Article

En-Gendered Surveillance: Women on the Edge of a Watched Cervix

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Abstract

The aim of this paper is to provide a worked example, using cervical cancer screening, of how a nuanced consideration of the gendered and sexualized contexts in which surveillance is conducted might help to illumine the study of surveillance. In particular, the paper argues that neither the implementation nor the effects of women's health surveillance can be understood without appreciating the ambiguous mutual dependences of gender constructs and surveillance practices. The first section of the paper examines the World Health Organization's global program for comprehensive cervical cancer control, and raises the issue of how gendered and sexualized contexts are implicated in that program. Section Two then examines how health promotion strategies in cervical cancer screening are served by, and help to reinforce, gender constructions of women as 'docile' by nature. Section Three, by contrast, examines the ways in which some women respond to the controlling effect of surveillance by attempting to 'take control' of the screening process through various forms of activism, and thereby give effect to different gender constructions. The paper concludes that while surveillance contributes to creating screened populations burdened with gender constructs and imperatives, responses to surveillance are also shaped by gender constructs, and contribute to new gender constructs.

Introduction

Surveillance may well help to produce social order (Lyon 2007: 3) through the production and management of particular populations, but it does not irrupt on a world innocent of dividing, classifying and ordering practices. For surveillance to function at all, it must do so in the face of already effective forms of dividing, classifying and ordering populations. Since the effects of surveillance cannot ultimately be separated from the effects of such ubiquitous social practices, the study of surveillance requires sensitivity to the social context within which surveillance is deployed. Who is watching whom, and where and why is it happening? How are the watched affected? Further, if the watched become aware of and return the watching, how do they affect surveillance? In his recent and excellent book, *Surveillance Studies: An Overview*, David Lyon has noted the importance of context for understanding surveillance (Lyon 2007: 6-7) and also argued that, "In those contexts where surveillance is perceived as or has the effects of control, the fact that its subjects interact and react with surveillance means that its effects are mitigated or magnified in part in relation to their involvement" (Lyon 2007: 7). The aim of this paper is to provide a worked example of how a nuanced consideration of gendered and sexualized contexts might highlight Lyon's argument and thus help illumine the study of surveillance. In particular, the paper argues that neither the implementation nor the effects of surveillance can be understood without appreciating the ambiguous mutual dependences of gender constructs and surveillance practices.

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The Watched Cervix

For an overview of surveillance studies by a leading scholar in the field, Lyon's book (2007) does not have much to say about gender and sexuality—a brief mention of gender with regards to human resource management in organizations (pp. 84-5), and an even briefer mention (p. 144) of gender dimensions in Margaret Atwood's dystopian novel, *The Handmaid's Tale*. Given, however, that constructions of gender and sexuality are key shapers of social contexts in general, surveillance ultimately cannot be free of socio-political struggles over gender and sexuality, no matter how remote from them it may seem. There is a need, therefore, for greater consideration of gender and sexuality with regard to surveillance (a need also evidenced by this special issue of the journal *Surveillance and Society*). The chosen vehicle for that consideration in this paper, cervical cancer screening, provides a fruitful and appropriately complex instance of the ambiguous mutual dependences of gender constructs and surveillance practices.

The kind of surveillance at work in cervical cancer screening is medical surveillance; but given the intended outcome, perhaps 'health' surveillance would be closer to the mark. Other forms of health surveillance could do just as well for the broad aim of this paper—not just cancer screening of various kinds in general but surveillance of cholesterol, sugar levels, blood pressure, bone density, etc; all the things, in other words, that are presumed to place our health at risk. Even so, given that cervical cancer screening involves gazing at female genitalia, and peering into and penetrating vaginas, it is sexually sensitive for women in a way that other forms of health screening are not (not even breast cancer screening, though clearly it too would provide a useful example). It also raises issues of power relations and gender inequalities. To be clear from the outset, in discussing these issues this paper is *not* aiming to call cervical cancer screening into doubt (for example as an agent of the subjugation and oppression of women), or criticize it, or even propose better ways to do it; nor is it skeptical that in public health and statistical terms cervical cancer screening saves lives. Rather, we are using it to illumine the study of surveillance.

