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The broken triangle: women's gender based oppression, community development and the promotion of women's health and wellbeing in Ireland.

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Abstract

The starting point for this study were the challenges I experienced in my efforts to develop a feminist approach to the promotion of women's health in Ireland. This approach, informed by a social determinants model of health identifies gender as a determinant of women's health and wellbeing and as a socially constructed social injustice. I argue that, as a social justice issue, gender as a determinant of women's health and wellbeing should be addressed by those avowing a social justice agenda. The research questions are explored with community development practitioners in the Republic of Ireland.

My position is based on personal experience of living as a woman in Ireland and working for almost a decade as a women's health officer in the Irish health services, principally in health promotion. The 'Broken triangle' of the title of this study refers to the damaging disconnect which I argue exists between the three constituent elements, women's gender based oppression, community development and the promotion of women's health and wellbeing. In theory the elements should fit neatly together as a joint framework for professional action. In reality there are a number of obstacles preventing the connection of the different elements which is necessary for the operationalising of the framework. One of the obstacles is the inclination of both health promotion and community development, despite the rhetoric, to maintain professional separateness. Building healthy communities is recognised universally as a goal of community development and efforts to achieve this goal are informed by such principles as social justice, empowerment and respect. Theory relating to the promotion of health extends the understanding of health to include wellbeing and mental and emotional health and recognises the impact and importance of social and cultural factors as determinants of health. I explore some of the reasons for this lack of connection between community development and health promotion.

The principal barrier to fixing the triangle identified in my argument is the absence of a feminist analysis in community development and in health promotion. Feminism in professional practice, particularly in community development, is not an issue that has received much attention. Nearly forty years after Wilson's call to 'inject some feminism into community development'

(Wilson, 1997) Emejulu and Bronstein (2011) conclude that feminist community development is still in a precarious position' (Emejulu and Bronstein, 2011, p.283). Using a feminist postcolonial analysis I explore the particular challenges presented by the patriarchal culture in Ireland, including a level of accommodation and denial by practitioners themselves.

Acknowledgements

A sincere thank you to everyone who played a part in making this work possible.

All in all, completing the study has been quite a journey, one that I came very close to ending at regular intervals. Somehow I hung in there. There are many influences that drove me on, reasons why I did not give up. Some of the reasons I can only guess at. One reason I am certain of, however, is the need to get things off my chest, to give voice to thoughts and feelings that remained repressed and largely kept hidden for so long when I worked and lived in Ireland. I no longer live there but keep tuned in to matters of importance and of interest to me. There has been one outstanding event in the two years since I left. With women in Ireland and elsewhere, I shed a tears of joy, relief and sadness all combined, on the 26th of May 2018 when the result of the referendum to repeal the 8th Amendment of the country's Constitution was announced. It was an incredible achievement, one that I would not have thought possible only two years earlier. When I left Ireland, after living and working there for nearly two decades, I remained baffled at the level of women's accommodation with and denial of the oppressive patriarchal culture that I found so disempowering.

My admiration for those who managed to repeal the 8th is massive. When women spoke out about the suffering that was the reality that lay behind the few sentences in the Irish Constitution that was the 8th Amendment justice prevailed. The fact that such an injustice managed to remain impervious to challenge for 35 years is an indication of the power of the particular patriarchal culture which supports a gender regime which oppresses women in Ireland on a daily basis. My hope is that the consciousness raising that enabled the success of the Repeal the 8th movement will now recognise women's oppression as a general injustice that needs addressing, especially with women in marginalised communities. Having worked with ordinary women in Ireland in all kinds of settings I am very conscious of the invisibility of gender and the negative impact it has on women and in women's lives. The invisibility of this social injustice and its impact is helped by the high level of accommodation and denial among women, something which I experienced as a particular characteristic of Irish culture. I hope this

study is a source of some support to the further development of a feminist consciousness and identity in a post-repeal the 8th Ireland.

My first acknowledgements and heartfelt thanks for the existence of this study have to be to the 'ordinary' women in Ireland, mostly in marginalised communities, that I had the good fortune to work during the two decades of my life when I lived and worked there. I was a relatively successful professional woman when, in my mid-40s, a fork in the road of my life journey meant a return to live in Ireland, a career reconfiguration and the opportunity to meet and work with the women who took part in the projects I led. I feel genuinely privileged to have met and worked with them. I learned so much from them and their hidden and taken-for-granted efforts on behalf of others. This and their constrained potential have driven me on through all the doubts to complete this study.

Of course the study could not have been completed without the research participants, the community development practitioners who took part in the research. Without them, their commitment and their effort this study simply would not exist. So, thank you all. A special thanks also goes to colleagues in health promotion in Ireland who wanted to take part but were prevented by work demands and a gender blind culture. My particular thanks to Denise, a valued colleague and friend, who so often put her head above the parapet when others ran for cover.

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Last, but certainly not least, I thank Brian. Where do I start in describing his unceasing caring and support? Thank you for the cooking, shopping, cleaning, getting cars to the garage and general life management. On top of this thank you for the not insignificant task of getting our new home built and renovated. I almost forgot the proof reading. That took some patience. Mainly thank you for believing in me. Life after EdD promises so much. Here's to the future.

Chapter 1: Introductory Chapter

1.1 Rationale and Research questions

In this dissertation I consider the health and wellbeing of women in Ireland, and how both are shaped and limited by Irish cultural identities. I explore the ways in which female community development practitioners experience and understand the concepts of health and wellbeing; whether and how they see gendered experience impacting on health and wellbeing; and whether and how they see a role for practice in helping to counter the negative impact of women's gender-based oppression.

I argue that the development of a feminist identity is necessary to problematise the issue of women's gender based inequality and the impact it has on women's health and wellbeing. The vision that drives this study is a triangle with fragmented sides. At one point of the triangle is gender as a socially constructed inequality that oppresses women and has a negative impact on their health and wellbeing. A second point is health promotion where health is understood within a social determinants model which recognises the influence of social conditions on health and extends the understanding of health to include wellbeing. The final point of the triangle is community development which describes the approach necessary to complete the chain. The feminist perspective, with its starting point of gender as a social injustice, is the analytical approach that forms the missing link and is necessary to complete the framework. The fragmentation between the different points is the issue to be addressed. In other words the missing link needs to be identified and incorporated into the structure by joining the three different points that are currently unconnected.

In this introductory chapter I will set out the rationale for the study and the research questions. I will then move on to set out some introductory context of themes that are important in the study - the context of feminism in Ireland; the link between post-independence nationalism and patriarchy in the Irish context; how this relationship is reflected in the Irish Constitution. The chapter closes with an outline of how the dissertation is structured and what is covered in each chapter.

The research emerged from my feminist analysis of my experiences as a woman living in the Republic of Ireland for almost two decades and working as a women's health officer in the Irish health services for the latter half of that time. The period referred to, from the late 1990s until 2016, coincides with a period of unprecedented economic growth in Ireland commonly referred to as the 'Celtic Tiger' era and the equally sharp economic decline and austerity that followed. 'It has been recognised that attempts to understand the position of women in a particular society need to be located within an understanding of that society' (O'Connor, 1998, p.6). Living in Ireland I very quickly became conscious of a level of structural gendered inequality of power in Irish social, economic and political life that I was unused to and that I use the term patriarchy to describe. The concept of patriarchy and its relevance to this study is discussed in Chapter 2. Legislation, influenced particularly by Ireland's entry into the European Community in 1973, had supported a number of positive changes in the position of women. In 1973, for example, there was the removal of the marriage bar which prohibited women from working in the public services after marriage. The Anti-Discrimination Pay Act 1974 allowed for equal pay for equal work, and the Maternity Protection Act 1994, gave women entitlement to maternity leave.

However, opinion was divided on the level of real change, and the question tended to 'elicit two views: that it has changed completely, and that it has not changed at all' (O'Connor, 1998, p.1) as there was equal evidence that, for example, women remained excluded from positions of power and influence. My experience positioned me primarily in the latter category. In 2015 the continued subordinate position of women was confirmed in an EU report which concluded that 'Inequality continues to be a persistent feature of women's position in Irish society', that 'women are hugely under-represented in the Irish political and decision making systems' and that the 'policy framework for gender equality is weak' (EU, 2015, p.33).

A major interest and concern of mine throughout my time living and working in Ireland was the disparity between my conception of and feelings about women's position in Ireland and the apparent accommodation of professional colleagues in health promotion and community development with the influence of the

patriarchal culture on women. A desire to understand this disparity and to build a body of knowledge to support improved practice in addressing women's gender based oppression influenced this study.

A key idea in this study is the conceptualisation of women's health as a matter of *social justice*, and the potential of this conceptualisation to provide a framework for the development of a strategy that merges the promotion of women's health and wellbeing with the generally neglected injustice of women's gender based oppression. Women's health, gender as a determinant of women's health and women's health as a matter of social justice are discussed in Chapter 2. My point of entry into understanding women's health is to see it as a positive concept, 'a resource for everyday life' (www.who.int), and with an emphasis on social, emotional and psychological health. It is situated within a social determinants model of health (<https://esrc.ukri.org/about-us/50-years-of-esrc/50-achievements/the-dahlgren-whitehead-rainbow/>) and, reflecting my feminist perspective, one that recognises gender as an overarching determinant of women's health and wellbeing. This point of entry provides the launch pad for exploring the relationship between gender, women's health and wellbeing and women's health as a matter of social justice, all key concepts in my quest for a specific strategic framework to tackle women's gender based oppression and promote women's health. Such a framework is required, this study argues, because, despite espousing principles of social justice and related values, the relationship between promise and practice has always seemed to be fragmented, particularly with regard to women's gender based oppression, and the impact of that oppression on women's health and wellbeing, in both health promotion and community development in Ireland. The potential for harm lies, as I shall argue, in the tendency for both health promotion and community development to maintain the gender based 'status quo' through gender-blind programmes that are presented as women friendly but actually work to reinforce women's traditional role as guardians of family health. Such programmes generally fail to question the impact of this responsibility and the discourse surrounding it on women themselves and their health and wellbeing. The individualist, 'victim-blaming' discourse infused in the popular lifestyle approach to health promotion,

for example, increases the pressure on women themselves and as gatekeepers of family health.

1.1.1 Research Questions

In order to address the research issue I have outlined I developed the following research questions:

1. What are the perceptions of community development practitioners in relation to:
 - i. gender
 - ii. health and wellbeing and
 - iii. the relationship between the two?
2. How do community development practitioners' understandings of these concepts relate to their own past and present practice and experience?
3. In what ways, if at all, are these perceptions, experiences and practice related to their wider social context, in particular to the wider social, historical and political context of Ireland as a postcolonial nation?
4. What are the implications for future strategy, policy and practice in this area, from a critical feminist perspective?

1.2 My experience of women's health in Health Promotion

The research questions are directly informed by my own experience as a women's health officer in health promotion in Ireland for over a decade and my experience of living as a woman in Ireland for just over twice that length of time, from the late 1990s until the first decade of this century. Both experiences combined to inform my view about what I recognised as the institutionalised nature of patriarchy in Ireland and the nature of its influence on attitudes and practice. Daly's description of patriarchy as being 'characterized by oppression,

repression and depression’ (Moane, 2011, p.vii) certainly made sense to me and my experience.

In the late 1990s, as a newly-arrived immigrant from England I lacked the necessary social networks to explore my thoughts about my observations, a situation not helped by the denial and ‘unease’ (O’Connor, 1998, p.7) I saw in other women when I attempted to share my experiences and concerns. ‘It (patriarchy) is seen as socially provocative’ and, where there was acknowledgement opinion was that it was something that ‘may have existed in the past, but this is no longer the case’ (O’Connor, 1998, p.7). As I reflected on my experiences and tried to learn how to manage the situation, I was slightly mystified at how other women in Ireland seemed to have a capacity to live with or accommodate what is now commonly referred to as ‘everyday sexism’ (Bates, 2014, p.4), something I regarded as demeaning and discriminatory. By the time I became a women’s health officer I had been involved in training and development programmes with practitioners from a range of disciplines from both the health sector and community based organisations. I had also had very rewarding and informative experiences of working with women in socially and economically disadvantaged areas. As a result, women’s gender based oppression and the issue of internalised oppression were, to me, evident priorities in the promotion of women’s health. Another concern for me was that the discourse and practice in both statutory and non-statutory institutions actually reinforced women’s gender based inequality. The generally gender-blind discourses and practice in both disciplines often served to reinforce women’s traditional roles as mothers, home-makers and carers while ignoring the potential impact of these responsibilities and related expectations on women themselves (Daykin and Naidoo, 1995).

1.2.1 The national plan for women’s health

I was one of the first women’s health officers in Ireland when I took up post. Other appointments followed relatively quickly in most although not all of the Health Board areas in the country. The appointments were the result of a discrete initiative in women’s health, an initiative which was strongly influenced by the Beijing Platform for Action (BPfA), an outcome of the Fourth World

Conference on Women in Beijing in 1995. One of Ireland's commitments as a signatory to the BPfA was the production of a women's health plan and, subsequent to the publication of 'A Plan for Women's Health 1997-1999' (henceforth referred to as the Plan), most Health board areas appointed women's health officers to organise and oversee plan related to women's health activities. In Ireland, as in other countries, there had been years of women's activism in relation to various women's health related issues (Broom, 2009) so it was understandable that the publication of the Plan was regarded as a promising development. In practice, from a gender-aware, social determinant perspective, there were significant flaws with it.

There is no definition of health in the Plan but there is acknowledgement in the closing pages that 'throughout the consultation process, women sought a more holistic model of health', one that took 'more account of the context of the lives of women' (DoH, 1997, p.82). Despite this acknowledgement the contents reflect a strongly medical model of health, a model in which 'the interests of women have been particularly damaged' (Doyal, 1995, p.16). In the circumstances, O'Donovan's conclusion that '*A Plan for Women's Health* endorses the established wisdoms of medicine and these wisdoms do not necessarily reflect the interests of women' is not surprising (O'Donovan, p.159). Actions outlined in the Plan are the responsibility of the Health Boards and relate to various medical health services. However, the prospect for actions outlined in the Plan was bleak, as the Women's Health Council (WHC) noted:

The Plan was developed with little or no input from medical service personnel; key stakeholders questioned the need for an initiative focused on women's health and there was no mechanism or process to connect the Plan with the health services (Women's Health Council, 2002, p.37).

