowerment in relation to healthcare, I will be able to document broader changes in feminist
approaches to reducing inequality. I will investigate how it has changed from its inception in the 1970s to the present day, by comparing the first edition of Our Bodies, Ourselves and the last edition, published in 1973 and 2011 respectively. Our Bodies, Ourselves serves as an exemplary manifestation of the key elements of the feminist empowerment movement, including education, consciousness raising and activism. In order to best understand how this movement has changed over time, this thesis will explore two key questions. In what ways have the goals of feminist health advocacy changed over time as manifest in Our Bodies, Ourselves? And what might account for the observed changes?
Chapter 2: Exploring Empowerment through Feminist Texts

This thesis focuses on how the health activism of *Our Bodies, Ourselves* has changed across its 40-year history. The text serves as a concrete example of successful and popular activism, with nine editions in the United States, and publication in 31 languages. *Our Bodies, Ourselves* has sold four million English copies since it was published in 1973 indicating that the text has widespread popularity and a deep history, both of which compel us to explore it in greater detail. Although the text has been used as a tool by feminist activists since its publication, to date there has been little research on the ways in which the text’s health activism has changed over the course of its many publications. Given that the changing landscape of health activism is a significant element of the feminist movement, it is time for a closer exploration of the text.

Health activism is a key avenue of empowerment for women, as it has the potential to disrupt and change a powerful societal institution that is responsible for much of the expression and distribution of power over women. According to Foucault, modern disciplinary power spreads through society with the help of institutions, including healthcare (Pavlich 2010). The execution of power through institutions is so ubiquitous because it operates invisibly, allowing individuals to feel as if they have freedom and choice, when in reality their options are carefully controlled to allow only the illusion of choice (Foucault 1995). Within the field of healthcare, we see prime examples of the variety of forms of power expression that influence and shape the lives of all patients (Pavlich 2010). According to Foucault, medicine provides an optimal environment for the manifestation of discipline and power. Doctors have the power to determine what is normal and what requires alteration through examination, authoritative knowledge, and social prestige; they can thus exert power over people, particularly women, by declaring their bodies, behaviours, and desires to be abnormal (Foucault 1995). Healthcare, then, serves as an arena for controlling the behaviours and lives of women. Because of this influence, healthcare as
an area is rich for an exploration of resistance to patriarchy and changes in approaches to empowerment that have taken place over the last 40 years.

Empowerment has been a key focus for activists as it is considered a key avenue for positive changes in the lives of women. There are various approaches to empowerment among feminists, but most agree that empowerment must provide women with more power to control their lives and circumstances (Batliwala 1994; Cornwall 2016; Stromquist 2015). This redistribution of power is particularly important in the healthcare context, as evidence suggests that increased patient empowerment leads to better health outcomes (Ratna and Rifkin 2007; Stevenson and Allen 2017) and gives patients better control over their health (Upadhyay et al. 2014). Feminists also agree that a key feature of empowerment is choice. Empowerment, by necessity, must focus on increasing individuals’ self-determination (Batliwala 1994; Cornwall 2016), and reducing the unjust control of marginalized people by other individuals and institutions (Christens 2013). This focus is the main connection between the study of empowerment and the women’s liberation movement. Feminist empowerment emerged as resistance and dissatisfaction with the control powerful groups have over marginalized groups, particularly in relation to health (Burt Ruzek 1979; Cornwall 2016; Fee 1975; Frankfort 1977). This focus on control relies on individuals being able to experience material conditions in which they are not oppressed, manipulated or controlled (Swirsky and Angelone 2016). This includes access to income (Vinkenburg 2015), homes without violence (Hoyle and Sanders 2000) and gender inclusive healthcare policy (Souza 2011; Vinkenburg 2015).

In the United States, women have seen an improvement in healthcare since the first edition of Our Bodies, Ourselves was published in 1973, including reduced need for abortion because of better access to birth control pills (Christens 2013) as well as increased survival rates among those diagnosed with breast cancer (Canales and Geller 2003). However positive these
successes have been, major challenges regarding women’s experiences of healthcare remain. American women’s health conditions are routinely over-managed in the form of medicalization, which is defined as the practice of assigning medical significance to non-medical experiences (Lorber and Moore 2002; Riessman 2009). In addition, women’s illnesses are often not attended to with enough care, a situation that can lead to further health complications spiraling out of control (Yu and Hu 2013). The ubiquity of situations such as these indicates that healthcare continues to be an institution where women are controlled and oppressed. Aside from the harm inflicted upon women in general, these oppressive conditions have differential impacts on different groups of women, highlighting the inequitable conditions faced by women of certain vulnerable groups, including those of minority races, lower income, and disability.

One avenue through which the organization of healthcare promotes the subjugation of many women is the prohibitive cost associated with accessing care in the United States. As stated above, some groups of women, namely those of a lower income, are disproportionately mistreated in healthcare situations, with their health and the risks of care often being ignored or else downloaded onto the individual (Yu and Hu 2013). When marginalized women face this inequitable care, their ability to search for a new doctor is further hindered by the overwhelming cost of seeing a doctor for even a single introductory visit, leaving them with little mobility or actual choice (Sansone and Sansone 2012; Worley 2012). This forces those with the least resources to take far more personal responsibility for their healthcare, to accept waits and unaffordable costs to find a new doctor, or to stop taking care of their medical needs altogether (Collins and Hershbein 2013; Westeneng and D’Exelle 2015).

A woman’s access to safe and respectful healthcare is paramount for her wellbeing. Even further, women’s reproductive healthcare, namely the ability to delay or avoid pregnancy, has broad impacts on all facets of life. Historically, the inability to avoid or terminate unwanted
pregnancy meant that many women were kept out of post-secondary education and the labour market, making them financially dependent on their male partners and reducing their overall independence (Grant 1993). Additionally, because of the suburban boom of the 1960s, many mothers in North America were located in sprawling residential neighborhoods far outside of cities (Hayden 1981). Away from easily accessible childcare and often without the freedom that a car would allow, these women were relegated to remaining in their home, focusing on household and reproductive work (Haden 1981; Grand 1993). Allowing women to control their pregnancies has provided them with freedom to delay (or prevent altogether) motherhood in favor of education or employment, offering women tools to overthrow some of the oppression they experience. This is particularly important for impoverished women because, as previously noted, they face additional difficulties accessing safe healthcare, and these burdens and risks are amplified by pregnancy. These difficulties highlight the need for a feminist restructuring of healthcare with a focus on power and privilege, in order to eliminate the disproportionate burden carried by marginalized women (Bowleg 2012; Eckstrand et al. 2016; Hankivsky 2012).

It is largely because of this ability to change so many aspects of women’s lives and allow them freedom to work, learn, and live independently that women’s reproductive healthcare is a key area of work for feminists. This was widely recognized by second wave feminists and, as such, their approach to advocacy was largely designed around best practices in increasing women’s empowerment within the healthcare system. Within the United States, the second wave of feminism began in the early 1960s and coincided with a healthcare industry that was rapidly changing, largely due to a new focus on private insurance and the passing of Medicaid and Medicare Acts (BWHBC 1973, Birden 2004). The healthcare system was disorganized, costly, and abuses directed at women were common (Birden 2004) including such atrocities as
nonconsensual and often undisclosed sterilizations, particularly of poor black women (BWHBC 1973).

The 1970s saw the rise of both healthcare as a monolithic industry with momentous opportunities for profit and the second wave feminist movement. The feminist movement involved specific feminist health advocacy, focused on reducing the oppression of women within healthcare. A specific subset of the movement, called the Women’s Health Movement focused on addressing issues related to health and the human body (Burt Ruzek 1979). The Women’s Health Movement was propelled to action by restrictive antiabortion laws in the United States. Eventually the Women’s Health Movement began to address widespread problems with healthcare that developed both because of and in tandem with the growth of the American healthcare industry, including an increased reliance on the insurance and pharmaceutical industries (Hayden 1982). In particular, the Women’s Health Movement worked to address inequity within the male-controlled healthcare system (Burt Ruzek 1979; Fee 1975; Frankfort 1977). At the time healthcare was a man’s arena. Most doctors were men largely because women were discriminated against in medical school applications (Jefferson, Bloor, and Maynard 2015). The Women’s Health Movement sought to encourage women to fight back against masculine power within healthcare both directly and indirectly, to challenge the power that Foucault (1995) described as being exercised over women by medical professionals who are able to decree what is normal and what is not normal. The Women’s Health Movement encouraged individual women to directly fight back against this control by interrupting their doctors in such a way that demanded respect and an equal sharing of information, for example by ripping down the curtain used to prevent a woman from seeing the doctor during a pelvic exam (Frankfort 1977). Women were also encouraged to share personal experiences with other women (Dreifus 1977) in order to generate women-driven knowledge that could indirectly dismantle masculine power in medicine.
This sharing of information was the foundation of consciousness raising and is a key strategy for empowering women. The process of sharing knowledge fostered critical awareness that had the potential to create structural change leading to increased empowerment of women in healthcare (Christens 2012).