Cervical cancer screening is presented as a public health good because decreasing cervical cancer mortality rates is an excellent result for everyone concerned. For individual women living on the 'edge' of a watched cervix, however, there are consequences in addition to the broad public health agenda of saving lives. Screened women are implicated in the screening as both watched and as watchers. They are 'watching their health', but also viewing it, as it were, displaced from the direct object of surveillance, off to the 'edge' of their cervix. They are also 'on edge' in the sense of being anxious that this part of their body might become unruly and threatening, such that they live under its threat and are regularly reminded of that threat by recurrent surveillance. Of course, not all women respond in the same way, even in the same social context. That variability is in part what gives space to different constructions of gender and sexuality to affect surveillance outcomes. Before concentrating on that variability in women's responses, however, it is first important to understand and appreciate the nature of the global surveillance program for cervical cancer screening.

Among the forms assumed by what has been called 'Surveillance Medicine' by David Armstrong (1995; 2002), cancer screening takes a prominent position in the public imagination. In developed countries it is difficult not to be aware of cancer screening programs because the various types of screening available are so vigorously promoted and advertised—all in a good cause, health promotion generally, and not just for one's own benefit. Indeed, we are all urged to think of *others* if we are too irresponsible to comply with screening for our own sake (even to think of the 'drain' on the health system, or lost productivity in the workplace).

Much of the optimism about cervical cancer screening derives from the claim that, as the World Health Organization puts it in their publication, *Comprehensive Cervical Cancer Control: A guide to essential practice*, "cervical cancer is one of the most preventable and treatable forms of cancer, as long as it is detected early and managed effectively" (WHO 2006: 3). There is deep concern that most of the deaths from cervical cancer (about 80%) occur in developing countries, where most women (WHO estimates

95% have never been screened) do not have access to screening and prevention programmes. It is an issue of health equity, driven by the express principle adopted by the World Health Organization of “the right of everyone to equitable, affordable and accessible health care” (WHO 2006: 7). More particularly, this WHO publication affirms a gender-based perspective: “the discussion considers gender-related factors that may affect the power balance between men and women, reduce women’s power of self-determination, and affect the provision and receipt of services” (WHO 2006: 8). This is one sense in which cervical cancer screening provides a space in which gender constructs and surveillance practices exhibit mutual dependences.

The World Health Organization regards cancer generally as a global *epidemic* and crisis (WHO 2006: 3), and expects deaths from cervical cancer in particular to rise significantly. The urgency of taking action is tied to the fact that cervical cancer tends to kill women in the prime of their life: women “raising children, caring for their family, and contributing to the social and economic life of their town or village” (WHO 2006: 3). The WHO guide deems cervical cancer screening to be unnecessary for women aged over sixty-five. Death by cervical cancer is regarded as tragic for being ‘unnecessary’, with no room for stoic resignation or fatalistic sentiment. There is a medical imperative at work: because we *can* save women’s lives through active intervention, we must, even if our humanitarian concern is denounced as just another form of cultural imperialism. But how are women affected by such intervention? In asking this question we risk sounding subversive. As already noted however the aim of this paper is not to question whether cervical cancer screening *should* be conducted, but to examine its promotion and implementation, and responses to it, in the hope of illuminating the study of surveillance.

The World Health Organization’s concern that power imbalances between men and women may affect the provision and reception of cervical cancer screening and services raises the issue of gender equity very directly. The implication that androcentric bias adversely affects women as subjects of cervical cancer screening and services is fertile ground for illuminating the study of surveillance: in suggesting that the behaviour of men must also be subject to surveillance and control if cervical cancer screening programs are to succeed in decreasing mortality rates, it shows how difficult it is to contain the extent and effects of health surveillance. This is not to say, however, that any surveillance of itself is ‘bad’, a slippery slope to total surveillance and the subversion of human dignity. Rather, it is to say that depending on the goals of particular kinds of surveillance, it might be necessary to extend the gaze of surveillance more than anyone might have initially anticipated, and link it to very significant kinds of behavioural change: in this case, for both women and men. Given the desired health outcome, ideally, that is that no woman should ever die from cervical cancer, the ‘force’ required to achieve that outcome could restructure societies globally. The watched cervix would become the fulcrum for the exercise of new power structures and the reshaping of gender constructs.

Whatever one might think is the point of ‘doing’ surveillance studies (Ball and Haggerty 2005), that point is ineluctably tied to socio-political life by virtue of the fact that any kind of surveillance is goal-oriented and, importantly, *funded* by some segment of society. To watch the watchers is not neutral. To study forms of socio-technical organization is to enter into association with them, and even to run the risk of being construed as a potential enemy. Thus, no analysis of cervical cancer screening can be neutral with respect to vested interests. For that reason, this paper adopts a reflexive stance about its intrusion into cervical cancer screening even though that is tangential to its aim of illuminating the study of surveillance.