Despite the shortcomings of the Plan, I remained hopeful of being able to make good use of the opportunity provided by the fact that women's health was now an accepted area for action. My post as a women's health officer was positioned within a health promotion department, so my hopes of meeting women's desire for a more holistic approach to women's health, one that recognised the importance of women's lives and experiences, were high. This positive outlook

was based on a developing philosophy interweaving a number of complementary theories and models. The approach conflated the social model of health with gender as an overarching determinant, the values of health promotion and a critical social constructionist feminist perspective which challenged the belief that purportedly natural sex differences are socially constructed. It was an approach that I believed would result in a supportive alliance, benefitting both women's health and health promotion. My experience as a women's health officer, despite the disruption caused by frequent organisational and management changes, provided me with many wonderful opportunities for reflection and learning and for the development of theory informed practice in the promotion of women's health and wellbeing. That learning provides the foundation for this research study.

1.2.2 The move to community development

I remained in my post as a women's health officer for about ten years. Throughout that time there was a continuous process of reorganising and restructuring within health promotion and the health services generally. The organisational restructuring was based on New Public Management (NPM) and reflected the influence of a neoliberalist ideology in Ireland (Ayo, 2012; Fraser et al, 2013; Mooney, 2012) It meant that health promotion and health promotion practitioners in Ireland were reconfigured as providers of 'off-the-peg' 'lifestyle' programmes informed by a medical model of health. Women's health and gender as a determinant of health were removed as an identified area of interest and I was offered reassignment to generic, clearly defined and gender-blind lifestyle related programmes.

At the design stage of this research study my intention was to explore attitudes to gender and women's gender based oppression with health promotion practitioners in an effort to understand what I felt to be widespread resistance to my particular feminist perspective within the profession in Ireland. When I put the research proposal to senior health promotion management permission for the research was denied on the basis that it would not benefit the work of the organisation. Without management permission health promotion practitioners were unable to take part in the research. So despite the supportive

efforts of colleagues, practitioners who were also interested in the issue, and keen to participate in the study, I had to abandon my original plan. The ensuing reflections and my continued learning led to a revision of my original focus for the study. In the study I have persisted with a critique of the potential of health services based health promotion for the development of a feminist vision for the promotion of women's health. I have now though expanded the study to explore the potential of a different but complementary discipline, community development, as a more suitable setting for the development of the envisioned strategic feminist approach. The research questions remain unchanged. The focus of the interviews is on participants' attitudes, beliefs and experiences in relation to gender, how these influence their practice, as well as their understanding of gender as a determinant of women's health. The willingness of community development managers and practitioners to participate in the research is some evidence of community development support for consideration of gender as a determinant of women's health and wellbeing. It also points to community development as a more appropriate setting for the development of my vision for the promotion of women's health and wellbeing as part of an agenda to address the social injustice of women's gender based inequality.

1.3 Feminism in Ireland

One constant in the ever changing cultural, social and political landscape in Ireland and the foundation for 'its own unique 'gender-scape' (Ging *et al*, 2009, p.52) is patriarchy. However, some analysts observe a growing denial of patriarchy in contemporary Irish culture and a growth in anti-feminist opinion. In her analysis, based on a review of a comprehensive range of media in Ireland including newspapers, television, social media, books and advertising, Ging (2009) describes the development of a post-feminist culture, a culture that is anti-feminist and is in denial of patriarchy, a culture in which there is 'a growing prevalence of essentialist or bio-determinist accounts of gender difference' (Ging *et al*, 2009, p.59). In this contemporary post-feminist Ireland opinions expressed in the media regarding gender equality and feminism are 'that the feminist movement is either held in contempt or is considered to have been so successful as to have rendered itself obsolete' (Ging *et al*, 2009, p.69). Over the years feminism in Ireland has had a lot of success with, for example, legislation

for divorce, women's employment, contraception and same-sex marriage, but feminism continues to face new challenges. Membership of the EU has been a significant contributory factor in the modernisation of Ireland and in providing 'greater legitimacy' (Cullen, 2015) to feminist challenges to national policy. Irish feminism's use of the UN, CEDAW and the Beijing Platform for Action to pressure the Irish Government in relation to gender based issues of inequality has also met with some, but still limited, success because, 'although a gender equality perspective is sometimes applied in the policy-making process fundamental areas of economic and social policy are *gender blind*' (Barry, 2008, p.29).

Some of the foundations for the challenges feminism in Ireland continue to face were laid during the very founding of the Irish Free State, what is now the Republic of Ireland. Ireland is typical of other postcolonial states in its use of history and the celebration of significant historical events in its invention of tradition to mark its uniqueness and define it as an independent state.

'Invention of Tradition' was the term conceived by Hobsbawm (1992) to describe the establishment of practices, rules or rituals which suggest continuity of a rich historic past. 2016 was the centenary celebration of the 1916 Rising, the Irish revolt that paved the way for the setting up of the Irish Republic some years later. Women in Ireland used the centenary celebrations to highlight women's invisibility in Irish history. Although women had been active members in the 1916 Rising they were invisible in historical accounts of the event. When it became obvious that the centenary celebrations were going to continue that patriarchal tradition, women in Ireland, particularly feminist historians, organised events to celebrate women's involvement and their commitment to activism prior to the denial of their rights in the Irish Constitution of 1937, a constitution that set the stage for 'the real experience of women to be specifically excluded from Irish national identity' (Meaney, 1991, p.7). The situation is summed up in the poem 'The Women of 1916'. The Irish Constitution and Article 41, which is referenced in the title of the poem, are reviewed in Section 1.4: Nationalism, patriarchy and the Irish Constitution.

'the state recognises that by her life within the home'

article 41.2.1. The Irish Constitution

Years before the offending article

was even conjured up by De Valera
and the very Reverend John Charles McQuaid
with the help of a pack of Jesuits -
the plan was set in train
to banish these biddies
back to their kitchen sinks.

The banishing tool of choice
was the airbrush. (Higgins, 2015, Poethead)

The postcolonial analysis in this research study identifies the combined influences and power of nationalism, church and state as producers of the gender regime in Ireland and the particular challenges it presents for feminism. The relationship of nationalism and patriarchy is addressed more fully in Section 6. In the following paragraphs I focus on the influence of Catholicism on the position of women and feminism.

Unlike the influence of the relationship between nationalism and patriarchy on the gender regime in Ireland the influence of Catholicism is generally acknowledged. There is for example the acknowledged influence in Article 41 of the Irish Constitution: 'The Church's influence is reflected in Article 41 which defined the family as based in marriage and women's role within the family as confined to their domestic duties as wives and mothers' (Burley and Regan, 2002, p.205). The power of the Catholic Church has undoubtedly diminished in Ireland but there is much to suggest that it maintains a significant influence. The Catholic monopoly of the state funded education system has been criticised for being unconstitutional and undemocratic, a fact that has been acknowledged by a senior representative of the Church itself: 'The monopoly of the Catholic Church in the Irish education system is "anything but healthy" Archbishop of Dublin Diarmuid Martin has said' (Gleeson, 2018).

Despite the significant social and cultural changes of recent years this monopoly remains intact and the vast majority of children continue to be educated in Catholic schools (O'Kelly, 2017). As evidence of Catholicism such as a baptismal certificate is increasingly required for enrolment, especially in oversubscribed schools, it is little wonder that in the 2016 Census almost 80% of the population identify as Catholic. This religious influence Meaney (1991) believes, 'inhibits women's will for change and recruits women damaged by patriarchal ideology to the cause of patriarchy itself and sets them campaigning and voting against their own interests' (Meaney, 1991, p.5). Some women choose to collude with the oppressive gender regime because of the status and power it gives them, however limited and defined it is by others. 'Such women seek to perpetuate the idealised virgin/mother figure of woman so that they can be that figure. Such identification offers women one of the few roles of power available to them in patriarchy' (Meaney, 1991, p.4).

In the circumstances it is not surprising that feminism and feminist activity in Ireland has waxed and waned throughout the decades. By and large activism has focused on single issues that are clear inequalities or injustices such as the right to work, contraception and divorce. Often campaigns are triggered by a tragic event involving the death or inhumane treatment of a woman. One such tragic event occurred in 2012 when Savita Halappanavar died from a septic miscarriage when her request for an abortion was refused on the grounds that it would be illegal under Irish law. As well as sparking protests throughout Ireland this event led to a significant increase in activism in relation to abortion, activism which was successful in getting the Eighth Amendment of the Irish Constitution repealed and for the passing of the Protection of Life During Pregnancy Act which allowed for abortion in Ireland. Campaigns are often relatively short lived and are generally well supported by women, women who do not necessarily identify as feminist. However, the zealot-like determination of those who want to maintain the status quo make these battles for basic justice, when the 'social, economic and psychological costs of resistance are considerable' (O'Connor, 1999, p.4), exhausting and requiring courage and commitment. For example two referendums were required to liberalise the laws on divorce. The first in 1986 was convincingly defeated. By the time of the

second referendum in 1995, although Ireland was the only remaining country in Europe where divorce was still illegal, the result was very close with 50.28% in favour and 49.72% against.

In a patriarchal culture fear is a potential influence on women's decision to challenge gender based oppression. Freire (1996) identifies fear of 'still greater oppression' and a fear of 'running the risks it requires' (Freire, 1996, p.29) as a characteristic of oppressed people and an obstacle to getting involved in activism. Questioning Ireland's determination 'to deny women full rights over their reproductive health' Jones (2013) identifies a culture of 'fear' based on a distrust of women that underscores 'deep rooted misogynistic and sexist attitudes prevalent at every level of Irish society' (Jones, 2013). Echoing the culture of fear identified by Jones, Armstrong et al (2007) explain that the narrow margin of difference in the divorce referendum was due to 'highly organised and effective fear campaigns' (Armstrong et al, 2007, p.44). These campaigns focused on the need to 'defend the moral superiority of Irish nationalism' (Armstrong et al, 2007, p.38) and claimed that divorce would 'tear apart the fabric of Irish society' (Burley and Regan, 2002, p.203). As divorce in Ireland is expensive and remains restrictive by international standards Ireland has the lowest divorce rate in Europe. Although the divorce campaign was typically bitter and divisive at least it was successful.

Smyth (2006) has voiced concern in relation to feminist activism due to the absence of a 'radical analysis of power relations' in Irish feminism and because feminist discourse in Ireland 'has become markedly more accommodating and euphemistic' and that 'the language of feminism is being replaced by 'gender speak'' (Smyth, 2006, p.9). Smyth's analysis of the direction of feminist politics provides some explanation for Ging's (2009) sense of surprise at 'the expediency with which a complacent and often regressive discourse has assumed centre stage' (Ging, 2009, p.69) in recent years in Ireland.

As a practitioner who struggled to work within a feminist framework I found that the 'armchair theorizing' (Meyerson and Kolb, 2000, p.553) of academic feminism provided little theory or guidance about how to use the academic knowledge in practice. My experience has persuaded me that since the heyday of second wave feminism a clear rift has opened up between academic feminism

and practice, in this context community development practice, and a goal of this study is to help narrow that gap. My personal experience leads me to me to concur with hooks' (2000) belief in the importance of the 'lost currency' of consciousness raising as a cornerstone of developing feminist practice and as a tool 'for the transmission of feminist thinking' (hooks, 2000, p.10). Practitioner proficiency in the rhetoric of gender discrimination is not enough. Practitioners need 'to first confront their internalized sexism as part of becoming feminist' (hooks, 2000, p.10) before they can apply a feminist lens to their analyses of their own and other women's experiences and increase their capacity to become genuine advocates for women. In the absence of a feminist lens, the ways patriarchy oppresses women and the impact it has on their lives remain invisible. So building capacity to challenge patriarchy is an essential cornerstone in any genuine plan to address women's oppression and to promote their health and wellbeing.

1.4 Nationalism, patriarchy and the Irish Constitution

DeValera who was the head of Government in Ireland between 1932 and 1948 is generally credited with almost single handedly redrafting the original 1922 Irish Constitution to produce the 1935 Constitution, the document that still sets out the basic law and values of the state of Ireland and is central to a postcolonial analysis of Ireland. Over its eighty year history the Constitution has been amended but it is still regarded as a document that 'says much about how Irish society sees itself and where its values lie' (Brady, 2012, p.7). This sense of Irish exceptionalism is characteristic of a postcolonial state which 'typically perceives itself as an island of authenticity surrounded by an alien world' (White, 2010, p.7), a perception that strengthens a state's authority to pursue a strong nationalist agenda. The constitution is also infused with Catholic social teaching and morality and in which the Catholic Church was given a special place. With its special recognition in the Constitution a clear connection and a formal merging of religion and Irish national identity was established and Catholicism and being Catholic 'had become a defining element of what many believed it meant to be Irish' (White, 2010, p.10).

The level of power and control exerted by the successful integration of the triumvirate of nationalism, Church and state in post-independence and postcolonial Ireland arguably produced a particular type of authoritarianism that resulted in a high level of compliance and deference to authority and an ‘unquestioning acceptance of their directions’ (White, 2010, p.7). In such a culture any breaches of what is understood as part of the collective identity may be regarded as bringing dishonour and shame on the whole community and any criticism or questioning of the dominant ideology may be regarded as criticism of the whole community. Loyalty to country and culture then signifies community membership while any criticism identifies one as an outsider. Within this culture women have become ‘accustomed to making choices and creating meaning and identity within structures which are, to a greater or lesser extent, not of their own choosing’ (O’Connor, 1999, p.13).

Nationalism, a key influence in Irish identity, has been identified as ‘The ideology which members of the community, those who are of the *same kind*, share—through which they identify with the nation and express their national loyalty’ (Mayer, 2000, p.1). Because of the significant social and economic developments Ireland has experienced in recent decades it might be reasonable to presume that nationalism belongs to the past and, as an ideology, may be in decline. However, the continuing fascination with the search for the definitive, unique Irish identity suggests this presumption is misguided. In fact Malesevic (2014) is of the opinion that ‘nationalist ideology and practice has actually intensified over the last several decades and is much more powerful and socially embedded than that present in DeValera’s era’ (Malesevic, 2014, p.11).

A postcolonial analysis identifies nationalism as the third powerful influence, along with church and state, in relation to the position of feminism in the Irish context. Alert to the fact that a postcolonial analysis is a contentious one, Moane (2014) argues that Ireland’s history of colonisation is one with ‘distinctive features’ and she provides ten examples of ‘where legacies of colonisation continue to be manifest in Ireland’ (Moane, 2014, p.122) in defence of her viewpoint.