The founding ideology of the Women’s Health Movement focused on three specific types of activism, all of which are categorized as feminist health activism. The first centered on increasing access to health services including pelvic, breast and cervical exams, as well as safe abortions (Burt Ruzek 1979). The second was concerned with creating change within established health institutions, a task that involved advocating for more female doctors; insisting on fair, respectful, and honest doctor-patient relationships; and ending the infantilization of women in healthcare situations (Burt Ruzek 1979). Finally, and most pertinently for this line of research, the Women’s Health Movement had a large focus on raising awareness among women about abuses of care that other women were experiencing, deepening their understanding of the gender-based inequality they faced (Burt Ruzek 1979; Kelly 2009). This process occurred via education groups, information sessions, and written texts. One such education group was the Boston Women’s Health Book Collective which began as a group of women focused on education about their bodies, but eventually developed into a writing collective that culminated in the publication of *Our Bodies, Ourselves*, an educational text. According to the Women’s Health Movement, women needed to develop an awareness or consciousness of the pitfalls of the healthcare system and demand change. *Our Bodies Ourselves* was written in part to further these goals of the Women’s Health Movement (BWHBC 1973).

The Collective’s first affordable booklet was followed by a full-sized text, *Our Bodies, Ourselves*, in 1973 (Burt Ruzek 1979; BWHBC 1973; Wells 2008). This text addresses bodily education, as well as the tools for empowerment (education, question-asking, responsibility) that
the Women’s Health Movement advocated (BWHBC 1973). The text also advocates for the reduction of oppressive and unnecessary medical intervention, including unnecessary and non-consensual hysterectomies and tubal ligations that were commonly used to further control and subjugate minority women (BWHBC 1973; Dossey 2015).

The Women’s Health Movement focused broadly on education of women about their health and healthcare. This education included information sessions and lectures where medical information was taught, including instructions for procedures they could do on their own, (e.g., cervical exams) to increase bodily knowledge and prevent pregnancy (Burt Ruzek 1979). Women were also taught about specific ways they could fight the paternalistic care they were receiving from doctors, including asking questions, demanding second opinions, and participating in pelvic examinations by watching the doctor and asking about each step (Burt Ruzek 1979, BWHBC 1973). These educational sessions began as small groups that grew in number, scope and impact. Larger educational meetings sometimes turned into writing groups that produced informational papers, posters and books that were very widely shared (Burt Ruzek 1979, BWHBC 1973). This is the case for the Boston Women’s Health Book Collective.

The Boston Women’s Health Book Collective placed a great emphasis on empowerment given how essential it is for women engaging with the healthcare system. Empowered women are able to exercise their freedom to choose healthcare options, including choosing abortion or birth control, and this ability reduces the control that doctors and the medical system have on women’s lives (Burt Ruzek 1979; Cornwall 2016; Fee 1975; Frankfort 1977). Further, by empowering women with the ability to choose between motherhood or not, women are better afforded opportunities to get jobs, go to school and provide for themselves, giving them far more autonomy to further empower themselves and reduce inequality (Grant 1993).
Moreover, how feminists approach empowerment directly shapes the impact of their feminist health activism. While almost all feminists agree that empowerment should be a key focus, there are multiple views on how to achieve (and, indeed, define) empowerment. A focus on financial empowerment argues that increasing women’s access to money and financial freedom is the most important way to liberate them from oppressive conditions, especially in healthcare (Chiapperino and Testa 2016). The logic is that: “positive consumerism expects citizens to gain power by acting on a wealth of information to choose among a range of care options” (Chiapperino and Testa 2016: 205). This line of reasoning rests on the assumption that empowerment allows women the freedom to make consumption choices. This perspective is criticized on several grounds, one of which is the inherent assumption that participation in healthcare is a free choice when in reality it often can escalate to become a choice between life and death, in which seeking care is the only reasonable option (Goldstein and Bowers 2015). Further, many feminists propose that empowerment is a fluid, culturally based, and locally influenced experience (Lee-Rife 2010; Porter 2013) which demands broader social change, specifically a change in attitudes (Porter 2013). This broader change has the ability to empower all women, not just those who are able to participate in the marketplace.

As feminists approach the problem of how to best empower women in healthcare, they continue to question who their empowerment efforts must target in order to create lasting change. A focus on financial empowerment allows individuals more consumer freedom and consumer choice but is restricted to those who are able to participate in labour markets. Financial empowerment disproportionally targets able bodied women and women who do not face multiple oppressive factors. According to Cornwall (2016), financial freedom will reduce poverty and thus change some women’s lives but is limited to those women whose oppression stems from only financial constraints, not broader social circumstances. A more holistic perspective of
empowerment entails a radical approach which will ensure that power is shifted into the hands of women because of a shift in societal ideals and beliefs, not just financial freedom (Chiapperino and Testa 2016; Christens 2012; Cornwall 2016; Keddie 2011). While providing women with more economic opportunities is important for creating opportunities for freedom, it does not fundamentally change the everyday circumstances and structures in which women live. Additionally, financial empowerment primarily impacts women who have the freedom to work and to spend money, effectively excluding many younger, older, incarcerated and differently abled women.

Just as there are different perspectives on how to empower women in healthcare, feminism in the 1970s had multiple factions that debated over how to accomplish the movement’s goals. The second wave of feminism takes its roots from multiple areas, creating a movement that was both diverse and divisive during the 1970s, with two primary branches: liberal and radical. 1970’s American liberal feminism was rooted in John Stewart Mill’s liberal feminist perspective which asserted that “women have been victims of history, unjustly denied access to their own potential, prevented by the unquestioned habits of mankind from flourishing as fully human beings” (Burt Ruzek 1979; Kelly 2009). Mills suggested individualism as a key method of reducing the injustice (Ring 1985), and this approach also influenced the 1970s activists. Liberal feminists in the 1970s were concerned with the shortcomings of American legislation on equity in the workplace (Turk 2010). These feminists channeled their dissatisfaction into helping create new legislation which fought to reduce discrimination (Whelehan 1995). One example is the Equality Act of 1963 which aimed at creating equality for women within the workplace who were facing issues such as sexual harassment and unequal pay (Whelehan 1995). Liberal feminists worked to both reduce the oppression of women and increase the autonomy of women to make choices based on their individual needs (Mackenzie
and Stoljar 2000). The activism of the second wave liberal feminism focused on the individual woman, encouraging each woman to fight for her own equal rights within their workplace. Liberal feminism was hugely influential, but not without criticism; other feminists questioned if their individualistic method was enough to actually tackle the significant oppression that women faced (Schwartzman 2006).

The second wave of feminism in the United States was diverse in its approaches to feminist activism, which effectively created clearly defined subdivisions of the movement. Another branch of the second wave movement in the United States, referred to as radical feminism, oftentimes called for the dismantling of any social structure, institution, or relationship that sustained male domination in every realm of life, including education and medicine (Bowden and Mummery 2014; Daly 1990; Harding 1986). Radical feminism also proposed that after existing patriarchal institutions were dismantled, the creation of a new society based on the experiences of both women and men would be necessary to create equality and emancipation (Hartsock 1996). The radical second wave shaped perspectives and best practices regarding empowerment by spreading the idea of the dismantling of oppressive social institutions rather than simply providing women with increased financial freedom (Christens 2013). Within the second wave, both liberal and radical feminism shared the goals of reducing gender inequality and advancing the status of women.

Unfortunately, gender inequality has not yet been achieved, and thus additional feminist models continue to work towards this goal. The third wave of feminism began its development in the 1990s when it appeared that women had “made it” with increasing education, employment and sexual freedom, but still had not reached a true place of equality. Much like the second wave of feminism, the third wave also has multiple branches. Broadly, the third wave developed out of criticisms of the second wave, primarily the lack of a critical exploration of race and what some
perceived as an anti-sex narrative (Mann and Huffman 2005). These two significant criticisms have influenced the development of the multiple approaches of the third wave.