As a *global* guide to practice, *Comprehensive Cervical Cancer Control* (WHO 2006) makes it quite clear that the control of cervical cancer requires that women *and* men be ‘controlled’. This is obvious in the guide’s approach, despite the rhetoric of the ‘right’ of women to “accessible, affordable and effective services for the prevention of cervical cancer” (WHO 2006: 3), since even in cases where such services are available, there is still a problem with securing women’s compliance. By ‘educating and counselling’ men in order to enrol them as agents of the control of women (to increase compliance), men become part of the system of cervical cancer control. Furthermore, now that there is clear consensus that infection by sexually transmitted human papillomavirus (HPV) is the primary underlying cause of cervical cancer, the

sexual activity of both men and women must *also* be controlled (Helman 2007: 382-3). Vaccination against HPV may seem to undermine this claim, given the concern that it licenses sexual liberty for young women (although neglecting other sexually transmitted diseases), but it attempts to control at least this possible consequence of sexual activity. That is, it is solely a matter of risk minimisation and thus does not eliminate the need for cervical cancer screening (Cutts *et al.* 2007), and still triggers social, political and religious calls for the control of sexual behaviour (Vamos, McDermott and Daley 2008), including that of men as possible carriers of HPV (McPartland, Weaver, Shu-Kuang and Koutsky 2005). Accordingly, it is difficult to conclude that the gaze at work in cervical cancer screening is exclusively androcentric and works to control women. Rather, the gaze is what we could call ‘health-centric’, and the behaviours of women and men work either for or against the full effectiveness of that gaze.

The fact that the surveillant gaze has a goal is crucial to understanding why it is inherently divisive. That is, circumstances are cast as either for or against the attainment of that goal. Is there neutral ground? That depends on the specific goal. The attenuation or even elimination of death by cervical cancer is a global enterprise because the explicit health goal is, and must be, tied to the pursuit of social justice and the rights of *all* women, for no one is suggesting that women in developing countries be abandoned. In that sense, health-centrism knows no boundaries other, perhaps, than locally effective ethics committees that take wider rights, including those of animals, into consideration; but this aligns those committees with the same global intention of securing rights. The relevant question with regard to the goal of cervical cancer control is, what stands in the way? The World Health Organization does identify what it calls ‘barriers’ to such control: that is, political, community and individual, economic, and technical and organizational barriers (WHO 2006: 19). Its argument is that all these barriers must be overcome before cervical cancer can be controlled.

The description of these barriers makes plain the enormity of the task. The “lack of priority for women’s sexual and reproductive health” and the “lack of national policies and appropriate guidelines” (WHO 2006: 19) are identified as the political barriers. To prioritise women’s sexual and reproductive health *also* means shifting other priorities around. It means identifying the reasons why women’s sexual and reproductive health is not prioritised in the first place, and what actually is prioritised and why. Presumably, gender-related factors play a role in establishing such priorities, or the lack thereof. To implement national policies and guidelines requires very significant political agitation and much hard work of the lobbying, drafting, and funding variety. Community and individual barriers include “lack of awareness of cervical cancer as a health problem”, and “attitudes, misconceptions and beliefs that inhibit people discussing diseases of the genital tract” (WHO 2006: 19). Here too gender-related factors are directly implicated, particularly the stigmatisation of the female genital tract, and problems that arise from using men as health care providers in this area. Economically, a lack of resources betokens the lack of prioritisation, as do technical and organisational barriers. It is difficult to tease these barriers apart, so perhaps it is better to try to understand their interconnectedness. In this way, it becomes clear why only a well functioning health *system* can hope to control cervical cancer. If the problems are systemic, the surveillant gaze must be up to the challenge in those same terms.