Expressing concern about the essentialist nature of the question of Irish difference, Connolly (2014) identifies the ‘notion of Irish exceptionalism’ as ‘one

of the pervasive concerns in contemporary Irish studies’ and ‘in a range of other fields’ (Connolly, 2014, p.230). Interest in the question of Irish exceptionalism is not confined to academic texts. One observer commented that ‘few countries spend so much time and intellectual effort on self-definition as does Ireland’ (Garvin in Connolly, 2003, p.173) and in his search for the ‘key to the Irish psyche’ Moncrieff, a London born Irish broadcaster and journalist, believes that the ongoing Irish interest in Irish identity is because ‘we find ourselves fascinating’ (Moncrieff, 2015, p.1).

Although there is ‘a vast and complex literature that explores the theoretical issues’ (Kohn, 2013) relating to colonialism, postcolonialism and nationalism the literature is generally gender-blind. This blindness is particularly noteworthy given ‘the pivotal role of gender in nationalist ideology (Cusack, 2000, p.557) and when, ‘despite nationalism’s ideological investment in the idea of popular unity based on formal equality, nations have historically amounted to the sanctioned institutionalisation of gender difference’ (Gilmartin, 2017, p.271). Relative to the recognised body of literature in relation to nationalism and postcolonialism feminist analyses are scarce. However, ‘feminism has raised awareness of the processes taking place’ and of the fact that ‘gender relations are at the heart of cultural constructions of social identities’ (Yuval-Davis, 1997, p.39). In agreement with De Wan (1997), this study believes that ‘no analysis in the Irish state can be accomplished without seeing the integral role that gendered nationalism has played in Irish culture’ (De Wan, 1997)

Typical of postcolonial nationalisms elsewhere Irish nationalism post-independence has been male led and masculine. Referencing Nandy, Meaney (1991) explains that ‘the subject people, in rebelling and claiming independence and sovereignty, aspire to a traditionally masculine role of power’ (Meaney, 1991, p.7). So, having been dominated and exploited by a foreign power, there is a post-independence need for male authority to be restored. Invoking the innateness of the masculine and feminine, clear roles for women and men are identified. In Ireland, as in other postcolonial nationalisms, women are accorded special symbolic status in references such as Mother Ireland and in the use of mythical female characters such as Cathleen Ni Houlihan and Roisin Dubh in representations of the nation. In these symbolic narratives the nation is

represented as a beautiful, passive and vulnerable young woman who needs protecting by the sons of Ireland, sons who have been instilled with love and respect for and a sense of duty to the Irish nation by the women who are the mothers of the nation. As the social and biological womb of the nation women need to be pure and modest and ‘exemplars of virtue’ (Cusack, 2000, p.546) as ‘only pure and modest women can produce the pure nation’ (Mayer, p.7). The gender differentiation, so necessary to the reproduction and honour of the nation, was institutionalised in the 1937 Constitution in a range of Articles which reify marriage and family, identifying women only in their role as mothers and anchoring women in the home with specific responsibility for the domestic or private arena. In these circumstances men, as the protectors of the nation were required to control women’s bodies and fertility (Bell, 2009; Ranchod-Nilsson and Tetreault, 2000).

The post-independence patriarchal culture of Ireland is a culture that presents significant challenges to feminism and women’s activism. In the chronicles of the development of the Irish nation, women and feminism are largely invisible but feminism in Ireland, despite the challenges it faces, has been a significant force for change over the decades.

1.4.1 The Irish Constitution

Constitutions perform a number of functions, one of which is ‘the making of broad, symbolic statements about the nature of the state and the society’ (Brady, 2012, p.7), a function that ‘is of substantial political significance’ (ibid). With its clearly defined gender roles and a strong patriarchal family ideology the Constitution laid the foundations for the development of the new free state of Ireland. Over the eighty years of the Irish Constitution there have been nearly thirty amendments to it. However, a number of Articles relating to women, Articles that have attracted repeated criticism and demands for change both from women in Ireland and from international bodies such as the U.N. Human Rights Committee and CEDAW, have remained intact and immune to change. Article 41.2 of the Irish Constitution ascribes the role of care-giving and homemaking in Ireland exclusively to women:

‘41.2.1° In particular, the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved.

41.2.2° The State shall, therefore, endeavour to ensure that mothers shall not be obliged by economic necessity to engage in labour to the neglect of their duties in the home’

(Bunreacht na hEireann, 1937, p.160)

This Article, which ‘is difficult to defend by any contemporary standards’ (NWCI, 2012, p.39), creates a separation of private and public spheres, allocating full responsibility for domestic and caring duties solely to women. No other individuals are singled out in the Constitution or have roles or responsibilities allocated to them. Those who support retention of Article 41.2.1 and 41.2.2 argue that it recognises and shows respect for the important work that is primarily done by women, work that is generally devalued and invisible. However, when the value of women’s work in the home has been tested as legally enforceable in relation to payment or socioeconomic rights of women in the home it has been unsuccessful. In a landmark divorce case a claim by a wife for equitable ownership of the family home on the basis of the contribution that she had made through her fulltime work in the home the court ruled that Article 41.2.1 does not give any ownership rights to the women. On the basis of this decision O’Connor concluded that ‘this judgement threw into sharp relief the hollowness of the rhetoric surrounding the social value attached to women’s position in the home’ (O’Connor, 2000, p.88).

Criticisms of Article 41.2 point to the biological essentialist ideology (as discussed in detail in Chapter 2, Section 1) which suggests that women are naturally predisposed to fulfilling the caring duties they have been assigned. This negative normative message presupposes that women, as Irish citizens, should be willing to fulfil an outdated traditional role. In this context women’s refusal to fulfil their role can be seen as a refusal to support the common good, an action that could result in the country’s downfall.

In her research with women Moane (2011) uncovered feelings about the reality of women’s experiences regarding their position in Irish society. In her

interviews Moane (2011) discovered that, despite the supposed status accorded to women as mothers and the work they do in support of home and family by the Constitution, 'what women experienced was a loss in status and respect on becoming mothers, a denigration and neglect of their skills as mothers, and a complete lack of acknowledgement of their contribution as carers' (Moane, 2011, p.131). In Moane's research this discrepancy between the public discourse regarding women's role and women's real experiences was identified 'repeatedly as a source of low self-worth and of anger for women' (Moane, 2011, p.130). These feelings and the impact of them are powerfully expressed by Smyth in her poem 'Flooze in the Jacuzzi':

Flooze, Skivvy, Whore is my name, marker and symbol of my identity.
Which brings me in passing to the
Question of Irish women's place
Within but without culture and
Identity
Transparent floating capacious signifier,
From what place can I speak?
Confined 'by the waters of Babalong'
In sink, sewer, bidet, Jacuzzi, in a
Flowing babel of other-determined
Myths, symbols, images, can I speak
Myself at all?
'Cuinas! Quiet!
I can't hear myself think' (Smythe, 1989. P.11).

Set against the background of the Irish State's stubborn resistance to change in relation to Article 41.2.1 and 41.2.2 is the success of the referendum to change Article 41.3 and extend the right to marriage to same sex couples. The subsequent amendment to the Constitution epitomises the inherent contradictions and confusions of the 'uneven modernisation' and the 'cultural jaggedness' (Dillon, 2015p.8) of Ireland.

In what is commonly known as the marriage equality referendum, Irish citizens were asked to vote on the addition of a clause to Article 41 granting people of

the same sex the right to get married. Compared to the 1.6 million who voted twenty years earlier on divorce, 1.9 million voted in the 2015 referendum. There was also significant difference in public support for each of the issues. The vote for divorce scraped through with a difference of only 0.56% between the yes and no vote. In the marriage equality referendum the percentage difference between the yes and no vote was carried by a majority in favour of 22.14%.

Following the result the country celebrated with the result being described as ‘a social revolution, an expression of decency and a country coming of age’. The group that led the ‘yes’ campaign described the result as ‘transformative’, declaring that Ireland was now ‘more truly a nation of equals’ and that it meant that ‘all of us - lesbian, gay, straight, family members, friends, colleagues, allies, voters - belong equally to the Irish national family’ (www.yesequality.ie). As the first country to legalise same sex marriage through a popular vote Ireland bathed in almost global admiration of its positive consciousness in relation to LGBT rights and the country’s capacity for justice and equality.

For those who support LGBT rights the success of the marriage equality referendum was indeed a reason to celebrate. However, from a feminist point of view, the image of Ireland as a beacon for human justice is somewhat overstated. It is an evaluation that highlights the invisibility of women’s gender based oppression. The ongoing resistance to women’s efforts to challenge patriarchy and gender based injustices contrasts sharply with the image of the country suggested by the result of the Marriage Equality referendum. In her introduction to a collection of essays outlining ‘new feminist perspectives on women in contemporary Ireland’ Susan McKay (2008) concurs with this assessment and concludes that ‘we have a long way yet to travel before women in Ireland become a ‘significant force’, and a longer way still before we achieve equality and justice’ (McKay, 2008, p.xxii).

But, how, seemingly against the odds, did the marriage referendum succeed when women, who make up a significantly larger proportion of the population, continue to struggle in their efforts to challenge gender based oppression in Ireland? The ‘yes’ campaign emphasised their trust in the Irish people and their desire for belonging. A core strategy of the campaign involved LGBT people, parents , grandparents and neighbours sharing their personal stories to explain

why they were voting 'yes'. The 'yes' campaign strategy combined a support for traditional values of Ireland, marriage, family and community, with an image of Ireland as a modern, liberal country taking a leading role on the international stage on issues of justice and equality.

1.5 The road ahead

Determination to retain a traditional, gender based role for women as carers and home-makers and control over women's reproduction confirms its centrality to Irishness and national identity. There is, however, an inevitable erosion of traditional, dominant ideologies over time and the hegemonic patriarchal religious nationalism in Ireland has been challenged and changed during the life of post-independent Ireland. The protagonists driving Ireland's particular variety of religious nationalism and the patriarchal culture that it supports remain powerfully positioned and dogged in their determination to maintain that position. These forces maintain significant control in the political, social, legal, academic, education and health institutions that are responsible for knowledge development, policy development and decision making.

Building the authentic collective identity which is a core constituent of post-independence nationalism requires allegiance to established systems and valued social institutions such as family and marriage and traditional gender regimes. Who or what can belong to the collective identity is defined by who or what counts as foreign. The understanding that Irishness is generally understood as not-English is so well established it is almost invisible in Irish discourse. How the authentic collective identity delegitimises and silences feminism is an issue that needs understanding and addressing.

Nationalist regimes are, by definition, exclusionary. In nationalist discourse, criticism of any aspect of the nation is a slight on every member of that community and members understand that it is their duty to defend their community from critics or outsiders. As feminism conflicts with the patriarchal ideology that is central to Irish culture and identity, efforts to establish a vocal, clearly recognised feminist movement or voice have been of limited success and activity has reflected a predominately liberal rather than a radical perspective. As women are feted as having particular responsibility for the reproduction of

the nation and culture and 'are accustomed to making choices and creating meaning an identity within structures which are, to a great or lesser extent, not of their own choosing' (O'Connor, 1999, p.13) they understandably will question the benefit of connecting with feminism, the outsider. The need is there however. The changes that have taken place in Ireland in recent years, changes that have been significantly influenced by outside factors, have, I believe, produced a false impression of equality. Fundamentally much remains the same for women. Towards the end of the first decade of the twenty first century McKay (2008) wonders about the position of women in Ireland and concludes that women are 'not where we want to be' and that 'feminism is not much spoken about these days' (McKay, 2008, p.xiv).

Excluded and silenced by the academy and other influential institutions, women in Ireland have traditionally found their voice in literature. Flynn (2015) uses comic irony to describe women's position in Ireland and underline the difference between what appears on the surface and the reality for Irish women. 'You'll never have to wonder how a good girl should act if you live in Ireland ... The basic requirements are silence, obedience (real or put on) and invisibility' (Flynn, 2015, p.109). The stubborn endurance of the particular patriarchal culture in Ireland is supported by and reflected in the dominance of male analyses in opinion and knowledge production. This oppresses women, limits women's potential and capability for health and wellbeing needs to be challenged by organisations that have a duty to justice and equality. Success depends on the development of a more gendered agenda informed by a feminist consciousness. This study aims to explore the challenges and possibilities of such an agenda.

The frustration and desire for change is obvious in this extract:

'I am Ireland and I'm sick
I'm sick of this tidy house where I exist
That reminds me of nothing
Not of the past/not of the future
I'm sick of depression
I'm sick of shame
I'm sick of poverty

I'm sick of politeness
I'm sick of looking over my shoulder
I'm sick of standing by the shore/
waiting for some prince to come on the tide' (Medbh, 1993, p.58).

1.6 Exploration of my positionality

This research study is influenced by social constructionist feminist theory, as well as a critical interpretivist research epistemology. The rationale for these particular theoretical choices and their significance is addressed later in this section. In these introductory paragraphs I discuss the issue of positionality, what it is and why it is important. The presentation of positionality generally includes a description of the researcher's world view, how this view is informed by her life experiences and the researcher's understanding of how her positionality informs the research project. In this presentation of positionality, in other words, I aim to locate myself as the researcher in relation to all aspects of the research and explain how it is shaped by my values, beliefs and experiences. I draw from an understanding of positionality as 'a scholarly exercise that discloses the scholar's (or the scholarly field's) social/political position as (potentially) relevant for research or as an exploration of the implications of the inseparability of subject and object' (Amoureux and Steele, 2016, p.4). In addressing the question of positionality the researcher provides reference points to help orient the reader to the values and principles that provide the framework for the research and to guide the reader through the research process. In being transparent about personal biases and how they inform the research the researcher is acknowledging responsibility for what she writes. Such disclosure is important in building the trust of the reader. According to Sultana (2007) transparency in relation to positionality also contributes to more ethical research: 'It is critical to pay attention to positionality, reflexivity, the production of knowledge and the power relations that are inherent in research processes in order to undertake ethical research' (Sultana, 2007, p.380).