While intersectional approaches to feminism were first introduced in the 1970s by writers like bell hooks and Angela Davis, it did not become the dominant framework until the third wave of feminism in the 1990s. The intersectional subdivision of third wave feminism has its roots in the lack of attention to the critical role race plays in the status of women and was developed primarily by women of colour. Lorde (2013) argues that: “White women focus upon their oppression as women and ignore difference of race, sexual preference, class and age” (p. 289). This critique reflects an approach to feminism in line with third wave intersectionality. This approach to feminism is exemplified by the work of Patrica Hill Collins (1999) in which she argues that “The overarching matrix of domination houses multiple groups, each with varying experiences with penalty and privilege that produce corresponding knowledges” (p. 234). Intersectional feminism strives to be conscious of the way in which individuals, women specifically, encompass multiple power relations and identities and the ways in which each social location contributes to their experiences of oppression (Crenshaw 1991). An intersectional approach in the third wave focuses on understanding the way various power relations interact to increase inequality among women.

In addition to intersectionality, the third wave includes a branch of feminism focused on the role individual choices play in the reduction of inequality. Specifically, proponents of a newer rendition of liberal feminism called ‘choice feminism’, argue that any choice is a feminist choice if it is made by considering the political, social and economic impacts of the choice (Čakardić 2017; Thwaites 2017). By this logic any choice made by a woman is ‘feminist’ simply because it represents the fact that women are free to make a choice at all (Thwaites 2017). This approach relies on the idea that one’s own experiences and perspective are the only true
knowledge that an individual can base their choices upon, and because of that there is no universal definition of a feminist or non-feminist action (Kirkpatrick 2010). The emphasis on choice is reflected in recent views of empowerment that prioritize financial empowerment (Chiapperino and Testa 2016; Lee-Rife 2010). The logic follows that if women are afforded more financial freedom, they can make their own economic choices, which helps them establish control over their lives, particularly in healthcare (Chiapperino and Testa 2016; Goldstein and Bowers 2015). This perspective has limitations, however. Chiefly, by advocating for only financial empowerment, neither poor women nor those who are unable to participate in the marketplace freely (e.g., incarcerated women) benefit from feminist activism. Further, as mentioned previously, this perspective ignores the fact that participation in healthcare is never wholly voluntary, and it is often a matter of life and death (Chiapperino and Testa 2016). Additionally, by not questioning the context and implications of the decisions they make, individuals can inadvertently contribute further to the inequality of women, which is decidedly unfeminist (Thwaites 2017). The third wave of feminism, like the second before it, encapsulates multiple viewpoints that can be at odds with each other, and choice feminism is no exception. Nevertheless, both waves and all their outlooks share a common goal of reducing gender inequality through empowerment.

Though the feminist movement is diverse in its approaches, empowerment remains as a key goal for all involved. Feminists acknowledge that patriarchal power exercised over women is a key factor in their oppression which is why empowerment is a key component of feminist activism. According to Batliwala (1994) a key element of empowerment is identifying and modifying power relations between men and women. The goal of the modification of power relations is to create a more equal balance of power between men and women (Batliwala 1994; Cornwall 2016; Stromquist 2015). In order to do so, Cornwall (2016) suggests that simple
redistribution of power is not enough. Instead, Cornwall (2016) stated that those who serve to control women must relinquish the control entirely, so women are given total power and the freedom to decide for themselves what is needed to reduce inequality.

A final key element of the empowerment of women is responsibility. In order to create a more equal world for women, some argue that individuals, institutions, and the state all must take responsibility for the necessary changes (Souza 2011; Vinkenburg 2015). Many feminists take this argument further, criticizing those who focus on individual choice within feminism by stating that such a focus relieves institutions and states from their duty to change inequitable policies (Souza 2011; Vinkenburg 2015). By focusing on both individual and broader institutional change, the impacts of increased empowerment have the potential to reach a broader range of women with longer lasting results (Woodall, Warwick-Booth, Cross 2012).

The role of women’s empowerment is of great importance to healthcare specifically, which is why it plays such a significant role in the feminist health activism within Our Bodies, Ourselves. Empowered women are able to exercise their freedom to make choices within the healthcare system, including choosing abortion or birth control and reducing the control that doctors and the medical system have on women’s lives (Burt Ruzek 1979; Cornwall 2016; Fee 1975; Frankfort 1977). Further, by being able to make the choice between motherhood or not, women are better afforded opportunities to get jobs, go to school, and provide for themselves, giving them far more autonomy to further empower themselves and reduce gender inequality (Grant 1993). When empowerment allows for the power relations in healthcare to be dismantled and doctors no longer treat women paternalistically, ignoring women’s own knowledge of their health and bodies (BWHBC 1973, 2011), women are better able to access care that reflects their needs and desires. In order for empowerment to have positive impacts it must focus on the empowerment of both the community and the individual. This focus will allow for a shift in the
fundamental social organization which currently oppresses women and makes their long term individual empowerment impossible (Christens 2013; Grabe 2012; Keddie 2011). Finally, when the healthcare system, doctors, government and women all share the responsibility for safe, respectful healthcare, women face fewer risks within their care (Yu and Hu 2013). As feminists work to create a more equal and respectful healthcare system for women, empowerment serves as a key avenue for lasting positive impact. This thesis will explore two editions of *Our Bodies, Ourselves* (1973, 2011) through content analysis in order to highlight changes in the feminist health activism which strongly supports empowerment. Next, this thesis will detail the methods in which the content analysis was undertaken.
Chapter 3: Methods

This thesis employs content analysis to investigate the changing nature of women’s health activism between the years of 1973 and 2011. I selected six chapters of *Our Bodies, Ourselves* (1973, 2011) in order to trace changes in feminist discourse over this 38-year period. I chose the first edition (1973) to reflect the beliefs of the second wave of feminism most clearly, whereas the final edition was selected because it was published in 2011, during what is commonly considered the third wave of feminism. The first edition was borne out of a group of women who had come together to educate themselves and others via consciousness raising. As their education took hold, they collected key information and produced a pamphlet which was then expanded into a full-length book (BWHBC 1973; Frank 2012). This information was made accessible to clinics, medical schools and women’s shelters at a reduced cost in an effort to bring women everywhere education about their own bodies based on the key educational principles of the Women’s Health Movement (BWHBC 1973).

By 2011, *Our Bodies, Ourselves* was a household name, selling over four million copies and having been translated into numerous languages to reach a wider audience (BWHBC 2011). The 2011 edition is much longer with many positive improvements, including a more inclusive approach to gender non-conforming people and non-heterosexual women. The 2011 edition is well suited for this project as it was published in the tumultuous years following the 2008 market crash and accompanying recession which impacted many areas of social life within the United States. It was also the final edition of *Our Bodies, Ourselves* published in print. In 2018 the collective announced that the 2011 edition of *Our Bodies, Ourselves* would be the last edition published. The collective also stated that due to lack of financial resources that their ongoing efforts would be volunteer-driven and would focus on sharing of health information and quotes from older editions of the book on their website. This decision was arrived at largely because of
the increasing financial strain associated with publishing the text and running the website with paid employees (Our Bodies, Ourselves 2018).

The nearly four decades between the publication of these two texts was a period of significant change in the United States. I have employed portions of both Our Bodies, Ourselves texts as my data for three reasons. Firstly, Our Bodies, Ourselves has a history of focusing on women’s personal experiences regarding healthcare (Hayden 1997) which is a result of its roots in the Women’s Health Movement (Dreifus 1977). Secondly, both editions of the text are authored by The Boston Women’s Health Book Collective; by analyzing the writing of a collective, I am able to read the work of multiple women as a text assembled through the collective discussion and writings of a group, not just isolated chapters written by different authors. Finally, across editions, the introduction of Our Bodies, Ourselves explicitly outlines its goals regarding female empowerment, particularly in relation to women’s health. This highlights the fact that the text is a strong example of the discourse of the Women’s Health Movement, particularly focusing on the activism and education goals of the movement.

The work of women’s health activism encompassed empowerment-facilitating processes that focused on helping women change their own healthcare experiences for the better. This involved informing women of the ways in which the system was creating some of the inequality. These processes involved consciousness raising which is the practice of educating women about the various ways in which the healthcare system functioned in unequitable and oppressive ways, and the impact this had on their health and wellbeing (Frankfort 1977; Hayden 1981; Morgen 2002). After women became aware of the pitfalls of the healthcare system, it was imperative to provide them with both personal knowledge about their bodies, and alternative health options to offset and correct some of the healthcare system’s problems. Developing knowledge of one’s health and body is imperative to the activism, as it allows women to make informed judgments
about their own care, and accurately assess the treatment they receive. The personal education model used by feminist health activists relies on the sharing of stories between women in education groups (Burt Ruzek 1979). Since education may come from medical sources, this carries the risk of maintaining male medical bias (Levison et al. 1995), so to avoid this, feminist health activism prioritized teaching women about their own bodies and health through shared conversations with other women. This type of activism serves to highlight alternatives to the current medical system, providing guidelines for change. This activism includes proposals for structural changes and personal care advice that is intended to reduce reliance on the medical system.