What factors, then, prevent complete extension of the surveillant gaze of cervical cancer screening? There has been significant interest in these factors, primarily with a view to increasing the provision of, and women’s compliance with, screening. In one sense, the basic requirement is simple: the more women in relevant categories presenting for screening and follow-up services, the better. In cases where screening programmes are not readily available, political, economic, organisational and technical factors come to the fore; but not without community and individual co-factors. Where screening programmes are available it has, however, proved difficult to ‘control’ women; or to put it less bluntly, to persuade them to comply with screening programmes. There are many factors recognised as affecting women’s participation in cervical cancer screening, including education, socio-economic status, risk perceptions, attitudes and beliefs, geography, incentives, quality of service, levels of support, cultural values (Oaks and Harthorn 2003; Helman 2007), ethnicity, providers’ constructions of women, women’s constructions of providers, levels of health awareness, perceptions of cancer, shame and embarrassment, privacy, and stigmatisation

of the female genital tract (see, for example, Binns and Condon 2006; Canfell, Sitas and Beral 2006; Kim *et al.* 2008; Lovell, Kearns and Friesen 2007; Orbell, Hagger, Brown and Tidy 2006; Sabates and Feinstein 2006; Todorova, Baban, Balabanova, Panayotova and Bradley 2006; Winkler, Bingham, Coffey and Handwerker 2007). Given all these factors, it is hard to know just what to do in order to increase the health system's ability to control cervical cancer. Indeed, there is no one thing to do—the strategies will depend on the target groups.

For the purposes of this paper, we can leave the detailed strategic planning to increase control of cervical cancer to the relevant health-care providers who must take account of the sheer diversity of target groups, even and especially within the same broad community given that a woman's risk of developing cervical cancer in either developed *or* undeveloped countries is associated with her socio-economic status. The focus of this paper is on the general issues that can help shed light on the ambiguous mutual dependences of gender constructs and surveillance practices. For that reason it is important to examine the way in which the health system, in abstract and global, as opposed to concrete and local, terms constructs women for the purpose of controlling cervical cancer.

Health Promotion and the Construction of 'Docile' Women

If it is accepted that cervical cancer control is but one aspect of health promotion, then organised and systematic surveillance of the cervix for pre-cancerous lesions is part of a general health package for women globally. Since the aim of health promotion can hardly be seen as objectionable, it is understandable that compliance with a benign (and rights-securing) health-care system can be promoted as in women's best interests, no matter what kind of country or state we are talking about. Indeed, failure to comply would be deemed to be irrational behaviour by women, a failure to understand and act on what is best. This is the reason why one of the World Health Organization's key strategies for increasing cervical cancer control is health education (WHO 2006: 43-61): if *only* women understood the facts, they *would* comply. The linchpin of the educational push is the preventability of cervical cancer; and such education must ensure women understand that the medicine of symptom and curative care is inadequate in this particular case: once there are noticeable symptoms, that is, noticeable to the women themselves, it is typically too late for a 'cure'. Rather, it is only by acting on *precancerous* lesions that cervical cancer can be prevented. Thus, women must learn the language of risk and prevention, and know that they must act, counter-intuitively, while in the asymptomatic state, understanding that just because you *feel* well doesn't mean you *are* well.

The World Health Organization holds that "numerous studies have shown that many women do not attend screening programmes because they are not aware of their risk of cervical cancer nor of the benefits of screening in its prevention and early detection" (WHO 2006: 48). It also claims that it is largely women's fears and misconceptions standing in the way of compliance, and that those "fears and misconceptions can be dealt with by reassuring women about what is involved in an examination and screening" (WHO 2006: 48). The rhetoric is very much that of medical-scientific enlightenment battling ignorance and superstition. This is a powerful (and centuries old) script, with a salvatory promise: all it requires from those women who would be 'saved' is compliance. Interestingly, however, there is also at work here a gender-based expectation that women are good targets for compliance-seeking strategies, and not just in Western countries but globally, although it is important to recognize that Western presumptions about gender can be ill-suited to non-Western contexts.

It is not the case that men are curiously free of any imperative to comply with health promotion programmes; for example, and to use a comparable health risk, prostate cancer screening. However women, unlike men, are typically, or characteristically, expected to comply, whereas men, in a very different gender construction, are "assumed to be 'normal' and 'healthy', requiring less in the way of medical advice or intervention, unlike the 'weak', 'sickly', 'less controlled' bodies of women" (Lupton 2005: 204). Women, in this gender construction, both have to be cared for, as the 'weaker sex', while *also* having responsibilities for the care of others, a point emphasised by the World Health Organization. They

cannot, therefore, be allowed to take risks, unlike presumed 'healthy' males, who are expected to be risk takers. Gendered assumptions about women have already been implicated in women's subjection to greater public health interest than men (Petersen and Lupton 1997). Whether or not men come to be reconstructed as a vulnerable gender, thanks to an ever greater reach of health screening techniques, and thus seen as manageable targets of public health scrutiny lies in the future: Lupton notes, for example, that the men's health movement "recognises that certain elements of masculine identity and behaviour can be hazardous to health" (Lupton 2005: 205). In light of these gender constructs, however, women seem to be especially 'constituted' for medical surveillance. What could possibly make them so? The argument in this section of the paper is that women are construed as a 'docile' gender.