Addressing the issue of positionality underlines researcher belief that no research can be totally objective because researcher bias in the form of values

and beliefs and experiences are fundamentally present and inseparable from every aspect of the research. There are many different possible approaches to research and not all research or researchers consider the issue of positionality or its relevance to the research project. Sensitivity to the issue has developed in tandem with challenges to the hegemony of positivist research beliefs and practices in the mid-twentieth century. These challenges come from a range of schools of thought, including feminism, and focus on fundamental beliefs regarding ontology or the nature of reality, epistemology or how we know what we know and methodologies or how research is constructed or conducted. The positivist is based on the belief of a fixed reality that can be uncovered by objective, value free research using rigorous and replicable methods which offer reliable and verifiable data using quantitative methodologies. Within this paradigm the researcher is understood to be distant and objective and is regarded as an autonomous expert. Objective separateness 'is accomplished by (researchers) hiding their identity, legitimising a sense of unconnectedness (and) bracketing out the personal experience and views of the researcher' (Sarantakos, 1998, p.25). Proponents of qualitative research generally believe that 'people's orientation is based on and constructed with values, which direct thinking and action, and cannot be neutralised, isolated or ignored' (Sarantakos, 2005, p.93). I would definitely position myself and this study in the latter camp.

1.6.1 Positionality in Feminism and Feminist research

'Feminist researchers have been at the forefront of discussions about the need to be open and honest about the research process' (Maynard and Purvis, 1994, p.16). As part of this openness and honesty feminist researchers 'reject the artificial separation of the researcher and the researched' (Sarantakos, 2005, p.68) so addressing the question of positionality is a typical characteristic of much feminist research. As social constructionist feminism is one of the key influences in my conceptualisation of the research it is important in this statement on positionality to consider what that means and how it impacts on my study.

Over the decades feminist research has had been a significant influence on research practice and culture. While there are many different feminisms there is

general consensus on the political agenda of feminist research. The starting point for feminist research was women's invisibility in research, the androcentric nature and 'gender insensitivity' (Sarantakos, 2005, p.64) of existing research. Feminist researchers have worked to produce knowledge to further women's struggle for justice and 'to generate knowledge for and with women for the purpose of reclaiming women's experience and breaking down male dominated structures' (Byrne and Lentin, 2000, p.62), knowledge that will, in other words, make a difference to women's lives through social and individual change. The aims of this study and the assumptions that inform it are characteristic of feminist research and my hope is to add to that body of feminist knowledge. The context for this increase in knowledge is the practice of community development and other sectors with scope to empower women through addressing gender as a social injustice in tandem with the promotion of women's health and wellbeing in Ireland. This political agenda is another reflection of its feminist credentials.

Many general research methodology textbooks devote sections to discussing feminist principles in relation to research (Cresswell, 2007 and Sarantakos, 2005). However, opinion differs regarding the question of what exactly comprises a distinct feminist methodology. Feminist research tends to be predominantly qualitative and integrationist in that it generally employs the same methods as other research models although aspects of the process are often modified to meet the values and principles of feminism. Feminist research has, for example, been at the forefront of including the question of positionality in research. When addressing the question of positionality feminist researchers commonly employ the practice of reflexivity. Reflexivity is the term used to describe the self-conscious scrutiny required to meet the challenge of answering the positionality question through the disclosure of the preconceptions the researcher brings to the process (Alsop, 2002). Reflexivity is not a process that overcomes 'bias', which is always present. The intention is to provide clarity regarding the researcher's particular perspective, clarity that, in turn, enables the reader to reflect on how this background influences the research and supports the aim of ethical research.

Because of the diversity in feminist thinking simply identifying research as feminist limits the reader's capacity to reflect on the impact of researcher positionality. However, writers on feminist research have identified a level of congruence regarding commonly held beliefs in feminist research, beliefs that have strongly influenced my own perspective on, and approach to, this study. Cook and Fonow (1986) identified five key features characteristic of much feminist research. These features include the recognition of gender and how it impacts on women's everyday worlds; (for feminists within radical as well as 'critical' paradigms) the use of 'consciousness raising' as a way of understanding wider social problems through shared experiences; a rejection of objectivity and acknowledgement of participants as experts in their own experiences; the importance of ethics and, (again especially for radical and critical feminists), 'an emphasis on the transformation of patriarchy and the empowerment of women' (Cook and Fonow, 1986, p.2).

The rationale for this research study identifies the pervasiveness of a patriarchal culture as a key issue in women's oppression in Ireland. The concept of patriarchy in feminist theories is generally associated with radical feminism where the particular focus is the sexual exploitation and objectification of women, control of women's and women's bodies through rape and violence and 'the legitimization of women's oppression in medicine, religion, science, law and other social institutions' (Lorber, 2010, p.121). Not surprisingly the focus of radical feminist activism is the protection and support of women with, for example, the provision of rape crisis centres and women's refuges. During my life I have been involved in supporting such activity in both a voluntary and professional capacity. The need for such support is undeniable and I respect and admire those involved in such activism and who continue to fight against the odds to support women and challenge these forms of oppression. While acknowledging the value of such activism my social constructionist feminist perspective also understands the need for the challenge to patriarchy to be multi-level. The pervasive influence of patriarchy and the subsequent invisibility of gender based oppression in the 'dailiness of women's lives' (Aptheker, 1989, p.37) and the impact of that oppression on women's health and wellbeing in

Ireland was my concern as a women's health officer and is an influence on this research.

The issue explored in this study is identified from my work as a women's health officer in the health services in Ireland. In my work with women, which was informed by my social constructionist feminist analysis, I used a Participatory Learning and Action (PLA) methodology. This approach created opportunities for critical reflection, enabling women to explore the 'dailiness' of their lives 'the children, the elders, the relatives, the holidays, the cooking, the cleaning, the shopping, the mending, the laundry' (Aptheker, 1989, p.39). In these projects my aim was to raise the awareness and build the capacity of professionals as well as women to counteract the social injustice of gender in the power and influence of gender norms and support the promotion of women's health and wellbeing. The response from women was, without exception, very positive. Participants in the projects seemed unperturbed by my obvious 'outsiderness'. In fact they seemed to welcome my different perspective and assertive, yet empathic, questioning approach. However, my efforts at collaboration with health promotion and community development colleagues were not so successful, a situation that seriously limited the potential for development of the projects. An aim of this research is to attempt to identify the possible reasons for the difficulties I experienced with practitioners.

1.6.2 Using autoethnography to explore my position as an 'insider/Outsider'

In this sub-section I focus on exploring some of the personal experiences and values that shaped my positionality using a process of self-reflection. Self-reflexivity can take many forms. For the purposes of clarity in this exploration I use autoethnography which 'is an attempt at practicing this self-reflexivity by having a closer look at one's longings and belongings' and 'places the self within a social context by connecting the personal and the cultural' (Alsop, 2002, p.2).

I value autoethnography for a number of reasons but primarily because it can give voice in situations where, as in my case, the voice has struggled for insider recognition and/or acceptance. Describing these otherwise hidden experiences allows for a more comprehensive analysis and understanding of the world being explored.

Feminist research attaches great importance to the relationship between researcher and research participants. The focus is often on the potential imbalance of power between both parties, with the common assumption being that power lies primarily with the researcher as she is regarded as the ultimate authority (Byrne and Lentin, 2000 and Fox et al, 2007). There can be significant differences in positionality between the researcher and the research participants in feminist research that is carried out with women in disadvantaged areas. The wider social dynamics of inequality such as race and/or class may be amplified and the question of power imbalance needs to be addressed. I likely presented as a white, Irish (in relation to accent and name), middle class woman with a similar professional background to the research participants. So, in this particular research situation I felt that the commonalities between me, the researcher, and the research participants seemed to outweigh the differences. Although there were power dynamics in relation to me the researcher and the participants as the researched, these dynamics were, throughout the process, fluid and complex and were by no means unilinear.

Despite the commonalities I came to the research process with an overriding concern regarding my positionality, specifically in terms of what I considered to be my 'outsider' status in relation to my nationality. These concerns were not generated specifically by the research process or participants. The seeds of my concerns were sown in some of my earliest interactions after my return to Ireland, more than a decade before, after living in England for nearly thirty years. The simple, everyday interaction described here is indicative of the type of exchanges I had with local people (typically referred to as 'locals') in my area as they were getting to know me.

It was a sunny spring day shortly after I had moved to Ireland. My male partner and I were living in the city while work was completed on the derelict cottage in the country that was to be our new home. Having checked on the cottage we were having a walk in the area. As we passed two people walking in the opposite direction I smiled and said 'hello'. Although we were obviously continuing on our way we had to stop when the other couple, obviously aware that we were the new owners of the cottage, explained that they lived in the area and asked about how the work was progressing. The questions continued,

firstly about our plans for the cottage before then moving on to focus on my partner, where he was from and what his job was. When he replied that he worked in the health services it was clear from the comments that followed that the presumption was that he held a senior position of some kind. I was not asked specifically about what I did for a living. It was clear from subsequent comments that there was a presumption that I was responsible for the job of home-making and childcare, the responsibilities traditionally understood as women's work. As a professional woman with a relatively successful career and no children I was used to being identified as having a career equal in importance to that of my partner. I was unused to being identified as someone not in paid employment. I felt diminished by this unequal categorisation. The fact that I was struggling with my unemployed status at the time added to my feelings of discomfort. I felt further diminished when, subsequent to my attempt to clarify the situation by explaining that I was unemployed but was looking for a job, the locals suggested that my 'husband' would be able to find me a job in the health services as a typist. After explaining that I could not actually type my partner and I wished the local people good day and went on our way.

As well as assisting the 'locals' (a common phrase in Ireland - see below) to get to know me I was also trying to get to know the people and culture of the country that I was again part of so, in these exchanges, despite my feminist self feeling peeved, I refrained from challenging or attempting to undo the gendered thinking which I found offensive. The clear difference in world views emphasised a feeling of belonging to the 'they' and excluded from the 'we'. As I settled into my new life I realised that the gendered attitudes and values expressed by my new neighbour were a reflection of what seemed to be prevalent values and beliefs in Irish culture and society. Against this background I felt that my feminist beliefs and values positioned me as an 'outsider' or as what are called in Ireland 'blow-ins' (Inglis, no date).

I am quite well acquainted with the use of the terms 'locals' and 'blow-ins' in Ireland to categorise and label people. Interactions between locals and strangers such as the one I described are used by locals to ask as many questions as possible to get to know as much as possible about strangers or blow-ins. This

information makes strangers less strange and can be used to classify and categorise them socially and culturally. Such interactions are useful for establishing 'similarities and differences and the strength of the bonds and boundaries that could unite or divide them' (Inglis, Institute for British-Irish Studies). In his explanation of the significance of identity with place in the ongoing construction and redevelopment of personal and social identities in contemporary Ireland Inglis concludes that 'not only is identity with place of living still very strong, but that it is deep and complex and enmeshed with a sense of belonging to the place people grew up, the wider county and the nation' (Inglis, no date).

In these 'getting to know you' interactions between locals and blow-ins the importance of place is evident in the fact that asking people where they are from is 'one of the most common communication probes after asking people their names' (Inglis, no date). This importance of place is underlined in the collective sadness expressed about the enforced separation of Irish people from their homeland due to emigration and the often expressed desire for the diaspora to return home. However, according to Moncrieff (2015) there is a contradiction between the pain and sadness expressed about emigration and the experience of returning emigrants. The literature on this issue is sparse but something of the challenges faced by the Irish diaspora coming to settle in Ireland are described by Moncrieff (2015): 'Invariably they reported a difficulty fitting in and an initial surprise that the difficulty was there at all. Some shrugged and got on with it. Others found it deeply hurtful' (Moncrieff, 2015, p.21). The inherent contradictions between the expressed pride in and love for the Irish diaspora and the challenges faced by those returning to settle in Ireland are highlighted in a Crosscare report published in 2017. As well as the basic difficulties regarding employment and accommodation the main challenges identified in the report are 'Reintegration into Irish life' and 'Cultural and social support and emotional wellbeing'. The latter challenge is subdivided into: 'Loss of support networks, isolation and reverse homesickness' (The Crosscare Migrant Project, 2017).

I can relate to those who described their experiences as hurtful. I do not relate, however, to the negative experience of feeling like a foreigner in England. Of

course I was often perceived as an outsider and remained an outsider throughout my time there. My obviously northern Irish accent alone, although with identifiable English intonations, shaped my own identity as an outsider, and how others positioned me, as it did on my return to live in Ireland. On the basis of my accent alone I was never going to be identified as English. When I was leaving England after a stay of nearly thirty years friends and colleagues referred to the move as a 'return home'. For me the feelings of hurt identified by Moncrieff (2015) and the biggest challenge for me to contend with came from my experience of living as a woman in a country where I felt that patriarchy was so institutionalised and seemingly culturally embedded and accepted. My feelings resurrected memories of when I was seventeen:

From the moment I reached puberty I felt a sense of anxiety around me in my family situation. Almost overnight things changed. I felt it but did not understand it. When, at age fifteen, I left my convent boarding school tensions rose and, although I still did not know quite what the problem was, I began to rebel, my behaviour and relationships with my family deteriorated even further. I experienced deep unhappiness and confusion caused, I now understand to be what Jaggar (1996) describes as 'gut level awareness that we are in a state of coercion, cruelty, injustice or danger' (Jaggar, 1996, p.181). I felt constrained, controlled and diminished. I was angry about being pressed into being a girl/woman I did not want to be. In my confusion I did doubt my own sanity. A visit from my godfather who was originally from the area but was settled with his family in London agreed to support me in a move to London. So at seventeen I moved to London. I adapted quickly to my new environment and culture. Feelings of hope replaced those of hopelessness when I could explore aspects of myself that were repressed at home.

Alsop (2002) sums up the benefits of my outsider identity when I lived in England: 'discovering the unknown environment and unknown parts of ourselves makes us feel empowered, empowered by expanding our potential and reinventing ourselves' (Alsop, 2002, p.4). Throughout my years in England I experienced life's normal ups and downs and, although I remained an outsider, friends and colleagues were there to support and celebrate as appropriate. For

me, being an outsider in England was a positive experience, one that allowed me the space and opportunity to understand the feelings of confusion and despair that were so damaging when I was a young woman growing up in Ireland. Leaving Ireland also changed my status at home because as well as seemingly turning me into an outsider in my adopted country I also became an outsider in Ireland. Cultures ‘tend to divide the world into a *here* and *there*, *we* and *they*’ (Alsop, 2002, p.5) and leaving meant that I was no longer part of the collective ‘we’ having chosen instead to be part of the ‘they’. Alsop’s observation helps explain the experiences of returning emigrants outlined in the Crosscare report referenced above.