*Our Bodies, Ourselves* provides a significant example of the various elements of women’s health activism. Throughout the text, the collective writes about the functioning of the healthcare system in an effort to raise consciousness, including drawing attention to the influence of capitalism on the functioning of doctors’ clinics, the racial and gender discrimination patients face, and the lack of oversight of doctors’ behavior. For example, in the 1973 edition, the collective writes: “It is evident that women as workers and patients occupy the wide base of the [healthcare] pyramid with white male doctors controlling everything and everyone below them for their own interests” (p 38). The 2011 collective also notes: “The United States does not ensure access to health and related services… many of us will struggle to get the care we need” (p 119). The work of the collective to raise consciousness among readers about the pitfalls of the healthcare system positions this text as an excellent example of women’s health activism. Additionally, the text works in two ways to educate women on their bodies in a way that helps circumvent the male medical gaze. The text is written by a group of women who developed it out of discussion groups about bodies and health, which ensures that the information presented reflects the Women’s Health Movement’s personally based information sharing education
model. The text also includes many personal examples written by women not in the collective to add a diversity of perspectives, all the while maintaining a focus on personal experience as the backbone of bodily education. Finally, the collective includes information directed at training women in providing their own healthcare services. This is particularly strong within the 1973 edition of the text and includes, for example, tutorials for providing menstrual extraction and at-home cervical exams. *Our Bodies, Ourselves* is a pillar of the Women’s Health Movement, and the content of the text actively assists the movement in achieving its feminist health activism goals which makes it an effective subject for this study.

My sample consists of a total of six chapters from two editions of *Our Bodies, Ourselves*. Three of these chapters are from the first edition of *Our Bodies, Ourselves* which was published in 1973 after the widespread popularity of a pamphlet that the Boston Women’s Health Book Collective had developed from their discussion groups about women and their bodies (Boston Women’s Health Book Collective 1973). Three chapters from the 2011 edition of the text are also used, the final edition of the book that was produced 38 years later. Both books were published in the United States and refer exclusively to the American context, though the Boston Women’s Health Book Collective have worked to translate the text into over 30 languages (The Boston Women’s Heath Book Collective 2017; Davis 2007).

I have chosen my sample using a criterion sampling technique which resulted in the selection of six chapters using two criteria. First, the selected chapters are focused on consciousness raising; that is, on expanding women’s awareness of the inequality within healthcare. This is in direct contrast to some other chapters which focus on providing anatomical information. While both approaches are educational, the feminist element of consciousness raising was of greater relevance to the present research. Second, all chapters selected are present in both the 1973 and 2011 editions to allow for comparison. From each edition I selected: the
introduction, titled “A Good Story”, the chapter “Birth Control”, and the chapter “Navigating the Healthcare System”. I chose the introduction because in both cases it outlines the history of Our Bodies, Ourselves, which is deeply rooted in the Women’s Health Movement’s feminist approach to knowledge sharing. I chose the chapter written about birth control because I believe it reflects popular feminist discourses regarding both choice and responsibility, which are highly relevant to empowerment. Finally, I chose the chapter “Navigating the Healthcare System” as it provides details regarding the structure and functioning of the healthcare system, which focuses on encouraging women to be informed and empowered patients.

The examination of the data selected from each text is a comprehensive content analysis of each chapter focused on their feminist health advocacy information. The primary purpose of the content analysis is to identify the feminist activist elements in the text in order to understand what they contribute to the overall process of feminist activism regarding healthcare (Krippendorff 1989). ‘Feminist activism elements’ refers to content in the text which is meant to educate the reader on the social and political conditions that further the inequality of women while also highlighting ways to create change to reduce said inequality.

The goal of this data analysis is to map the changes which have occurred between the two editions of the text in order to draw conclusions regarding changes in the Women’s Health Movement, which is achieved by identifying the key content in both editions and determining the key differences between them. This process of content analysis relies on using codes to organize the content selection in order to maximize comparison opportunities.

The coding process I undertook involved creating a detailed coding scheme through a retroductive coding process which involved both relying on the literature and the text to generate inductive and deductive codes (Ragin and Amoroso 2010). While roughly 18 codes were initially created, I reduced the number of codes based on whether they were truly relevant to the research
question, the frequency with which they were found within the text, and their similarity to other codes.

The code selection was done in such a way as to prioritize the comparison of the texts in terms of their feminist activism content (for example, discussion of political and social conditions of health, critique of doctors, how to create social change) though there are many other overlapping content areas (for example, anatomy of the body and basic health facts). This study focuses on feminist information specifically, and not anatomical information, and thus the codes used within this study focus on health agency and activism. In order to determine the significant codes, I began by coding the data line by line. This produced a large number of individual and highly specific codes which I later incorporated into broader codes to lend strength to my interpretations (Campbell et al. 2013). Given concerns surrounding the reliability of qualitative coding, I employed a second coder to ascertain reliability. I trained my second coder on my codebook and had them code 10% of my text which had been randomly selected, repeating this process iteratively and discussing the results until an agreement rate greater than 80% was reached (Campbell et al. 2013).

Table 1: Selected Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Example from text</th>
<th>Proportional Agreement of Inter-coder Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility</td>
<td>1973: ““Total responsibility means that if men don't have some kind of birth control and we are pressed to have intercourse, it is up to us to say no, it means if we have sex”</td>
<td>87</td>
</tr>
<tr>
<td>Code</td>
<td>1973</td>
<td>2011</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Choice</td>
<td>“we must work hard politically to get rid of every one of these obstacles (high cost of birth control), for they assault and endanger the right of women to decide whether and when we will have children” Pg 106 2011: “But advances in birth control technology have created more choices than ever before, making it more likely that a woman can find an option that meets her individual needs” Pg 201</td>
<td>83</td>
</tr>
<tr>
<td>Capitalism</td>
<td>“the recent organization of medical power into urban based around university teaching hospitals, where the priorities of profit, research and medical education all come before patient care.” “Pg 238 2011: (In regards to doctors encouraging prescription drug use) “There is a vested interest in convincing people to take their drugs. The more people use their products, the larger the drug companies’ profits” Pg 128</td>
<td>94</td>
</tr>
<tr>
<td>Risk</td>
<td>“Some people argue that this (increased blood clot risk for those using birth control pills) is not too bad because more women die during pregnancy and delivery (25 per 100,000) then with blood clots on pills (3 per 100,000). But this argument is not entirely reassuring” Pg 114 2011: “Factors to consider include safety and effectiveness, and how much you are willing to risk” Pg 206</td>
<td>85</td>
</tr>
<tr>
<td>Drug Companies</td>
<td>“The prescription task force of the Department of Health, Education and Welfare estimated that in 1968 the drug companies spent $4500 per physician per year on advertising and promotion of all drugs” Pg 107 2011: “another problem with commercially funded studies is that the articles are sometimes ‘ghostwritten’ by companies hired by pharmaceutical companies” Pg 136</td>
<td>100</td>
</tr>
</tbody>
</table>

These codes illuminated key trends within the text that shape the findings of this research by highlighting the differences between the 1973 and 2011 editions. The first code ‘responsibility’ draws attention to the way that responsibility for one’s own healthcare is discussed. This includes diverse perspectives on who is responsible for ensuring safety, and the delivery of appropriate care. It also addresses the discussion of who, in sexual relationships,
should be responsible for preventing pregnancy. The ‘choice’ code encapsulates a key area of work for feminist health activists by addressing the importance of women having the freedom to choose their birth control, as well as if and when to have children. This code highlights the different approaches to choice including the subtle differences between freedom-to-choose and forced-choice narratives. The ‘capitalism’ code highlights the ways in which the texts draw attention to and critiques the role of capitalism in healthcare. This code serves to draw a comparison between critical and noncritical discussions of capitalism by feminist health activists. The code titled ‘risk’ was created when it was clear that it was a large ‘responsibility’ subcode that required its own section. It helps to address the ways that risk is shifted from doctors and the healthcare system to individuals over the two editions of the text, and highlights how the focus on the individual has changed over time. The final code, ‘drug companies’ was selected as the topic of drug companies had been identified in all other codes and demanded its own attention given the complex relationship of drug companies to other players within the healthcare system. This code allowed me to illustrate the ways that the two editions portrayed the role that drug companies play in the choices, risks, and responsibilities that women face in the healthcare system. All of these codes draw attention to the changes that occurred between the 1973 and 2011 editions of the text. In order to best express these changes, I organized the codes into themes so that my discussion of the results maximizes comparisons between the editions.