In what sense is a docile gender hostage to the compliance-demanding interests of health surveillance? While surveillance creates populations, certain populations are rendered more amenable to surveillance than others by means of gender constructs. In part this facilitated by the sexism that is rife in medicine (Broom 2005), which ensures that gender stereotypes tend to be promoted and to persist in health surveillance. The next section of this paper will look at the ways in which challenges to medical sexism yield different constructions of women *and* surveillance. For the rest of this section, however, women's presumed docility and its relationship with the interests of health surveillance will be further explored.

It is not just that women suffer the 'unbearable weight' of body (Bordo 1993), but that embodiment makes them visible in a way that men, as 'spirit' and 'true self', are not: as Bordo argues, the "duality of active spirit/passive body is also gendered, and it has been one of the most historically powerful of the dualities that inform Western ideologies of gender" (Bordo 1993: 11). This duality, by treating women as "passive, vegetative, primitive matter" (Bordo 1993: 12), actually renders them uniquely subject to surveillance; and it is men who see them. Given that medicine is rife with sexism, it is hardly surprising that women are subject to greater public health scrutiny than men. The question is, in what sense does their presumed 'embodiment' contribute to the idea that women are docile by nature? In the dualism under discussion, matter is considered passive, something to be moulded and shaped by active spirit. It could be argued that the 'sickliness' of women actually derives from this passivity, since they, unlike men, are easily affected by active forces; and they may be prone to 'corruption' in virtue of their materiality, spirit itself being, in principle, eternal. Docility, in other words, is an effect of materiality. The further association of spirit with mind robs women of rationality (Lloyd 1993) and will: they must be told what to do. This 'livestock' view of women's worth is not only debasing, but also places men in charge of women, their compliance and manageability assured by their material nature.

If we add, to this 'material' mode of en-gendering women, feminist responses to Foucault's analysis of docility in terms of power (Foucault 1977; 1978), we find further mutual dependences of gender constructs and surveillance practices. For Foucault, it is disciplinary power, rather than materiality, that yields docility, even to the point where the 'inspecting gaze' is internalised such that individuals exercise surveillance "over, and against" (Foucault 1977: 155) themselves. Feminists, however, have argued that Foucault's analysis *neglects* gender (Bordo 1993a; McNay 1992; Ramazanoglu 1993). Lois McNay, for example, notes that, "Foucault's indifference to sexual difference, albeit unintended, reproduces a sexism endemic in supposedly gender-neutral social theory" (McNay 1992: 11). If the social dimensions of surveillance are to be understood, then gender-neutral social theory is inadequate. To understand the effects of cervical cancer screening on women, it is critical to understand that the signification of women in essentialist terms "produces concrete effects throughout diverse social practices" (McNay 1992: 22).

In so far as women have internalised essentialist discourse, their compliance with cervical cancer screening programmes perpetuates and enforces what McNay calls "the myth of immutable feminine qualities" (McNay 1992: 22). The watched cervix becomes yet another tool in the normalisation and discipline of women. To reinforce this point, while the docility of women is presumed in order to promote compliance with cancer screening programs, men, on the other hand, "tend to dismiss health needs as a means of constructing and performing dominant forms of masculinity" (Lupton 2003: 29). That is, even though, in the interests of health surveillance, men might be encouraged to comply with prostate cancer

screening programs, they might wilfully ignore promotion campaigns in order to prove how ‘manly’ they are, and have their ‘bravery’ rewarded by the admiration of their peers. Thus, both women and men, respectively, comply and fail to comply with surveillance in accordance with essentialist discourse or gender constructs. Surveillance, by acting in an already gendered social context, produces different effects in one sense: compliance and non-compliance; but the same effect in another sense: the reproduction and perpetuation of essentialist discourse or gender constructs.