Crowley suggests that the feelings of ‘confusion, disappointment or displacement’ felt by those returning to live in Ireland after being away for some time are due to the fact that ‘the place they encounter has probably changed quite drastically’ (Crowley, E., 2014, p213). However, writing at the time I returned to live in Ireland, O’Connor noted that there was a lack of consensus about the level of change in Ireland. While some believed that everything had changed others were equally convinced that nothing had changed (O’Connor, 1998, p.1). From my perspective there certainly were contradictions. It was the early years of the economic boom period known as the Celtic Tiger and in many ways Ireland presented as a modern, economically vibrant European state. However, from my perspective viewed through my feminist lens, this analysis obscured a different reality. In that reality the traditional patriarchal beliefs and values, which historically I felt had been so dominant in Ireland, were still seemingly strongly embedded in Irish culture.

1.6.3 Postcolonialism and crossing borders

I found living with the pervasive power and embeddedness of the particular patriarchal ideology in the institutions and culture in Ireland a challenge. My efforts for critical reflection on my experiences were hampered by the fact that at that time there was little available feminist scholarship in relation to Ireland. There were efforts being made to address the issue of women’s invisibility in historical and sociological accounts of Irish culture but ‘little of the work being

done could be said to be distinctly feminist' (Byrne and Lentin, 2000, p.68). Ultimately a feminist postcolonial analysis helped resolve the conundrum of my experiences in the culture in which I now lived and worked and my position within that culture. Postcolonial theory is described as 'the most expansive and outward-looking of the various modes of sociocultural analysis currently shaping Irish studies' (Cleary, 2005, p.1). A postcolonial analysis which incorporates a feminist perspective also has the capacity 'to extend the scope of enquiry to engage with the cultural dilemmas of subaltern groups such as women' (Cleary, 2005, p.1).

Although there is 'a vast and complex literature that explores the theoretical issues' (Kohn, 2013) relating to colonialism, postcolonialism and nationalism the literature has been often 'gender-blind'. This blindness is particularly noteworthy given 'the pivotal role of gender in nationalist ideology (Cusack, 2000, p.557) and when, 'despite nationalisms ideological investment in the idea of popular unity based on formal equality, nations have historically amounted to the sanctioned institutionalisation of gender difference' (Gilmartin, 2017, p.271). Relative to the recognised body of literature in relation to nationalism and postcolonialism, feminist analyses are scarce. However, 'feminism has raised awareness of the processes taking place' and of the fact that 'gender relations are at the heart of cultural constructions of social identities' (Yuval-Davis, 1997, p.39). Reflections on my experiences lead me to concur with De Wan's observation that 'no analysis in the Irish state can be accomplished without seeing the integral role that gendered nationalism has played in Irish culture' (De Wan, 1997)

Against this background my new situation in Ireland presented me with a new border to negotiate. My cross border identity meant that throughout my time in Ireland I never managed to satisfactorily answer the seemingly straightforward question 'Where are you from?' The problem was not simply that I did most of my growing up in England but it was not a place I now called home. My 'cultural hybridity' (Burke, 2009, p.2) and identity was made more complicated by the fact that the place I called home, although Ireland, actually straddled the border between the Republic of Ireland and Northern Ireland. Throughout my life I lived fairly equally on both sides. This geographical positioning created an

awareness of different and competing cultures and identities from a very young age and as a result of these experiences I was very conscious of the value people place on cultural identity. I was, however, equally aware of the potential of rigid identity categories and group membership to be exclusionary and restrictive and therefore, in my mind, anathema to social justice because, while group membership resulted in empowerment for some, it can result in the disempowerment of others. In my efforts to get support for the development of a feminist perspective in the promotion of women's health in collaboration with others I often felt I was situated in the latter. However, my different cross border experiences contributed to a culturally hybrid identity that, while it presented challenges, also presented opportunities for a cross pollination of cultural and ideological ideas, 'what Anzaldua describes as a "perspective from the cracks"' (Keating , 2006, p.9) in between the different worlds. Anzaldua used the concept of 'nepantleras' to describe those who used the 'perspective from the cracks' to assist with 'border crossing'. Nepantleras 'act as intermediaries between cultures and their various versions of reality. They serve as agents of awakening, inspiring others to deeper awareness (and) serve as reminders of each other's search for wholeness of being' (Anzaldua, 2003/4, p.20).

The value orientation of any culture is developed in response to the need to organise society and the issues associated with that need. In the Irish context, a postcolonial analysis identifies the powerful three-way relationship between State, Church and nationalism that formed the foundations for the postcolonial, post-independent Irish state and was cemented in the Irish Constitution. 'Embedded cultures emphasise maintaining the status quo and restraining individuals' actions that might disrupt in-group solidarity or the traditional order' (Davidov et al, 2014, p.268). In Ireland the Constitution has played a dominant role in the defining and embedding the value orientation of the newly independent country and its citizens. Over its eighty year history the Constitution has been amended but it is still regarded as a document that 'says much about how Irish society sees itself and where its values lie (Brady, 2012, p.7). With its special recognition in the Constitution a clear connection and a formal merging of religion and Irish national identity was established and being

Catholic 'had become a defining element of what many believed it meant to be Irish' (White, 2010, p.10). While the immeasurable influence of the Catholic Church has diminished in recent years it is reasonable to assume that, given its continuing dominance of first and second level and to some extent third level education, Catholicism continues to be an influence in the Irish identity construction. It also might be imagined that, given the social and economic developments Ireland has experienced in recent times, nationalism is now a thing of the past and, as an ideology, may be in decline. However, continuing fascination with the search for the definitive, unique Irish identity suggests this presumption is misguided. My experience concurs with Malesevic's (2014) opinion that 'nationalist ideology and practice has actually intensified over the last several decades and is much more powerful and socially embedded than that present in DeValera's era' (Malesevic, 2014, p.11).

Following Anzaldua, I tried to engage with other practitioners to explore our different versions of reality in relation to the impact of gender on women's position in Ireland and to increase our understanding of our different perspectives. My aim was to build capacity to develop a collective approach to addressing gender as a determinant of women's health and wellbeing. Among the factors that frustrated my efforts to build the necessary bridges was the culture of Irish exceptionalism. It makes sense in any nationalist discourse that the said nation is regarded as unique and exceptional in some way and the notion of exceptionalism is often partnered with nationalism. Asserting exceptionalism is a typical characteristic of postcolonial nations as it creates a strong sense of 'we' and of a collective identity and is 'part and parcel of maintaining ideological coherence and solidarity' (Inglis, 2014, p.3). Asserting exceptionalism is recognised as a characteristic of Irish culture and it is particularly evident in the everyday practices that are regarded as unique to Ireland and the Irish. Along with the significant contribution they make to the collective sense of 'we-ness', these practices reinforce the 'outsider-ness' of those regarded as 'they'. The need to protect itself from those who threaten the picture of perfection means that a culture of exceptionalism supports the embeddedness of the dominant cultural orientation and conformity with group norms. Preserving the cultural orientation that supports exceptionalism means

avoiding the inclinations and ideas of individuals ‘that might disrupt in-group solidarity or the traditional order’ (Schwartz, no date). Against this cultural backdrop it is reasonable to assume that a social constructionist feminist analysis of the impact of gender based inequality on women’s health and wellbeing had the potential to disturb the status quo.

Collaboration to address issues of social injustice is acknowledged as a key requirement of both health promotion and community development. However, despite this acknowledgement and my efforts to shrink the space between my feminist vision for the promotion of women’s health by challenging the gender based oppression faced by women in their everyday lives, relationships with potential professional partners remained strained. The disappointment of this lack of support was exacerbated by the fact that the response of women themselves to the various projects was so enthusiastic. To me this enthusiasm suggested a possibility for development of a collective energy for change with the potential to form the foundations for collective action. However, despite the eagerness with which women embraced the approach, practitioners in health promotion and community development resisted the opportunity to engage with me and the women I worked with in an effort to disrupt the traditional order. The aim of this research study is to understand the reasons for this resistance.

1.7 Brief outline of Chapters

Chapter 2 examines the theory relating to the key concepts and related issues relevant to this study, health and wellbeing, particularly women’s health and wellbeing and gender. Both are considered from a feminist, social constructionist perspective. The importance of the social model of health and understanding gender as a determinant of women’s health and wellbeing is explained. Throughout, Ireland as the context for the study is emphasised.

In Chapter 3 the disciplines that are of particular interest in this study, health promotion and community development are reviewed. The commonalities and differences of the disciplines are discussed, particularly the gap between the espoused values and the gender-blind practice of each. The neglect of gender as a determinant of women’s health and wellbeing and a matter of social justice is considered. There is a particular focus on the potential of each to address

women's gender based oppression through the promotion women's health and wellbeing. Again the particular context is Ireland.

In Chapter 4, Methodology, I discuss the theories which inform and support the approach to the study. I explain some of the challenges faced and the ethical issues considered. The chapter includes the questions I wanted the research to answer and how these were reformulated into interview questions. The processes of data collection and analysis are discussed.

In Chapters 5 and 6 the focus is on the data collected. The findings are presented and analysed, accompanied where appropriate with some contextual analysis referring to the relevant literature which has been referenced in earlier chapters. Participants' understandings of health and wellbeing in Chapter 5, is followed by their understandings of gender in Chapter 6.

In the final chapter, Chapter 7, I reflect on how the findings answered the research questions, what issues the research highlighted and what, I believe is necessary to address these issues and make the necessary links between the three points of the triangular framework to promote women's health and wellbeing by addressing the injustice of women's gender based oppression.

Chapter 2: Theory and concepts

This chapter critically analyses the key concepts of relevance to this research study. The chapter opens with an overview of the concept of feminism, including radical feminism, feminist standpoint theory and social constructionist feminism, the feminist theories of particular relevance to the theoretical framework supporting this study. In section two the focus is on my conceptualisation of health which is extended to include wellbeing. I first outline how conceptions of health have been dominated by a 'medical model' and how this is androcentric. I follow this with an analysis of the social determinants of health and wellbeing that complements a social constructionist view of gender and a critical stance towards patriarchal culture and, within this framework, considers women's health as a matter of social justice.

2.1 Defining feminism

'Feminism is a troublesome term' (Beasley, 1999, p.ix). It is a subject that can generate the expression of strong, frequently negative, opinions and the term is often used in a way that seems to presume understanding. However, despite an ever-growing and dynamic body of knowledge on feminism, the search for clarity about what feminism is can be challenging. As it is not uncommon for terms or concepts to have multiple meanings searching for the definitive meaning of terms and concepts in social theory generally can be a frustrating and confusing experience. In this regard feminism is no exception. Beasley (1999) suggests that part of the problem is that 'existing writers rarely attend to the issue of what it is that they are discussing' and the fact that 'the meaning of the term 'feminism' is almost invariably assumed and/or evaded' (Beasley, 1999, p.xi).

There are a range of reasons for avoiding definitions of the term feminism. For example, although it is frequently presented as a single entity, there are many different schools of feminist thought. These different perspectives have permeable boundaries and are positioned within an ever-developing body of knowledge. The size of this body of knowledge and the numbers involved in producing it has grown to such an extent that 'it is now so difficult for a single person to have an in-depth knowledge of the whole of feminist theory,

overviews of it are often partial and incomplete' (Jackson and Jones, 1998, p.2). hooks, an acclaimed, contemporary academic and activist explained her personal dissatisfaction at the lack of guidance for those looking for a definition of feminism. Her belief in the need for an accessible introductory text to answer the question 'what is feminism?' convinced her to address the issue herself. In the introduction to her book she described what she believed was needed:

'a concise, fairly easy to read and understand book; not a long book, not a book thick with hard to understand jargon and academic language, but a straightforward, clear book - easy to read without being simplistic' (hooks, 2000, p.vii).

Despite hooks' efforts at making feminist knowledge more accessible, the gap between grassroots feminism and academic feminism is undeniable. While the vastness of the field of feminist knowledge is welcomed the move of knowledge development from grassroots feminism to the academy has contributed to concerns regarding accessibility, connection and applicability and created a damaging gap between academia and activism.

Although it was a struggle, feminism believed that it was essential to establish itself in the academy. This belief was driven by the need to challenge what feminists increasingly argued was the male dominance and control of knowledge, particularly social and political theory. The dominance of 'malestream' thinking they argued universalised men's experiences and 'represented men's experiences as describing that which is common to all human beings' (Beasley, 1999, p.8). A key feature of 'malestream' thinking, and a primary concern for feminism, was the characterisation of concepts as oppositional pairs, or dualisms, a practice that identified one part of the pair as the dominant or more significant partner, an arrangement which inevitably results in a hierarchical ordering and establishes a clear inequality. As these oppositional pairings have traditionally been aligned with the concepts of masculine and feminine, with the masculine being positioned as the dominant and the feminine as the subordinate, they establish a gender-based inequality, in which women are subjugated and positioned as other. While there are many points of divergence and convergence within feminist theorisation there is general agreement on the

deeply gendered nature of women's inequality. In Chafetz's (1997) definition of feminist theory gender is the number one criterion and, because it results in social inequities that devalue and disadvantage women, it is a concept that feminism needs to challenge. hooks builds her definition of feminism around sexism: 'Feminism is a movement to end sexism, sexist exploitation, and oppression' (hooks, 2000, p.viii). Her later statement that 'most people do not understand sexism, or if they do they think it's not a problem' acts like an antidote to her simple definition. Mikkola (2017) agrees about the poor understanding of gender and the idea that they are one and the same: 'most people ordinarily seem to think that sex and gender are coextensive: women are human females and men are human males' (Mikkola, 2017, paragraph 1.1). Understanding is hampered by the increasing use of the terms interchangeably in policy documents as well as ordinary conversation, although some 'radical' feminist theorists (see below), and writers in the 'French Feminist' tradition such as Kristeva, Irigaray, and Cixous, arguably perceive gender in ways that can be regarded as essentialist (Ives, 2016).

In contrast much feminist thought rejects the biological determinist view that differences are fixed and the idea that biology accounts for differences in social, psychological and behavioural traits between women and men. In contrast feminism endorses a social constructionist perspective (one of a number of feminist perspectives informing this study) and the belief that what constitutes the categories of male and female are not natural or fixed and can, therefore, be changed.

In the following paragraphs I explore more closely some of the different orientations of feminist thought with particular emphasis on perspectives most pertinent to this research study. Most analyses of the different orientations identify three categories of feminist thought, reflecting the broader classical philosophical and political perspectives - Liberal, Marxist/Socialist and Radical. Most feminist thinkers also agree on the resistance of feminist thought to 'easy categorisation' (Lorber, 2010; Tong, 2009; Whelehan, 1995) and acknowledge that categorising 'an incredibly diverse and large array of feminist thinkers as 'x' or 'y' or 'z'' is a challenging task. Support for categorisation is based on the fact that the labels dispel the notion that feminist thought is a large, rigid, fixed

ideology and instead ‘help mark the range of different approaches, perspectives and frameworks a variety of feminists have used to shape both their explanations for women’s oppression and their proposed solutions for its elimination’ (Tong2009, p.1).