There were three steps involved in producing a theme out of multiple codes. First, in order for any given code to be incorporated into a theme, it had to have a significant presence in both editions of the text. This was to ensure comparison was possible. This left a number of codes that were present in one edition but not the other, all of which were excluded from the analysis. Secondly, the codes were assessed for similarity in content or meaning. This was the primary way of identifying the thematic codes. This process involved determining the key
elements that connected multiple codes either through identifying words (for examples “capitalism” “abortion”) or general topics (for example cost of care, responsibility in doctor/patient relationships). To illustrate, the code ‘doctors as businessmen’ and ‘capitalist disease creation’ both relate to the theme of economic and capital conditions of health. This identification process involved assessing and sorting every code into three broader themes, detailed below. The final part of the process involved processing overlapping codes. In the rare instance in which I felt codes fit into multiple themes, the theme that a code most frequently represented among all instances in the text was the theme under which it is categorized.

Three main themes were generated based on the strong contrast between editions and their relationship to the key features of activism within the women’s health movement. The themes are: a) ‘critique of the medical system’ b) ‘from free choice to forced choice’ and c) ‘shifting responsibilities’. ‘Critique of the medical system’ investigates the differences in approach each text uses in regard to the role capitalism plays in the healthcare system and healthcare delivery. The themes are composed of the significant codes identified. In order to be included, the code had to be present in both editions of the text. The next theme is “from free choice to forced choice” which captures the difference between the first edition’s advocacy for women to have more control over their reproductive choices and the most recent edition’s novel perspective on reproductive choice focused on forced choice. The final theme, “shifting responsibilities”, aims to explore the differing assignment of responsibility for healthcare information, provision, and control.

Below is a table that summarizes the codes which are grouped into topics in order to provide structure for this research.

Table 2: Summary of Topics
<table>
<thead>
<tr>
<th>Topics</th>
<th>Included Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Medical System</td>
<td>‘capitalist disease creation’, ‘doctors as businessmen’, ‘pharmaceutical industry influence’ and ‘cost of care’</td>
</tr>
<tr>
<td>Choice</td>
<td>‘forced motherhood’ ‘birth control access’ ‘abortion’ and ‘forced choice’.</td>
</tr>
<tr>
<td>Responsibilities</td>
<td>‘access to information’ ‘doctor’s responsibility’ ‘parenthood responsibility’ and ‘responsibility in choice’</td>
</tr>
</tbody>
</table>

Examples of each topic, and their broader theoretical significance, are explored in detail below.
Chapter 4: Observed Changes

The analytic process highlighted many codes which were organized into themes that suggest three significant temporal shifts in understandings of women’s health. The first is a shift in the critique of the American medical system, the second reflects a change in the role of choice, and the final change rests on a shift in the discourse of responsibility. Below, I will review each shift in turn. I begin with the American medical system, then choice, and finally responsibility. I have chosen this order because each theme builds on the one that comes before it, helping illustrate the symbiotic relationship that exists between the three. These changes are briefly outlined in Table 3, below.

Table 3: Summary of Findings

|--------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------|
| American Medical System | • Relationship between capitalism and American healthcare system is criticized  
• Influence of pharmaceutical industry is criticized | • Ignores lack of accountability by medical professionals  
• Ignores structural problems and advances individual solutions | Attention is shifted away from the problems of capitalism |
<table>
<thead>
<tr>
<th>Choice</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| • Provides women with knowledge to choose if, when and how to use birth control.  
• Criticizes the healthcare system’s lack of informed choice               | • Argues for shared responsibility between doctors, patients and government       |
| • Encourages women to choose between various birth control options, but neglects to promote the freedom to not use birth control at all  
• Personal responsibility and morality for choice and usage of birth control advanced | • Argues for education that is undertaken by patients and doctors                |
| There is a shift from the rhetoric of “free choice” to one of “forced choice” | • Reduces the responsibility of doctors to provide patients with unbiased information  
• Increases the responsibility of patients to critically assess medical information to determine safety | | Responsibility is shifted away from institutionalized barriers to women’s healthcare towards women themselves |

4.1 Capitalism becomes Acceptable

One of the key features of the Women’s Health Movement is its scrutiny of the American medical system. This feature is most evident within the first edition *Our Bodies, Ourselves*. A close reading of the first edition of the text highlights Women’s Health Movement’ critical perspective. The text emphasizes the problematic relationship between the health industry and capitalism. The critical perspective of the Women’s Health Movement identifies the relationship between the health industry and capitalism as particularly problematic. In this first edition, the American medical system is examined in terms of its integration into capitalism and the resulting impact on care. The 1973 edition of *Our Bodies, Ourselves* addresses the role of capitalism in healthcare by identifying the shift to a corporate profit-focused model. The Collective draws
attention to the formation of a strong private health care system, which is supported in tandem by
the growing pharmaceutical and insurance industries. The private model, supported by insurance
companies, was influential in creating health inequalities, as not everyone was able to access
comprehensive insurance coverage. The 1973 Boston Women’s Health Book Collective write
that the American medical system has shifted to focus largely on profit: “the recent organization
of medical power into urban empires based around university teaching hospitals where priorities
of profit, research and medical education all come before patient care”  
(Our Bodies, Ourselves 1973 p. 238). Further, they argue that the reason for the powerful role of capitalism within
healthcare rests on “the capitalist theory of disease creation” (p. 238) whereby doctors help
frame relatively harmless conditions as illnesses in order to increase the potential profits. The
Collective is critical of this intimate relationship between capitalism and health, promoting the
idea that the two are deeply intertwined, a situation which they say must be corrected to achieve
equity in healthcare: “The need to control the activities and change the profit-above-all policies
of some American corporations in the interest of public health” (p. 239). This critique of
capitalism and health is a foundational theme through the first edition of the text, arguing that
dismantling capitalism is of paramount importance to the work of feminists in women’s health.
This critique of the American healthcare system as a profit-driven capitalist institution implies
that capitalism is detrimental to creating and accessing respectful, safe, equitable healthcare.

The 1973 Collective was facing an American Health Care System which was structured
around additional capitalist institutions and practices, including pharmaceutical companies and
insurance companies. The text identified the antagonistic role drug companies played in the
health of consumers. For example, “it is next to impossible for doctors to be knowledgeable
enough about them all [drugs] to prescribe them with safety… the marketing practices of drug
companies are in-and-of themselves a health hazard” (p.239). The text draws attention to, and
chastises, the role doctors play as capitalists. “The psychological profile of most men in practice
today more closely resembles the American businessman: repressed, compulsive, and more
interested in money (and the disease process) than in people” (p. 252). Finally, the 1973 text
acknowledged that the structure of capitalism itself plays a role in the degradation of the
healthcare system. In particular, the focus that hospital administrators and doctors give to buying
the newest, state of the art equipment is, according to the Collective, detrimental to the health
and lives of people: “Many lives are lost because resources are sacrificed to the interests of the
marketplace” (p. 242). It is abundantly clear that the collective that authored the 1973 edition
was critical of the impact of capitalism on the American healthcare system and on women’s
health. They presented a strong anti-capitalist discourse, directly calling for the elimination of
“the profit motive from the healthcare system” (p. 242). The 1973 Collective was critical of the
American healthcare system in many ways, but their primary concern was the deeply symbiotic
relationship between elements of healthcare delivery and capitalism. The Women’s Health
Movement was dedicated to ensuring women had the freedom to make choices for themselves
that were not unjustly influenced by others, particularly those who already wielded excessive
power over women. This concern was particularly strong in relation to doctors and capitalism,
because the influence of capitalism over the behavior of medical professionals strengthened their
unnecessary and unethical influence over women. The strong relationship between capitalism
and healthcare directly hinders actions that promote empowerment, like free choice and unbiased
personally-based education.