This casts the disciplinary power required for the attainment of health goals in an interesting light. Yes, both women and men have to be disciplined for the sake of those goals; but the means to do so are in part dependent on gender constructs. While disciplinary power, as Lupton argues, “is maintained through the mass screening procedure, the health risk appraisal, the fitness test, the health education campaign invoking guilt and anxiety if the advocated behaviour is not taken up” (Lupton 2003: 35), the benevolent mask of health promotion disguises the requisite controlling strategy. Indeed, the internalisation of the surveillant gaze and consequent self-discipline serve to erase the trace of the controlling health system at work. Of course, attempts at control do not always proceed as smoothly as might be desired. It is not, after all, ‘docile’ women who comply by virtue of their docile ‘essence’, but real women who respond, in disparate ways, to attempts to persuade them to comply. Some of those responses accord with ‘docile’ constructions of women (perhaps even internalised docility), and some do not. In which case, why not? More particularly, how can we distinguish between reasons for complying that are not based on docility, and reasons for not complying? In other words, different constructions of gender can interact with surveillance, and surveillance can incite “new possibilities for gender that contest the rigid codes of hierarchical binarisms” (Butler 1990: 145). In the next section, we examine gender constructions of women that hinge on the idea that women do not have to *be* controlled, that they in fact can *take* control.

Women in Control

There have long been groups of women attempting to subvert the dictates of an (until recently) largely male medical profession (Ehrenreich and English 1978), from the ‘wise’ women of the 17th century through the anti-Contagious Diseases Act campaigners of the 19th century, the latter protesting about the forced examination and treatment of female prostitutes while conveniently ignoring their male clients (Dally 1991: 97; Moscucci 1990: 123). This female activism has itself tended to take on a ‘controlling’ guise, either encouraging women to ‘demand’ medical treatment and/or services and *then* comply with them, or alternatively, to criticise and resist them.

In her excellent and detailed case study of ‘women’s’ cancer in America (Gardner 2006), Kirsten Gardner has traced the evolution of active female participation in cancer surveillance, from early interest in cancer education, through later participation in awareness campaigns, to, recently, some resistance to the seemingly overwhelming propaganda of ‘early detection’ (the latter epitomised in Barbara Ehrenreich’s provocatively titled article ‘Welcome to Cancerland: A Mammogram Leads to a Cult of Pink Kitch’ (Gardner 2006: 215)). In whatever guise, as Gardner points out, some women have been involved in at least attempting to control whatever was the current cancer agenda and were far from being ‘silenced’, by the medical establishment, on issues of what other women ought to be doing about keeping their bodies healthy. The interesting aspect of these various historical attempts by women to take ‘control’, however, is the manner in which that controlling intention has manifested in different ways at different times. Perhaps reflecting the early to mid-twentieth century’s confidence in medicine, women in that period encouraged others to comply with doctors’ advice to look for ‘early signs’ and ‘warnings’. Such an approach was seen as a responsible one for women who, as has been noted previously, were usually in charge of households and thus should not irresponsibly run the risk of being sick or incapacitated.

While, as Gardner notes, “public cancer awareness programs relied on gendered notions of cooperative women who deferred to medical authority...often legitimising medical messages that insisted on early detection” (Gardner 2006: 5), in practice ‘early detection’ of cervical cancer, as opposed to the more obvious ‘lumps’ of breast cancer, was impossible until the ‘Pap’ smear became widely available in the

1950s. It was then promoted as the rational way for sensible women to ‘control’ the spread of a potentially deadly disease; a vast improvement on the previous mutilating and debilitating surgery necessary for advanced cervical cancer (Moscucci 1990: 100). Again, Gardner comments that, “Until recent decades, women publicised these conventional medical ideas without challenging them” (Gardner 2006: 6). By actively publicizing those ideas to other women, these female activists were of course subverting ‘docile’ gender images of women, even if their message entailed ultimate compliance with cervical cancer screening.

From the 1960s and 70s, however, feminism has provided a particularly vocal source of criticism of medical surveillance, drawing attention to the disparity between the needs and concerns of women and the attitudes and approach of the medical profession (see, for example, Ann Oakley’s *Essays on Women, Medicine and Health* 1993). As consumers of medical services, many women were dissatisfied with what they began to see as a patriarchal, paternalistic and sexist profession (*despite* women themselves now being part of it). The women’s health movement originated in America in the late 1960s and soon grew to become an international movement, with women asserting their right to exercise control over their own bodies. They also voiced their frustration over the encroaching medicalization, along with surveillance, of normal events in women’s lives, including childbirth and menopause, and the attitudes of male doctors towards such issues as abortion and birth control (Dally 1991: 227).