2.1.1 First wave and Liberal feminism

It is impossible to pinpoint the birth of feminism but histories generally begin with liberal feminism and the fight for equal rights for women. Liberal feminist theory rejects biological determinism and proposes that the cause of women’s oppression is due to ‘the creation of and belief in sex differences’ (Lorber, 2010, p.27). Mary Wollstonecraft’s ground breaking book ‘A Vindication of the Rights of Women’, published in 1792, is recognised as one of the earliest contributions to feminism. In arguing for women to have the same rights and liberties as men Wollstonecraft expanded the boundaries of classical liberal thinking on social justice. Wollstonecraft challenged the biological determinist belief that differences between women and men were natural. She argued that if men were confined to the same limited opportunities and experiences as women they would display the same characteristics regarded as flaws in women. In other words, any differences in attitudes or behaviours between women and men are considered to be due to processes of socialisation that create different gender roles rather to any innate biological or psychological differences. A central tenet of Wollstonecraft’s argument was women’s right to the same educational opportunities as men, giving them the same opportunity to achieve their full human potential. Equal opportunities for women remain a central concept in liberal feminism.

More than one hundred and fifty years after Wollstonecraft’s book another landmark publication which informed the development of liberal feminist thinking appeared. In ‘The Feminine Mystique’ (Friedan, 1963) Betty Friedan surveyed women to explore their experiences as wives, home-makers and mothers and their feelings about what society deemed to be the natural choice for women. The study was carried out in the post-war years when women who had worked outside the home doing jobs that men had left to fight in the war returned to their duties in the domestic sphere and when the educational

opportunities that Wollstonecraft had argued for so many years previously were now available to the women surveyed. Friedan's findings challenged the normative belief about women finding fulfilment in their lives in the domestic sphere as many of the women surveyed described feelings of dissatisfaction and loss of identity, feelings they were unable to share with others for fear of a negative response.

Friedan's analysis has been criticised by different groups for a number of different reasons. At the time women objected to Friedan's implication that women who concentrated on the responsibilities in the domestic sphere could never feel fulfilled. They felt that they and their work were devalued. Women were further angered by the fact that Friedan, reflecting classical liberal thinking, emphasised autonomy and self-determination as necessary characteristics for self-fulfilment. So, 'although, on the face of it, Friedan is attacking the patriarchal status quo which exhorts women to give all their efforts to childcare and housewifery, there is a subtext to her writing that seems to be blaming the women themselves' (Whelehan, 1995, p.36). There was no consideration in Friedan's argument of how women were going to continue to deliver on their domestic responsibilities to the standard expected while also committing to a career or any activity outside the home. Friedan's analysis of women's situation was based on white, well educated, middle class women and it has been criticised for assuming this as women's collective experience. It has been criticised for being classist and racist. There is, for example, no recognition that there were, in fact, many women already in the workforce, women who were unsupported by men and who had no choice but to work to support themselves and their families. hooks addressed the issue of racism in 'The Feminist Mystique' commenting that the problems highlighted by Friedan were those of 'a select group of college-educated, middle- and upper-class, married, white women' (hooks, 2000, p.1). Friedan, hooks explained, 'ignored the existence of all non-white women and poor white women' (hooks, 2000, p.2).

2.1.2 Second wave, Liberal and Radical feminisms

Both liberal and radical feminism were part of second wave feminism. This second wave, as the name suggests, was a continuation of earlier feminist activity which focused on equality and women's suffrage and was the beginning of a mass movement for women's rights. It was a period of rapid growth in feminist thought and activism and established the foundations for the feminism of today. It is not possible to pinpoint one particular year or event that marked the beginning of the period known as the second wave of feminism but it is generally positioned in the late 1960s and 1970s a time that 'witnessed an upsurge of youthful left activism throughout the Western world' (Jackson and Jones, 1998, p.3). The year 1968 is recognised as a watershed moment in global politics when there were world-wide popular rebellions against many different forms of oppression. In the US, as well as the civil rights movement, there were protests against the Vietnam war, protests that spread to major European cities. The escalation of feminist activism and the growth in feminist thinking that formed the second wave was part of a 'period of incredible energy and excitement generated by an optimistic belief in the possibility of radical social change' (Jackson and Jones, 1998, p. 3) when activists campaigned for a broad range of civil and political rights and against a wide range of social injustices. By the time of the second wave of feminism the limitations of the successes of earlier women's movement activism, which focused primarily on legislation, particularly women's suffrage, were evident. Women involved in civil rights activism, for example, began to see parallels between discrimination against black people and women and it became clear that more was needed to address discrimination against women. This understanding was influenced by women's experiences of gender-based discrimination as activists in left wing politics, where, despite supposed values of equality and empowerment when women were confronted by traditional sex-based discrimination that positioned the male as dominant and the female as subordinate.

As I have already noted the process of organising the diversity of feminisms and feminist thought into categories subsequent to the exponential growth during and after the second wave has not produced consistent categories. There is general agreement on the main three - liberal, Marxist/socialist and radical. In

her analysis Lorber, (2010) develops this common categorisation further by grouping her total of thirteen different feminisms into 'Reform', 'Resistant' and 'Rebellion' (Lorber, 2010, p.7), depending to how each defines the problem of gender-based oppression and what they propose as a solution. Liberal and Marxist/socialist are positioned under the umbrella of 'Gender reform feminisms' while radical feminism, a key influence in this study, is positioned in the 'Gender resistance feminisms' group. According to Lorber, gender reform feminisms believe 'the sources of gender inequality are structural' and their solution is gender balance and making the social order more equal.

Liberal feminism continues to focus on equality for women in employment, in political representation, in shared parenting, in breaking the glass ceiling. It continues to highlight how society discriminates against women and the inequitable distribution of responsibilities in the domestic sphere. Liberal feminism has been successful in breaking down many barriers: 'Women have entered every field, from mining to space travel. Women in the police force and the military are no longer an oddity, and women in high positions, including leaders of countries, are no longer a rarity' (Lorber, 2010, p.26). Liberal feminism has been very effective at a practical level, highlighting obvious injustices of gender discrimination and securing civil rights for women and girls. It continues to be popular and is 'often the first feminism women encounter' (Whelehan, 1995, p.42). Liberal feminism is the acceptable face of feminism and appeals to women in the 'I'm not a feminist but ...' category. However, liberal feminism has been most successful when and where it is most acceptable and many of the issues of gender inequality, even those supported with legislation, persist. The gender pay gap remains. The socialisation of girls and boys continues to be gendered and media representations of women and men continue to be highly gendered. Projects such as 'Everyday Sexism' and the 'MeToo' movement suggest that the problem of sexist harassment of women and girls and gender prejudice is actually increasing. Gender segregation in jobs and gender stratification in organisational hierarchies persists. A continued criticism of liberal feminist politics is 'centred on the needs of middle class women and would possibly not accept class or racial difference as a significant handicap in the path of self-advancement' (Whelehan, 1995, p.39). Many of the limitations

of liberal feminism are connected with its commitment to the tenets of classic liberalism. This commitment underlines the liberal feminism 'focus on the public sphere, on legal, political and institutional struggles for the rights of individuals to compete in the public marketplace' (Beasley, 1999. P.51). The aim of liberal feminism is for social not transformative change. Its commitment to the tenets of classic liberalism means that liberal feminism has no real desire to disrupt the status quo, a position that 'prevents any productive discussion of the root causes of women's oppression , since the guiding structures of contemporary Western society are not really questioned' (Whelehan, 1995, p.39). The ineffective implementation of the strategy of gender mainstreaming, a global strategy to integrate a gender perspective into the preparation, design and implementation of all policy, political, economic and social highlights the limitations of a liberal feminist approach: 'A review of gender mainstreaming policies implemented under the United Nations Development Programme, World Bank, and ILO found inadequate budgeting for the gender components of projects, insufficient development of analytical skills, poor supervision of the implementation of gender components and a general lack of political commitment both within the organization and at the country level' (Charlesworth, 2005, p.1). In Lorber's categorisation 'gender resistance' feminisms reject the notion that aiming to achieve parity with men is a sufficient solution to the problem of women's gender-based oppression.

Development s in the understanding of women's oppression moved to another level with the birth of radical feminism in the 1970s. People generally understand radical to mean 'extreme' but in the context of radical feminism radical means 'getting to the root of'. The birth of radical feminism is commonly attributed to a group of New York feminists who set up the Redstockings group in 1969. Shulamith Firestone, a central figure in radical feminism, was a founder member. The group included Carol Hanisch the woman often attributed with popularising the phrase beloved by radical feminism 'the personal is political'. The manifesto published by the group, the Redstockings Manifesto, is regarded as a blueprint for radical feminism. The Redstockings group remains active and according to their website:

‘Redstockings women would go on to champion and spread knowledge of vital women's liberation theory, slogans and actions that have become household words such as consciousness-raising, the personal is political, the pro-woman line, sisterhood is powerful, the politics of housework, the Miss America Protest, and "speakouts" that would break the taboos of silence around subjects like abortion’ (Redstockings, 2019).

In pursuit of this goal of ‘getting to the root of’ radical feminism rejects malestream or male dominated mainstream knowledge and thinking as it is based on and reflects a masculine perspective. In its theorisation of women's oppression radical feminism identifies patriarchy, a system of institutional and social power in which the power is held by men and in which men's perspectives and interests are dominant, as the root of the problem. The term ‘patriarchy’ was popularised by Kate Millett in her book ‘Sexual Politics’ published in 1970. In this book, which became a key text on radical feminist thought, Millett critiqued the patriarchal representations of renowned authors such as Norman Mailer, Henry Miller and D.H. Lawrence. According to Whelehan, Millett understood patriarchy as ‘the fundamental oppressive force, despite differing class and ethnic origins embedding individuals in various relations of power and causing local distinctions between forms of patriarchy’ and ‘argues that it is a system of power which encompasses and underpins all other forms of social relations’ (Whelehan, 1995, p.16). The pervasiveness and persistence of patriarchy is related to the power of gender ideology on which it is based. In the linking of sex to gender using a biological determinants framework biology is understood as destiny with ‘male qualities of objectivity, control and individual achievement’ being celebrated and positioning men as dominant. In contrast the female is constructed as naturally suited to childrearing, home-making and nurturing. In patriarchal cultures the apparent immutability of gender and its acceptance as the natural order of things is reinforced through its endorsement by the institutions and systems that inform socialisation and cultural ideology.

In radical feminism the concept of patriarchy includes ‘recognition of the deep rooted nature of male dominance in the very formation and organisation of ourselves (the psychological or unconscious internalising of social patterns of

sexual hierarchy)' (Beasley, 1999, p.55). Consciousness-raising (C-R) which is referred to in the Redstockings Manifesto as 'Our chief task' (Lorber, 2010, p.125), was a popular strategy developed by radical feminism to address the problem of women's internalised oppression and to challenge the pervasiveness and power of patriarchy. The aim was 'to develop a female class consciousness through sharing experience and publicly exposing the sexist foundation of all our institutions' (Lorber, 2010, p.125). The process of C-R brought women together in small groups where they shared their personal, individual experiences of living their lives as women. C-R addressed the issue of women's isolation which resulted in women believing their problems were personal and individual rather than the consequences of gender based oppression. The process highlighted the fact that what seemed like isolated, individual problems actually reflected common conditions experienced by other women. While C-R may have had some therapeutic benefit for those involved, the intention was not to solve women's personal problems. C-R was intended as a form of political action and an attempt to ensure that any programme for action was built on women's real experiences and realities. This connection between personal experiences and political systems and institution is summed up in the slogan that is recognised as a defining characteristic of second wave feminism - 'the personal is political'.

2.1.3 Feminist standpoint theory

The mix of feminist theories that guides this study, principally radical and social constructionist feminism, are both categorised by Lorber (2010) as resistance feminisms. Feminisms within this category 'developed an important theoretical insight - the power of gender ideology, the values and beliefs that justify the gendered social order' (Lorber, 2010, p.11). A key belief in the theorising of gender and the oppressive influence of patriarchy in resistance feminisms is the absence of women's, especially marginalised women's, perspectives from the production of knowledge.

But simply adding women where previously they had been excluded and employing conventional research methods was not sufficient for the development of a critical feminist paradigm. Efforts to develop feminist theory and challenge the distorted reality that inevitably results from this silencing of

women has been wide and varied. A key focus of the endeavours to reorient the androcentric bias of traditional scholarship and knowledge building has been challenging the claim to a value neutral, objective truth or reality, a position consolidated by postmodernism's rejection of metanarratives and universalist notions of truth and reality. Feminist research and theory is based on the assumption that the world, including gender, is socially constructed and gender as a social construct and 'the part it plays in shaping women's consciousness, skills, institutions and the distribution of power and privilege' (Sarantakos, 2005, p.56) lies at the heart of feminist scholarship. In recognising that, as a result of gender, women have different life experiences and perspectives than men the outcome of feminist research is typically the construction of a different and more complete reality. In other words feminist research 'could reach a more accurate take on reality than was available to those with vested interests in its misrepresentation' (New, 1998, p.2). Feminist standpoint theory (FST) is the result of efforts of feminists from a range of disciplines to develop a feminist epistemology that uses women's experiences as the starting point for social enquiry and forms the backbone of my own theoretical position, particularly authors such as Sandra Harding (2004, 2009), Patricia Hill-Collins (1998) and Dorothy E. Smith (2005). FST understands knowledge to be socially situated and that individual perspectives and experiences are shaped by and are conditional on our location in the world, beliefs that reflect the influence of consciousness raising practice and activism of second wave feminism. FST theory recognises women and marginalised groups generally, as experts in their own lives and better positioned to understand not only their own world but also that of those who are more socially and politically privileged. 'Members of an oppressed group can see more, further and better than the master precisely because of their marginalised and oppressed condition' (Smith, 2005, p.8). This unique viewpoint makes this a more productive starting point for enquiry.