In contrast to this powerful capitalist critique, the collective that authored the 2011
edition took a far less critical approach to the discussion of the relationship between capitalism
and the healthcare system, and by extension were far more accepting of this complex
relationship. When explaining how doctors may not provide the best care because of conflicts of
interest with drug companies, the 2011 text states, “Doctors and other healthcare providers may be constrained by such factors as financial incentives…that reward use of procedures [and]…pressure…from drug company representatives to recommend certain medications” (Our Bodies, Ourselves 2011 p. 657). This passage reflects how the medical system does not hold doctors responsible for ensuring their practices are ethical. The language used in this passage, including words like ‘may’ and ‘constrained’ indicates a significant lack of critique, and instead suggests that this potential influence over doctors is no longer their responsibility to avoid or mitigate through a critical perspective. It implies that doctors are simply working within the system as they must. This discourse of acceptance without critique does not end with the discussion of doctors. The text acknowledges that there is an ethical conflict between research results and the influence of drug companies but does so in a nonjudgmental way. “When drug and medical companies fund research directly through private contracts, they are able to influence the study design and the published results” (p. 667). Finally, the 2011 text clearly demonstrates that the Collective has accepted the deeply rooted relationship between capitalism and healthcare. The text states:

As consumers of healthcare services, we should be able to determine for ourselves if the treatments we are receiving are safe and effective, what our care will cost, whether our care providers are competent and whether the settings in which we receive care adhere to the best practices and reliably protect patient safety. (p. 686)

The 2011 text does not dismiss the fact that the current American healthcare system has problems that need to be addressed. What it neglects to do is identify capitalism as a key contributor to these problems. Furthermore, as evidenced above the Collective promotes an
individualistic solution to what are inherently structural problems, where each person is responsible for assessing their own healthcare for safety and effectiveness. The ability to determine the safety and efficacy of the healthcare they are receiving is far outside of the expected medical knowledge of an average consumer and places all responsibility and risk on individuals without demanding structural change.

Both the 2011 and 1973 editions purport to be at least partially dedicated to exploring the American healthcare system with a critical lens. Further, both editions of Our Bodies, Ourselves do offer some criticisms of the failings of the American medical system, but the 2011 edition takes a less critical approach in their treatment of capitalism. These differences highlight the manner in which feminist discourses have begun to shift towards embracing neoliberalism in the most recent edition. For example, in the first edition, the authors highlight that the capitalist system of marketing drugs is detrimental to human health. This directly challenges the value of capitalism and its place in healthcare. In the 2011 edition, the text explains the unethical role that medical and drug companies play in research, but it does not identify the profit-driven motives of capitalism as a driving factor of unethical behaviours. The 2011 text also does not offer any alternatives or elaborate on the harm this practice inflicts upon patients.

This practice of acknowledging a problem without acknowledging capitalism as its root cause is also evident in the discussion of doctors. The first edition of the text is highly critical of doctors. Capitalist doctors are negatively framed through the use of language like “repressed” and “compulsive” to describe both their behavior and their personalities (p. 242). When the 2011 Collective writes about doctors being influenced by companies, a distinctly capitalist experience, they are described as being ‘constrained’ by lucrative financial incentives. This passive language downplays the deeply problematic role of capitalism within medical practice. Words like “repressed” and “constrained” frame medical professionals as those who lack the power needed
to avoid or overthrow the influence of pharmaceutical companies. This is not the case however, as doctors hold immense financial and social power in the American healthcare system and have a responsibility to uphold their oath to provide the best care possible. The Collective does not call on doctors to act ethically, nor do they call on companies to reduce their unethical influence on doctors and thus the health of patients. The 2011 text seems to accept capitalism as the state of things without assessing the relationships between capitalism and inequality in health. This tendency to avoid drawing connections between capitalism and unethical healthcare practices exemplifies the neoliberal proclivity to ignore the detrimental relationships between social conditions and capitalism (McGregor 2001).

Finally, and most strikingly, the shift from an anti-capitalist feminist discourse to a capitalist-friendly neoliberal discourse within these texts is exemplified by the discussion of the healthcare marketplace. In the 1973 text, the Collective calls for a change in the way that we approach healthcare, chiefly a shift away from a profit focus. The most recent edition on the other hand, clearly communicates an acceptance of the relationship between capitalism and healthcare. Moreover, the 2011 text firmly establishes a neoliberal feminist view with the assertion that individuals (“ourselves”) should be responsible for determining what healthcare is safe and of high quality. This focus on individualism and personal responsibility directly reflects the neoliberal feminist belief that when it comes to health, women should take on all responsibility for their own care, well-being, and even their safety (Rottenberg 2013). This focus on personal responsibility is in direct contrast to the 1973 text’s call to dismantle capitalist healthcare in favor of viewing health as a human right and not a commodity, which should be safe and accessible to all. This change reflects a shift in empowerment as dismantling structural barriers to equitable healthcare, towards empowerment rooted in women as individuals being informed and taking healthcare into their own hands. This newer, personally based
empowerment does not require significant structural change, and thus does not create lasting, impactful empowerment for all women.

4.2 Free Choice becomes Forced Choice

As a feminist text, both editions of Our Bodies, Ourselves address the discourse of a woman’s right to choose the conditions of her life, including what—if any—birth control to use, if and when she becomes a mother, and if she will have an abortion. These are significant markers of an empowered woman and were a key focus of the Women’s Health Movement’s efforts to increase women’s empowerment and control (Rottenberg 2013). In the 1973 edition, the text is explicit about the significance of new knowledge about birth control and its ability to empower women through more choice. For example, “this knowledge has freed us from playing the role of mother if it is not a role that fits us” (p. 3). Here, the 1973 Collective highlights that women should have a choice in birth control, or a choice to not use birth control and become a mother. The 1973 text continues to address the complicated role that capitalism plays in augmenting a woman’s ability to choose. The text states “drug companies… have a lot of control over choice and acquisition of birth control methods” (p. 107). The 1973 text documents and criticizes the implications of this control, stating, “it seems that women all over the country are walking out of doctor’s offices and clinics with methods of birth control that they have not really thought about or clearly chosen” (p.107). The text claims that this lack of educated choice is not acceptable and argues that: “every woman deserves to make an ‘informed choice’” (p. 115). The 1973 text focuses on allowing women the freedom to choose the type of birth control and the freedom to use it or not use it at all. The Collective argues here that women must access the knowledge base that doctors control without being critical of the circumstances which women face that preclude them from easily accessing it. As Foucault (1995) addressed medicine remains to be an optimal arena for the control of women, because the prestigious knowledge doctors
control is easily used to exercise power over women. The 1973 Collective argues that in order to change the circumstances, changes to the medical system must occur, but the 2011 Collective is content with simply arming women with the same knowledge used by doctors in an effort to mitigate their monopoly of power. The 2011 Collective’s perspective is limited in terms of the lasting empowerment that could be enacted through this approach, as it does not allow for structural change.

The work of the 1973 collective also addresses the various barriers that may impact the freedom women have to choose. The text states that: “the whole attitude and approach in private care is still class-orientated. You are seen as having the money if you seek private care…and this does define to a large extent the attitude with which you are treated” (p.245). Here the text identifies the impact that socio-economic class has on a woman’s medical care, which is directly related to the amount they are permitted to question and challenge the care they receive (Fuller-Rowell, Evans, and Ong 2012). The 1973 Collective was acutely aware of the need for broad, social and structural change in order to facilitate widespread and lasting empowerment for women. However they also identify gender discrimination as a key factor influencing the care women receive, noting “how their [doctors’] official ideas about women affect the medical care [women] get and thus [their] very survival” (p.250). Finally, the 1973 Collective also acknowledges that the social factors that act as a barrier to free choice can often be taken to the extreme, effectively removing all ability to choose between birth control options or motherhood. Such extreme barriers include the use of sterilization procedures forced upon certain marginalized populations: “Notably, ghetto areas tend to do too many, and not entirely voluntary sterilizations. Black women in the South are all too familiar with the ‘Mississippi Appendectomy’ in which their fallopian tubes are tied, or their uterus is removed without their knowing it” (p. 135). The 1973 text presents a politically charged critique of the systems that bar
women from having total and complete freedom to choose the family planning methods best for themselves. The text asserts the importance of this freedom of choice for empowerment, and then provides direct examples of unnecessary and inappropriate barriers to choice.

In direct contrast to the work of the 1973 Collective stands the work of the 2011 Collective. The 2011 text still asserts the importance of choice, for example stating that we should fight to remove barriers to choice, “We can campaign for decent housing, jobs and child care for all so we can choose birth control freely instead of being forced to use it by our circumstances.” (p 204). Beyond this however, the discussion of choice shifts dramatically. The 2011 Collective writes of choice in such a way as to suggest somewhat subtly that women must make a choice among birth control methods, and that the choice of not using birth control is not appropriate. “Have a birth control method picked out and begin using it before the first time you have sexual intercourse” (p. 207). This tone indicates that birth control is the only option for women hoping to abstain from pregnancy. The 2011 text positions the use of birth control as a moral marker of goodness, stating: “having a conversation with your partner about birth control is a good way to learn of his interest in participating in the process, which can also be an opportunity to assess if he is a good choice for a sexual partner” (p. 204). The 2011 text, while attempting to frame this discourse as one focused on increasing choice for women, instead creates a discourse that positions choice as simply being able to decide which birth control they will buy and use, not if or when women should use it. This framing does not address the social conditions which shape a women’s decision, and by focusing only on birth control education creates a smaller variety of educated “choices” for women to make and achieve empowerment.