With the emerging and articulating of these attitudes by female activists, the notion of ‘control’, when applied to cervical cancer screening, took on a whole new meaning. Self-help (possible with breast cancer) was not viable here, as early ‘abnormalities’ in the cervix could only be detected by professional smear taking and then by examination in a laboratory by a trained technician (ironically, usually female). Nevertheless media campaigns showed women claiming that they indeed felt ‘in control’ by the very act of ‘going to be tested’, for they had thus achieved ‘peace of mind’. However, the feminist rhetoric began to suggest to some women that a ‘sleight of hand’ was at work here in which the supposed ‘controllers’ (the women ‘in control’) were themselves being controlled by creeping medicalization, turning everyone into a potential patient who was ‘well’ only until the next test had confirmed this: in such a situation the ‘safety’ and ‘peace of mind’ was a chimera; or at best, only transitory (Lupton 1995: 93). Women were, to all intents and purposes, anxiously living on the ‘edge’ of a watched cervix.

Although the attitudes of women were changing from an expected compliance to something much more complicated, the approach and rhetoric of the campaigns to encourage women to be tested continued to assume that non-compliance must be due to ignorance, prudery or fear (‘I’m too busy’, ‘I feel fine’, ‘It will hurt’, ‘It’s not nice’) and that therefore information and education was all it would take to correct these attitudes. However as Deborah Lupton has pointed out this assumption was based on a simplistic understanding of human behaviour and did not take into account the increasing sophistication of women’s understanding of the screening process (Lupton 1995: 111). Furthermore, as Gardner has noted, “Women objected to the insinuations of blame associated with the dominant message of early detection” and some then went on to “challenge its orthodoxy” (Gardner 2006: 6). Given that self-perceived ‘signs and symptoms’ were not adequate to control cervical cancer, the claim to be in control by women who complied with regular screening could be challenged by yet other women who had begun to see non-compliance as the only way of regaining control.

For the purposes of this paper, the historical developments described in this section provide evidence of the variability of gender constructions for and by women. Without taking sides in the politics of compliance or non-compliance, one can see the ambiguous mutual dependences of gender constructs and surveillance practices manifest in significant ways through cervical cancer screening. Clearly, women who are forging gender identities at variance with ‘docility’, and based on different ways of construing ‘taking control’, are trading on ambiguities in the notion of control, and a multiplicity in the ends of control. In that sense, the message of this section is complex in regard to gender constructions, but straightforward in regard to the use of cervical cancer screening to illumine the study of surveillance: surveillance is superposed on gendered social contexts, and even helps trigger new gender constructions.

Conclusion

The watched cervix is a clear case in which women do not act as a monolithic gender. This paper has highlighted a divide between ‘docile’ women, and women who ‘take control’, in order to reveal the ambiguous mutual dependences of gender constructs and surveillance practices. Cervical cancer screening is a significant intervention in women’s lives, and makes them aware of surveillance in a paradoxically ‘intimate’ yet invasive way. The fear engendered by such surveillance puts women ‘on edge’. ‘Docile’ women, and some women who claim to be ‘in control’, both comply with surveillance even if their attitudes to surveillance differ. To avoid compliance, women would have to be either indifferent to the possibility of cervical cancer, or become conscientious objectors. The World Health Organization’s manual, *Comprehensive Cervical Cancer Control: A guide to essential practice*, encourages self-determination in women, but it does not consider that self-determination could express itself as a refusal to submit to surveillance. Indeed, there is no scope for anything other than rational compliance in its conception of self-determination with respect to health. A woman who is a ‘conscientious objector’ seems irrational. But why should health surveillance be predicated in that way? The entire edifice of health surveillance is set up to ensure compliance, so this means that women who object have to go to great lengths to justify non-compliance and then have to live with the results if they do acquire cervical cancer. It would take a brave woman to present for treatment and have to admit that she had never submitted to screening programmes. In this sense, surveillance does contribute to the production of screened populations burdened with gender constructs and imperatives. Nonetheless, the responses to surveillance are also shaped by gender constructs, and contribute to new gender constructs. The mutual dependences are inescapable; and those who study surveillance must learn to deal with the ensuing ambiguities.

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