The proposed starting point of women's perspectives was necessary, according to proponents of FST, to counter the inadequacies of conventional research. Because those in mainstream research generally 'took their research problems, concepts, hypotheses and background assumptions from the conceptual frameworks of the disciplines of the social institutions they served' (Harding,

2004, p.5) the resulting priority interests and concerns which informed policy and practice ‘were not only not women’s but, worse, counter to women’s needs and desires’ (ibid).

FST was a significant influence in my work with women during my time in Ireland and inspired my use of Participatory Learning and Action (PLA). Like some of the renowned FST theorists the development of my standpoint began with my own life, and applied the learning from that experience in my work. In this excerpt Dorothy E. Smith describes her early adventures in feminist consciousness, the transformatory nature of those experiences, experiences that informed her work to develop an ‘alternative sociology that takes up women’s standpoint’ (Smith, 2005, p.11). ‘Starting with our experiences as we thought and talked about them, we discovered depths of alienation and anger that were astonishing. Where had all these feelings been? How extraordinary were the transformations we experienced as we discovered with other women how to speak with one another about such experiences and then how to bring them forward publicly, which meant exposing them to men’ (ibid, p.7). My experience leads me to concur with FST that reflexivity, inherent in the dual perspective resulting from the new insider/outsider position in which I found myself when I moved to Ireland, had the potential to afford me epistemic advantage. The advantage of straddling both sides has been recognised by bell hooks (1984): ‘Living as we did—on the edge—we developed a particular way of seeing reality. We looked both from the outside in and from the inside out...we understood both’ (hooks, 1984, p. vii). The epistemic advantage gained from straddling different realities helped to alert me to the danger of essentialism, a noted criticism of some, especially earlier, iterations of FST (see Hallstein, 2000) and the limitations of dominant ideas of what constitutes woman or feminine. The non-judgemental, empathic principles of the PLA approach I engaged in the projects worked in a way that recognised difference and that helped to build solidarity among different kinds of women in sometimes very different circumstances.

The success of the FST influenced PLA projects with women encouraged my decision to use a FST informed approach in this study. However, my experience also alerted me to the fact that standpoint is an achievement and, while perspective provides a starting point for standpoint, a perspective is not

standpoint. Standpoint requires more than simply telling of individual narratives. Achievement cannot be taken for granted. Work in the form of critical reflection is required 'in order to see beneath the ideological surface of social relations that we all come to accept as natural ... because the perceived naturalness of the dominant groups' power depends upon obscuring how social relations actually work' (Harding, 2009, p.195).

From FST's conception of the partial, androcentric conception of dominant forms of cultural knowledge comes the notion of gender blindness, a key concept in this study. 'Gender Blindness' is described by Ferber (2007) as the assumption that 'the women's movement has accomplished its goals and barriers facing women have been removed' (Ferber, 2007, p.273). After all, women can vote, they can access education, they can enter into contractual agreements in their own right and they are protected by a wealth of anti-discrimination legislation. In other words women have equal rights as men. The gender blindness of postfeminist ideology goes even further and argues that 'the push for equality has gone too far, arguing that men are now victims of feminist frenzy' and any problems women have now are of their own making and 'are the result of feminism, and women's push for equality, rather than the product of inequality' (Ferber, 2007, p.273).

The framework that informs this study recognises the potential challenges presented in getting behind a postfeminist inspired gender blindness that camouflages a patriarchal discourse and presents gender inequality as natural in order to explore attitudes and beliefs of participants. Experiences and perspectives are the starting point for our standpoints and participants' perspectives are therefore the starting point for my exploration in this study. My personal experience in my collaborations with health promotion and community development practitioners in Ireland was that there was resistance to gender sensitive practice or a feminist analysis. In other words, in my experience practice was gender-blind and lacked a perspective 'in which the categories of woman and the gender system are not taken as given but problematised and put at the front of the analysis' (Ettore and Riska, 1993, p.506).

This study aims to address the gap in knowledge that I believe exists in community development about the need for a feminist analysis in community

development practice in Ireland. Informed by the feminist framework described in this section the investigation starts with an exploration of practitioners own experiences.

2.1.4 The social construction of gender

The relationship between health and wellbeing and gender, and the understanding of these concepts as social constructs, is central to this research study. Social constructionist theory is concerned with how knowledge is constructed and understood. As a prominent theory in sociology and psychology it focuses on how social norms or taken-for-granted realities are established as truth in societies. As social constructs concepts are ever changing and are defined differently at different times in different cultures. Within the feminist paradigm which informs this study there is the belief that sex and gender are central to society.

‘Social construction feminism demonstrates that gender is a constant part of who and what we are, how others treat us and our general standing in society. Our bodies, personalities and ways of thinking, acting and feeling are gendered. Early and constant gendering gives the illusion of inborn sex differences, but social construction feminism argues that gender differences are not sex differences’ (Lorber, 2005, p.244).

As a result of socially constructed differences between female and male, women are almost universally positioned as subordinate to men in society. ‘Sex and gender are the organizing markers in all societies. In no country, political group or community are men defined as lesser human beings than their female counterparts. But almost everywhere women are so defined’ (Lorber, 2010, p.29). So gender, how it legitimises women’s subordination and the impact of gender on women and women’s health and wellbeing, is a core element in the conceptual framework for this study, a framework informed by personal experience, professional knowledge and feminism.

In the 1970s second wave feminism appropriated the term gender to distinguish between biological sex differences and social and psychological differences and to enable discussion about the difference between them. Some feminists now

criticise the sex/gender distinction and in contemporary feminist thinking 'the terms 'sex' and 'gender' mean different things to different feminist theories and neither are easy or straightforward to characterise' (Mikkola, 2011, 2). The sex/gender distinction has been very valuable to feminist efforts to counter the biological determinist view, which asserts that sex, which refers to the biological differences that identify human beings as female or male, determines human characteristics and behaviours. In contrast, gender theory argues that human characteristics are not innate but are in fact socially produced and are, in other words, the result of 'cultural practices and social expectations' (Mikkola, 2011, p.4).

Biodeterminism accords characteristics such as rationality, confidence, independence and competitiveness as 'male' characteristics, with the conception that humans categorised as men are particularly suited to leadership and decision making roles in society. Women, on the other hand, are understood to be nurturing, empathetic and gentle, making them 'naturally' suited to the perceived caring and nurturing requirements of the private, domestic domain. Whereas biodeterminism maintains that we are passive recipients of gender identities social constructionism understands that gender, like race and class, is a socially imposed category which is formulated, legitimated and controlled by the practices and discourses of the major social institutions such as government, religion, education, law, arts, sciences and family.

Gender is regarded as a primary frame by Ridgeway (2009) because in any relationship people are instantly sex categorised, a categorisation which sets the rules for how to behave in that relationship. The sex of every human which is ascribed at birth according to genitalia and chromosome mix is, Wingrave suggests, 'probably the most socially significant quality that is ascribed to any human being' (Wingrave, 2014, p.14). If, as biodeterminism believes, differences between women and men are natural and inherent they are set and unchangeable. In contrast if gender is socially constructed it is 'mutable and alterable by political and social reform that would ultimately bring an end to women's subordination' (Mikkola, 2011, p.4). Feminism uses the concept of gender to contest the idea of innateness and the unequal sex based categorisation of male and female that it supports. Gender, according to the

traditional sex/gender distinction understands women and men and feminine and masculine characteristics as socially constructed and the unequal categorisation of the male as dominant as a social injustice that oppresses women (Beauvoir, 1949; Haslanger, 1995; Lorber, 2010; Mikkola, 2011).

In the search for theory feminism has sought to develop new paradigms of social criticism and questioned what passes in the mainstream for truth. In this process poststructuralism has proven popular because it provides 'a new way of analysing constructions of meaning and relationships of power that called unitary, universal categories into question and historicised concepts otherwise treated as natural (such as man/woman) or absolute (such as equality or justice)' (Scott, 1988, p.33).

Postmodernism, which has had a broad influence on developments in art, literature, architecture and other disciplines focused originally on philosophy and is regarded as the 'elaborator of the basic principles of human nature and social reality' (Nicholson, 1990, p.2). A primary characteristic of postmodernism is criticism of or scepticism in relation to the grand narratives of the Western modernism of the nineteenth and twentieth centuries. Postmodernism rejected the idea of absolute truths and objective realities and replaced them with a conception of reality which understands that truth and knowledge are socially constructed and contextual.

The terms postmodernism and poststructuralism are frequently used interchangeably because 'poststructuralism shares broad features with postmodernism' (Beasley, 1999, p.89). Deconstructionism, a process of postmodernism that questions the metanarratives and concepts in philosophy, the humanities and the social sciences, was adopted as a key technique in the development of poststructuralist theory.

Reflecting its mistrust of generalisations poststructuralism takes the questioning of the sex/gender distinction further by identifying sex as much of a social construct as gender. The poststructuralist view challenges the sex/gender distinction for its essentialism and its reification of the gender relations that feminism challenges. In its fight against women's gender based oppression feminism shares common ground with poststructuralism and its deconstruction of

established binaries such as sex and gender and male and female. As well as showing that the pairing is socially constructed the critical dismantling of these binaries highlights their hierarchal ordering, an ordering that positions one of the pair as dominant or primary and the other as subordinate or secondary. The traditional sex/gender distinction, according to the poststructuralist perspective, reinforces a heteronormative view that divides into male and female, a construction that closes down options for human beings to choose their own individual identity. The poststructuralist feminist view that sex is a social construction does not deny the material reality of the biology of human bodies but is based on the fact that the biological materiality is used to delineate what is male and female. Once the categories of male and female have been ascribed, the socially constructed conventions that determine the behaviours of women and men take over and sex is subsumed by gender. Butler, one of the most renowned poststructuralist feminist theorists, explains the relationship between the two: 'If the immutable character of sex is contested, perhaps this construct called 'sex' is as culturally constructed as gender; indeed, perhaps, it was already gender, with the consequence that the distinction between sex and gender turns out to be no distinction at all' (Butler, 1999, p.10-11).

Theory is necessary in feminism generally and for feminist activism. Many feminist critics agree with the poststructuralist argument in relation to the weaknesses of metanarratives. However, the feminist poststructuralist theorisation of gender has been a hotly contested and divisive issue in feminism. Although not all feminisms view the root of women's oppression in the same way feminism is about ending the oppression that women face. The need for feminism and feminist activism remains very necessary as Segal (1999) explains: 'Why feminism? Because it's most radical goal, both personal and collective, has yet to be realised: a world which is a better place not just for some women but for all women' (Segal, 1999, p.232). Theory helps those involved in activism to avoid becoming involved in 'single issue, dead end work' and to help 'understand which issues are shared by all women and which issues affect different women differently' (Hartsock, 1987, p. 188). Gender is a fundamental issue for theorisation in feminism. However, Flax (1990) is of the opinion that

the differences and divisions in relation to gender theory has resulted in feminism being 'plunge(d) into a complicated and controversial morass' where 'there is by no means consensus on most questions, starting with 'what is meant by gender?' (Flax, 1990, p.43). Of particular concern in this study is the gap that has been created between academic theorists and activists as a consequence of what critics regard as the complex and grandiose nature of poststructuralist theorisation. Describing the problem, Clegg (2006) talks about women 'feeling silenced by not understanding the nuances of terminology ' and 'the fear of appearing theoretically and therefore, politically, inept' in the face of 'such obscure theorising' (Clegg, 2006, p.310).

Given that 'the concept and category of woman is the necessary point of departure for any feminist theory and feminist politics' (Alcoff, 1988, p.405) the poststructuralist theorising of sex as a social construction and the subsequent rejection of 'woman' as a category or group creates obvious problems for feminism. Alcoff (1988) sums this up neatly: 'How can we speak out against sexism as detrimental to the interests of women if the category is a fiction?' (Alcoff, 1988, p.420). Whatever the feminist poststructuralist theory of reality is, society and social practices informed by patriarchy make woman and womanhood a reality, a reality based on a hierarchical system in which those identified as female are positioned as subordinate to those identified as male. Women's oppression remains an issue that feminism needs to address and doing so requires effort and determination. However, the negative approach of poststructuralism in which everything is deconstructed without any positive alternative being offered diminishes the effectiveness of feminism and adds to the challenges it faces. As Alcoff (1988) concludes 'you cannot mobilize a movement that is only and always against: you must have a positive alternative, a vision of a better future that can motivate people to sacrifice their time and energy toward its realization' (Alcoff, 1988, p.419). There has never been a single, unified theory of feminism or consensus in feminist discourse. A positive outcome of the poststructuralist challenge to essentialist and universal conceptions of women is the encouragement of a greater recognition of diversity and that generalising from the perspective and experience of the privileged is a mistake not to be repeated. The debate among academic feminists about what

constitutes 'woman' continues but everyone knows who women are. As Finlayson (2016) suggests women are 'those who are oppressed as women (and oppressed also by dominant biologicistic and essentialist usages of the term 'woman' (Finlayson, 2016, p.46). Particularly from an activist point of view to ignore the fact that women are gendered is to 'ignore facts about our social arrangements that those who seek justice cannot ignore' (Haslanger, 2005, p.11).

In this study I will use the sex/gender terminology as it is traditionally understood because 'the refusal to use any sex or gender terms would make it virtually impossible for us to talk about what we want to talk about' (Finlayson, 2016, p.44). Challenging women's gender based oppression is fraught with difficulties. Those willing to consider facing the challenge need the support of a discourse that relates to their everyday experiences, and they need ideas that they can adapt to their own practice. It is understandable that, if faced with complex, theoretical language and arguments characteristic of much feminist literature, practitioners will instead put their energy into addressing one of the many, less challenging areas of injustice.

In this study the concept of 'doing gender' which was introduced by West and Zimmerman in 1987, is used to support participants' efforts to explain their understanding of the complex concept of gender. The aim of their often quoted article was to:

advance a new understanding of gender as a routine accomplishment embedded in everyday interactions (West and Zimmerman, 1987, p.125).

This 'new understanding' was premised on gender not as a biological trait but as a social construction based on sex categorisation of male and female. West and Zimmerman's proposal was that women and men perpetuate and reinforce gender differences in their ordinary, everyday interactions. In these interactions women and men create their own gender by structuring and demonstrating what is feminine and masculine and validating the female/male split as natural. Through these everyday interactions the established gender based differences that create the unequal social stratification that positions women as subordinate are legitimised.