The shifted discourse from free choice to forced choice highlights increasing neoliberalism present within the 2011 edition of Our Bodies, Ourselves. The trend of forced choice refers to the practice of presenting women with many options they have in regard to their
reproductive health (e.g., the number of types of birth control available) and, in turn, women are told that they must choose from the presented options, which in reality are often limited to just options which involve consumption of a product or service. In reproductive health, this often occurs with birth control options, while other options such as pregnancy, motherhood or abstinence are ignored, forcing women to choose only between the birth control options. Where the 1973 edition criticizes the restriction of choice for women and highlights the various social, economic and political factors that restrict choice, the 2011 edition accepts such restrictions and encourages choice within these boundaries. By ignoring the broader social contexts that restrict choice, the 2011 text perpetuates the neoliberal notion of individualism (Onge 2017). This individualistic focus is reflected in the approach to empowerment which is most popular among choice feminists but also the least impactful. According to Woodall, Warwick-Booth and Cross (2012) empowerment must address broad social conditions and individual choices in order to establish lasting empowerment for women. There is no denying that the practice of encouraged birth control consumption serves to protect women from pregnancy; however, it also benefits the medical establishment which regularly harms women (Chiapperino and Testa 2016). Doctors and pharmaceutical companies both have a vested financial interest in having women return to them periodically to acquire prescriptions and pills that the forced choice discourse asserts they must use. This seemingly subtle shift in the discourse of choice reflects a more significant example of neoliberalism quietly infiltrating feminism.

4.3 Personalizing Responsibility

The discourse of responsibility is recurrent in both the empowerment literature (Souza 2011; Vinkenburg 2015) and both editions of Our Bodies, Ourselves. Responsibility is discussed in the context of two key topics: birth control and the decisions made by doctors. The 1973 edition of the text clearly identifies ways in which women can share the burden of responsibility
by educating each other. It states “we must learn for ourselves and teach each other about every available method of birth control. We have to know enough to recognize when a doctor is not examining enough or explaining enough or demonstrating enough” (p. 206). Here the Collective clearly establishes that women must help other women in order to ensure we all have safe healthcare. This exemplifies the methods that the Women’s Health Movement employed for the disruption of the power dynamics that Foucault (1995) identifies. This activism, particularly the personalized education, helps challenge the medical power which Foucault (1995) claims is used by doctors to control women. This discourse of sharing the responsibility stands in contrast to the 2011 edition of the text. The latter edition states that: “Although some men carry condoms, you shouldn’t expect it. Protect yourself by carrying condoms with you” (p. 212). This clearly acknowledges that even in opportunities where men are willing and able to bear some of the contraceptive responsibility, women must not expect men to be responsible; instead, they should bear the entire burden themselves.

The two editions of the text are different in how they discuss shared responsibility of doctors and patients. As we have already seen, the 2011 edition accepts that doctors may allow conflicts of interest to potentially impact their treatment of patients. This acceptance allows doctors to shelve some of their responsibility to behave ethically and pushes it onto their patients. However, the 1973 version of the text states “The FDA required the drug companies to publish a list of contraindications that prohibit the use of the pill. The doctor should check a woman for each one of these contraindications” (p. 115). The text also states that “it is up to you to make sure you are checked for each one of the contraindications” (p. 115). This portion of the text highlights the complicated role responsibility plays in the healthcare arena. In the first portion, the text clearly puts the responsibility on the healthcare professionals and those who govern us, for example the FDA in order to maintain a safe healthcare system. But women are also
informed that they must share the responsibility. This shared responsibility relies on the idea that
government agencies (the FDA in this case) must regulate the behaviours of doctors to allow for
safe and efficient care. In the 2011 edition, however the Collective accepts that doctors are
abandoning their professional responsibility and shifting it to their patients. The text states:
“Even the most diligent healthcare providers have difficulty staying on top of every new study
that may affect their area of practice. When your own health is at stake, you may be more
motivated than your care provider to seek out and find the most current research about your
specific needs” (p.665). This suggestion both promotes acceptance of the practice of doctors
reducing their commitment to the medical profession and puts intense personal responsibility on
the patient. Being encouraged to undertake complex medical reading in an effort to make sure
the healthcare you receive is correct for your needs is clearly an unreasonable burden to place on
the average patient.

This practice of shifting the responsibility from being shared between the doctor, patient,
and regulatory agencies to the individual patient is directly in line with the views of
neoliberalism. Neoliberalism, and by extension neoliberal feminism, calls on individuals to take
total responsibility for their own wellbeing. Furthermore, this lack of reliance on the FDA in the
2011 edition reflects the neoliberal trend of downsizing government (Onge 2017), which further
supports the intense privatization of healthcare. This process negatively impacts all women, but
unfortunately has a disproportionally negative impact on minorities and lower income women
(James-Hawkins et al. 2018), fostering the need for lasting empowerment. These three themes
illustrate the influences of neoliberalism within feminist health discourse in Our Bodies,
Ourselves. The following chapter explores this influence and considers the implications of such a
shift in feminist healthcare advocacy.
Chapter 5: Discussion

5.1 Neoliberal Influence

The dramatic differences between the first and last editions of *Our Bodies, Ourselves* point to the shifts in feminism over many decades. The recent edition has strayed from the founding collective’s deep roots in the Women’s Health Movement and is now embedded in the neoliberal feminism. Today we are facing a powerfully neoliberal feminism both within and outside of healthcare (Banet-Weiser and Portwood-Stacer 2017; Dubriwny 2012; Ikemoto 2012; Rottenberg 2014), and the difference between these two books exemplifies its impact. Broadly, neoliberalism is the idea that “the economy should be deregulated, privatized and that government should have no interference with the market economy” (McGregor 2001).

Neoliberalism is a world view involving political structure, economic policies, and social beliefs and that focuses on increasing consumption and the distribution of resources from the top down. It operates as the dominant model within the Western world for how to best regulate the economic and political organization of society, with a focus on stimulating the economic market as a societal panacea, a remedy to all other social problems (Connell 2014).

In the American context, neoliberalism began its ascent to mainstream consciousness in the 1980s with the Reagan presidency (Apeldoorn and Overbeek 2012). Influenced by the classical liberal economic principles of Adam Smith (Campbell and Skinner 1982), President Reagan was supported by a global shift towards conservatism among major industrial countries, including Canada (led by Brian Mulroney) and the United Kingdom (led by Margaret Thatcher). While facing growing national debt, Reagan introduced the Economic Recovery Tax Act of 1981 to reduce personal, estate, and business taxes (Prasad 2012). The goal of this act was to give individuals and, more importantly, corporations more money to inject back into the marketplace in order to stimulate growth and innovation, with the positive effects passing down to all
citizens. While the act did not decrease national debt as intended and was scaled back less than a year later, it was popular enough to begin the neoliberal economic trends which shape American economics, politics, and social conditions today (Prasad 2012). Economically, neoliberalism calls for deregulation, with the main goal being: “the deregulation and privatization of all public and state-owned enterprises” (McGregor 2001: 25). This process occurs through the removal of laws that require government delivery of services or, as an alternative, changing or creating new laws that shift the control over said industries to private ownership in order to boost the market’s strength (Bezanson 2014; Gregoratti 2016; McGregor 2001). This privatization shifts the delivery of services that were previously publicly met on the basis of citizen’s rights to a private system with a focus on income-based access, dramatically increasing rates of inequality (Connell 2014).

As neoliberal approaches to economics grew in popularity in the 1980s, corresponding political and social trends surfaced. The above economic policies form the foundation of neoliberalism and provide guidelines to a variety of policies and trends. According to supporters of neoliberalism, if business owners are taxed less the workers and buyers will also reap benefits (Dubriwny 2012). Politically, neoliberal governments generally favor reduction in state responsibility, corresponding with a shift to private market responsibility (Bezanson 2014; Gregoratti 2016; McGregor 2001). This shift results in the reduction of social programs such as social security, education, roadworks, and healthcare. The social programs are then expected to be replaced by private companies which neoliberal advocates argue will be more economically efficient because they are controlled by the demands of the marketplace (Dahl and Soss 2014). The neoliberal organization of government operates on the premise that the services provided by private companies will be more efficient and affordable to the consumer because of the absence of the bureaucracy present in state-organized industries.
The influence of neoliberal views of capitalism within the 2011 edition of *Our Bodies, Our Selves* is striking. The first edition positions itself as a key source of criticisms regarding the deep connections between the medical system and capitalism. The 1973 text discusses the risks and pitfalls of the deeply intertwined connection between capitalism and health, and the particularly devastating impacts on healthcare. This critique is not evident in the 2011 edition. Instead, the 2011 text seems to accept capitalism shaping healthcare delivery. Allowing the market to dictate the healthcare system’s structure is a distinctive neoliberal approach to the healthcare industry (Chen 2013). By accepting the behaviours of doctors who are manipulated by the pharmaceutical industry’s business goals, the 2011 text prioritizes the capitalist marketplace over the health of women. Furthermore, this acceptance places the responsibility of navigating the healthcare system in the hands of healthcare consumers. This focus on individualism is a key neoliberal tactic that intensifies the downsizing of government and the reduction of social programs (Whelehan 1995), while also increasing personal burdens.

The focus on individualism that stems from the lack of critique in the 2011 edition is also exemplified by the approach to responsibility. While the first edition of *Our Bodies, Ourselves* approaches responsibility from a shared perspective, it becomes clear in the 2011 edition that there is an expectation that women are solely responsible for determining what is safe and acceptable within their healthcare experience. Further, doctors are not expected to avoid participating in potentially coercive relationships with the marketplace, including with drug companies. This approach assumes that all women are able to freely participate in capitalist healthcare by choosing a doctor based on quality and safety, an assumption that is patently false (Whelehan 1995). Having a doctor whose knowledge is compromised comes with increased risks which are expected to be managed by individual women rather than broader government bodies like the FDA, placing undue stress and impossible-to-meet standards on women, all while
continuing the neoliberal practice of reduced government control and regulation (Dubriwny 2012). Though the 2011 edition of *Our Bodies, Ourselves* continues to advocate for feminist healthcare, their individualistic approach indicates that the feminism they advocate for is firmly based in neoliberalism.

### 5.2 Feminism Evolving

The work of the Women’s Health Movement, exemplified in both editions, advocates for a woman to have the ability to make her own decisions about her life, her body and her healthcare. As highlighted above, the 2011 text employs a more limited perspective of choice, where choice is framed as ‘choosing between’ birth control methods rather than a more holistic approach which allows women to choose not to participate in birth control measures. The 2011 text’s approaches to birth control choice encourages consumption over a continuous period of time (Cairns and Johnston 2015; Chen 2013; Dubriwny 2012). Continuous consumption is a fundamental tenet of neoliberalism that has become deeply embedded in neoliberal feminism (Dubriwny 2012; Whelehan 1995). Choice is a very important feature of feminist activism and does offer women increased freedom and control over their lives, which in turn directly reduces their oppression. However, framing the simple action of making a choice without consideration of the broader political implications, or the ability to exercise choice, leads to the kind of ‘choice’ feminism that is aligned with neoliberalism (Chen 2013).

The feminist approach to health advocacy in the most recent edition of *Our Bodies, Ourselves* differs dramatically from that of the first edition. The two editions differ in their approaches to the healthcare system, responsibility, and choice, as demonstrated within the findings of this thesis. The fundamental difference between these issues is the type of feminism employed in order to advocate for changes in women’s healthcare. The first edition approaches the issues in women’s healthcare through a framework embedded in the Women’s Health
Movement promoting education, structural change, and collective advocacy. The most recent edition is individually focused, lacks a critical approach to capitalism, and focuses on the ideology that “any time a woman makes a choice it is an act of feminism” (Čakardić 2017:33). In order for impactful change to occur, activists must abandon their individualist focus and shift to an approach which prioritizes structural change. All of these elements highlight the 2011 edition approach to feminism as being a clear example of neoliberal feminism.

Neoliberal feminism focuses on the idea of personal choice as freedom for women, including freedom from government control (Čakardić 2017). While the work of the 2011 collective offers women some support in accessing respectful empowering healthcare, the individualistic focus on responsibility and choice without the critique of broader social structures controlling the healthcare system advances dangerous assumptions. One key assumption is that all women are able to make free choices (Whelehan 1995). This assumption ignores the many social factors that may limit a woman’s ability to do so, such as class and racial differences, different physical and mental abilities, and geographic location. This neoliberal feminist approach to health activism is not accessible to many marginalized groups and indicates that it is time for the Women’s Health Movement, including Our Bodies, Ourselves to review their approach and ensure they provide inclusive, intersectional activism.
Chapter 6: Conclusion

This thesis has been dedicated to the exploration of two editions of *Our Bodies, Ourselves*, a feminist health book written by and about women with a history stretching from 1973 to 2011. Designed to explore changes over time among the members of the Women’s Health Movement, this thesis addresses two research questions: “In what ways have the goals of feminist health advocacy changed over time as manifest in *Our Bodies, Ourselves*?” and, “What might account for the observed changes?” The coding and analysis of two editions of this text, the first (published in 1973) and the last (published in 2011), highlights the significant shift in content over the last 38 years. The most recent edition of *Our Bodies, Ourselves* has departed from its Women’s Health Movement roots and has embraced neoliberal feminism. This shift influences the content and, by extension, the activism promoted by the text. The differences between each edition of the text are starkest when comparing the approaches they take to the medical system, as well as their views on who is held responsible for healthcare safety and the role of choice. The contrast illustrates the neoliberal feminist influence of the 2011 edition which excludes many women feminist activism due to individualistic perspectives and lacking structural changes. In order for feminist advocacy surrounding women’s healthcare to have a strong impact, some significant changes to healthcare should be undertaken to create structural change.

This analysis has provided insight into the current theoretical perspectives regarding feminist health empowerment. Empirically, this thesis has deepened the conversation regarding the role that neoliberalism plays within feminism and activism. It has provided specific examples of neoliberalism and helps contextualize the broader social changes inspired by neoliberalism within the specific realm of reproductive health. Furthermore, this understanding contributes to a theoretical discussion of empowerment as a key focus of feminists in the United States. By
providing details in regard to ways in which feminist health activism has changed, this thesis has highlighted the need to expand empowerment from a primarily financial focus, to also address broader social empowerment. The findings of this work indicate that feminist health activism is becoming more individualistic, which means that empowerment-promotion efforts in turn are skewing towards individualism. These contributions may positively impact the academic discussion regarding empowerment. In addition to deepening the academic perspective, these findings have implications for feminist health activists.

I suggest those participating in feminist health advocacy and education approach their task with organizational analysis and address the widespread changes needed in the system to create a more positive health environment. This includes working for policy change, increasing access to clinics, and electing leaders with a feminist understanding of women’s health needs. In tandem with this approach, I suggest that activists, healthcare workers, and feminists in general revisit the important role of consciousness raising and education in order to work towards the equality of women. Encouraging women to educate each other and engage in open dialogue about their bodies and their health will help continue the work of the Women’s Health Movement. Finally, regularly questioning the role of capitalism in healthcare, both individually by asking doctors and providers about their financial ties, and structurally by encouraging tighter control and regulation of the relationships between medicine and the pharmaceutical and insurance industries, has the power to lessen the abuse of women.

Healthcare professionals have a very unique role to play within feminist health activism. In order to reduce their oppressive or harmful behaviours they must be in constant communication with their patients regarding the care they receive. In order to resume the activism which creates lasting change, activists should focus efforts on challenging the capitalist control of the medical industry. This is possible by educating doctors to reject ties with the
pharmaceutical industry which impact or influence their practices in an unethical manner. Activists may also focus on educating doctors on ways to provide care which is safe, appropriate, and respectful to their patients. Appropriate activism challenges and dismantles the patriarchal nature of the medical system, and in turn helps develop an equal relationship between healthcare practitioners and their patients, while working together to determine the best path for care.

Though the findings of this thesis have the potential to contribute to and influence further investigations regarding feminist health advocacy, it is not without limitations. The primary limitation is that of scope; data were selected from only three different chapters among two editions of the same feminist health text. This study could be expanded upon by addressing more editions of *Our Bodies, Ourselves*, as well as more chapters from the text. The findings of this research inspire questions about the implication of written-word activism and how the use of text influences the activist approach. This could be explored with studies regarding alternative avenues of feminist health activism, for example street-level protest activism or the broader fight for government changes, to develop a more holistic investigation of the changes observed in this study.
References