2.1.5 Patriarchy

Patriarchy is a system of social organisation based on the idea that men and women are biologically programmed to behave and think in a certain way. It creates a gendered social order based on these supposedly natural characteristics which positions men and male as dominant and women and feminine as subordinate. Patriarchy is an oppressive social system which devalues the roles and responsibilities regarded as women's work. In a patriarchal culture male characteristics and attributes are aligned with the core values of that society and the world is viewed from a male perspective. Johnson (2005) explains that 'a society is patriarchal to the degree that it promotes male privilege and by being *male dominated*, *male identified* and *male centred*' and that it is 'organized around an obsession with control and involves as one of its key aspects the oppression of women' (Johnson, 2005, p.5). For Daly (2011) patriarchy is a 'state of possession (that) stultifies women, who have layers of crippling thought-patterns comparable to the footbindings which mutilated millions of Chinese women for over one thousand years' (Moane, 2011, p.vii).

Characteristics socially constructed as masculine such as confidence, independence, decisiveness and competitiveness are arguably often easier for men to adopt and perform due to their culturally perceived 'appropriateness' (Francis, 2002). These characteristics are culturally perceived as more suitable for leadership roles and result in men generally occupying the most influential and public roles such as company executives and politicians. Meanwhile the supposed sensitive, nurturing and dependent nature of women results in the domestic roles of caring, childrearing and home making being regarded as women's responsibilities, particularly in patriarchal countries such as Ireland. In Ireland, as in other developed countries, much has changed in the gender system. However, due to what England (2010) describes as 'persistent gender essentialism' (England, 2010, p.149) the roles and responsibilities allocated to women continue to be undervalued.

In Ireland the system of patriarchy is endorsed by the Irish Constitution (Bunreacht na hEireann, 1937). As mentioned in the previous chapter, the constitution 'recognises a unique role for women in the home and as mothers' (Armstrong et al, 2007, p.4) and 'recognises the family as "a moral institution

possessing inalienable and imprescriptible rights” and guarantees to protect it and the institution of marriage’ (Armstrong et al, 2007, p.4). Women’s family and caring responsibilities remain embedded in the Irish Constitution and are underlined in social and economic policy.

The Constitution, according to Armstrong et al, is ‘particularly interesting’ because, despite the changes that have happened, ‘the Constitution is both relatively static (in that amendments require referenda) and of fundamental importance in shaping the content and scope of social policy’ (Armstrong et al, 2007, p.36). The power differential between women and men resulting from the patriarchal culture in Ireland means that, despite women’s objections to it over the eighty plus years since the drawing up of the Constitution, Article 41 remains:

‘41.2.1° In particular, the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved.

41.2.2° The State shall, therefore, endeavour to ensure that mothers shall not be obliged by economic necessity to engage in labour to the neglect of their duties in the home’ (Bunreacht na hEireann, 1937).

Article 41 is a reminder of the persistent and pervasive influence of the patriarchal gender regime in Ireland and how ‘unlike many other social differences, gender goes home with you’ (Ridgeway and Correll, 2004, p. 512).

Although it is a global issue, patriarchy, in relation to the cultural context of this study, ‘is useful as it highlights certain important and frequently ignored realities in Irish life’ (O’Connor, 1998, p.7). As discussed in Chapter One, Ireland has in the past been recognised as a particularly conservative country primarily because of the influence of the Catholic Church and the close relationship between the church and state. Today Ireland presents to the outside world as a modern democratic European state which set an example to the world when, in 2015, it was the first country to pass the marriage equality bill by a public vote. However, the ‘peculiarities’ of Ireland lead Armstrong et al to conclude that ‘Ireland is an unevenly modernised country’ (Armstrong et al, 2007, p.36) and, in contrast to the image of 21st century Ireland as a modern, democratic country, a

triumvirate of powerful internal influences, Church, State and nationalism, continue to combine to maintain a strong patriarchal culture. The especially insidious nature of these powerful influences creates particular difficulties for those who wish to challenge it, particularly feminism.

In the post-feminist, neoliberalist culture of post-Celtic Tiger Ireland (Ging, 2009) the gender related discourse has replaced the concept of 'ladylike' with the notion of girl-power. Girl power implies that women are now empowered and so the fun-killing, embittered rhetoric of feminism is no longer necessary. According to this post-feminist discourse gender equality is no longer an issue because, despite abundant evidence of gender equality deficits, gender equality is now a reality and empowerment is an available choice for every woman. In relation to women the contradictions in this post-feminist, neoliberalist narrative are patently clear with its confusing mix of gender related messages regarding women. Objectification of women is rife, and the influence of pornography is evident in the images of wide eyed, pouting, scantily clad young women on display everywhere. Post-feminist narrative presents this portrayal of women not as exploitative but instead as an empowered choice of women. For example, now that gender equality has apparently been achieved and women can act like men they can be 'free to make, and then enjoy, their own sexual decisions without interference from other people, the state, religion or the wider culture. In this land of make-believe 'Sex should be freely chosen, pleasurable, safe, uplifting and fun' (Redfern and Aune, 2010, p.49).

2.2 The social construction of health - the medical model

If the aim is to improve women's health and wellbeing a number of questions need to be addressed: What is health? Where is health created? and Which factors are important in improving health?

Two closely related but conflicting factors are particularly influential in understanding health. The first is that health is a social construct and a contested concept and what health means or how it is defined is dependent on the attitudes, values and norms and context of the situation. The second is that the biomedical model of health is the dominant influence in the understanding of health.

A clear truth about health is that it 'is not an objective fact. It is a subjectively understood concept' (Kiger, 2004, p.3). Menstruation for example has been, and still is in some cultures, regarded as a disease and it was believed that menstruating women could pollute things with which they came into contact such as crops, animals or humans. As recently as last century homosexuality was also classified as an illness in the western world and some cultures and religions continue to maintain that belief. So, ideas of what health is have changed radically over time. Viewed through a social constructionist lens 'the meaning we give to it (health), or the way that we understand it, is not straightforward or uncomplex' and there are 'many different ways of talking about health (discourses) may (and do) exist at any one time' (Warwick-Booth et al, 2012, p.17).

Health is a strong social value and 'is one of the few remaining social values that garners unambiguous support' (Hodgkin, 1996, p.1568), but getting clarity about definition can be challenging because people generally assume that everyone agrees about what health means. It is only when asked to come up with a definition of health, especially one that does not focus on health as simply the absence of physical disease, that people realise that defining health is not such a straightforward task.

In contrast to the examples of 'irrational' thinking about health mentioned above the 'rational', scientific certainty of biomedical science that is the basis of the medical model of health is comfortably convincing for many and is the dominant model of health and healthcare especially in the western world.

'One of the most criticized consequences of adopting the biomedical model is a partial definition of the concept of health' (Alonso, 2004, p.239). The scientific, reductionist and individualistic biomedical model of health which understands health in biological terms has a focus on physical health and curing disease, with health understood simply as the absence of disease. The traditional biomedical paradigm reflects the Cartesian division between mind and body (Alonso, 2004). In this understanding disease is a malfunction of the body and this malfunction is generally associated with a single, underlying cause and when 'medically defined illness and disorder are absent then health is assumed to be present' (Warwick-Booth et al, 2012, p.13). The biomedical model has made a significant

contribution to curing and controlling disease and it has ‘dominated medical practice because it has been seen to work’ (Bilton, et al, 2002, p.356). It has been and continues to be extremely influential particularly in Western societies and is the basis for most healthcare provision. However, contemporary post-positivist culture has identified a range of problems with the biomedical model and its understanding of health including: ‘(a) a reliance on quantitative and statistical approaches to understanding health and its determinants; (b) a tendency towards viewing the sources of health and illness as emanating from individual dispositions and actions rather than resulting from the influence of societal structures; (c) a professed commitment to objectivity or what is termed a non-normative approach to health issues; and (d) a profound de-politicising of health issues’ (Raphael et al, 2008, p.224). With the changing conceptualizations of health and increased acknowledgement of the social determinants of health, efforts have been made by health services to incorporate a social dimension into healthcare policy and practice. Efforts have met with limited success as ‘the focus on social factors has been directed to a narrow range of primary prevention activities - largely individual responsibility for personal health practices such as diet, exercise and avoiding tobacco which reduce the risk of disease’ (Ruzek et al, 1997, p.17). The lack of movement in relation to how health is conceptualised in medical research was uncovered by Alonso who found that ‘contrary to expectations, findings show no change in the conceptualisation of health in medical research articles written 20 years ago and now’ (Alonso, 2004, p.243).

2.2.1 An androcentric medical model of health

The biomedical model and the biomedicine that informs it is an example of the ‘institutionalized, normalized politics of male supremacy’ (Harding, 1992, p.568) so dominant in science. It is a typical example of what is identified in feminist scholarship as ‘androcentric’ because ‘it depicts the world in relation to male or masculine interests, emotions, attitudes or values’ (Anderson, 2011, p.6). How gender influences knowledge, our conceptions of it and how we understand and develop it forms the foundation of feminist epistemology and the discriminatory nature of male dominated knowledge production has been a cause of concern and focus of criticism in feminist epistemology studies for decades. The

androcentricism of medical science, which could only be purposefully challenged once 'a critical mass of women existed in the profession' (Dan, 1994, p.254), discriminates against women principally by excluding them from research. Male dominated science also discriminates through having 'a focus of problems of primary interest to males, faulty experimental designs, and interpretations of data based in language or ideas constricted by patriarchal values, (and because) experimental results in several areas of biology are biased or flawed' (Dan, 1994, p.253). The androcentric bias also affects the allocation of resources. As well as the ethical questions the under-representation of women in medical science raises, the paucity of research that includes women exacerbates the marginalisation of women and inevitably puts them at risk of inappropriate treatment and poorer quality healthcare (Hochleitner, Nachtschatt and Siller, 2013).

The workforce of health promotion is, like the health sector generally, predominantly female. However, health promotion is a minor occupation in a hierarchical, male dominated sector, one in which 'traditional medical and interprofessional hierarchies persist' (Gordon et al, 2015, p.1). This dominance controls an agenda that, it is reasonable to believe, is strongly influenced by an androcentric perspective.

The world of biomedicine and the ethical questions raised by the exclusion of women from medical research may seem to be far removed from the policy and practice of health promotion based on a social determinants model of health. However, the priorities of health promotion, as a discipline within the health sector, are informed by medical science, medical sector priorities and management systems, all of which generally work independently of the social context of peoples' lives. A lifestyle approach which focuses on such things as diet, physical activity, weight, smoking and alcohol consumption and has behaviour change as a goal is a disease based approach which locates responsibility for health with the individual. However, social structural conditions are a major influence on lifestyle choices and this is why a lifestyle approach 'lacks persuasive evidence of success' (Keleher, 2007, p.331). As a narrowly focused, disease based approach lifestyle, behaviour change

programmes 'do not reflect the more complex values and intentions of health promotion that reside in the WHO charters' (Keleher, 2007, p.31).

The dominant ideology of medicine is not the only influence on a choice of approach that many regard as contrary to health promotion ideology and values. Since the 1980s and the rise of the neoliberalist politics typified by Thatcher and Reagan, public services have been systematically targeted in efforts to reduce public spending. New Public Management (NPM) is the system of management designed to apply neoliberal principles to the management and structuring of the public services. Part of the efforts to develop a new ethos the policies of NPM 'employ a discourse that parasitizes the everyday meanings of their concepts - efficiency, accountability, transparency and (preferably excellent) quality - and simultaneously perverts all their original meanings' (Lorenz, 2012, p.599).

'Feminists have consistently played a key role in movements challenging the biomedical approach' (CWHN, 2009, p.1). The entry of feminism into medicine and other fields of knowledge acquisition meant that different questions were asked and the distortions of androcentric knowledge production and attribution were challenged. A feminist perspective on health is inherently social. It rejects the narrow disease focus of biomedicine and challenges the epistemic authority of the white male dominated culture in science that produces it and advocates for the production of knowledge that supports a social justice agenda. Feminist epistemology recognises that truth is never value free and therefore any truth is a partial truth but a better truth or a more complete perspective can be achieved by opening up research and knowledge development to incorporate different perspectives based on different experiences and different ways of understanding the world. Different perspectives ask different questions and identify different issues and incorporating these different perspectives into the process of knowledge development according to Harding (2009) leads to 'strong objectivity'. Strong objectivity is a central notion in Harding's standpoint theory, an approach which counters the androcentric culture of knowledge development and production through 'its commitment to the high value of women, their activities, needs and desires' (Harding, 2009, p. 193). In an effort to achieve a better truth 'Feminist scholarship and research strive to give voice

to women's lives that have been silenced or ignored, uncover hidden knowledge within women's experiences and bring about women-centred solidarity and social change' (Hesse-Biber and Leavy, 2007, p.54). In standpoint theory, one of the most respected and influential approaches to achieving this aim, the situated knower and how gender situates that knower are central concepts. The basic premise of this theory is that the knowledge of the situated knower is situated in the social, cultural and political experiences of individuals so that 'people may understand the same object in different ways that reflect the distinct relation in which they stand to it' (Anderson, 2011, p.2). Incorporating the knowledge of the marginalised and oppressed is important to set right the distortions that result from the partiality and bias of the dominant androcentric knowledge base and 'to repair the historical trend of women's misrepresentation and exclusion from the dominant knowledge canons' (Hesse-Biber and Leavy, 2007, p.56). Epistemic value and authority is accorded to situated knowledge due to its critically reflective nature. In other words the 'epistemically privileged standpoint is an achieved, not a given, perspective requiring critical reflection' (Anderson, 2011, p.16).

The seemingly 'objective', 'scientific' nature of the biomedical model, in which the presence or absence of disease is decided by scientific assessment regardless of how a person feels, is regarded as a negative model of health. Despite the successes of medical science its limitations could not be ignored by those responsible for the health and healthcare provision for populations and those with the desire for a more positive approach to health, one that would aim to produce health and not simply cure disease. The frequently quoted World Health Organisation's definition of health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease' (WHO, 1948) is perhaps the best known positive definition of health. This definition, which aimed to broaden the understanding of health, incorporates the concept of wellbeing and recognises the mental and emotional as well as the physical aspects of health. The 1948 definition, often criticised for being too idealistic, was refined in the Ottawa Charter of 1986 which asserted that:

'To reach a state of complete physical, mental and social wellbeing an individual or group must be able to identify and to realize aspirations, to satisfy needs and

to change or cope with the environment. Health is therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources (WHO, 1986)

This definition extends understanding of health to well beyond the medical sphere and implies an intrinsic relationship between the body and the self. The original WHO definition of health and the updated one of the Ottawa Charter suggests a positive, more holistic understanding of health that includes not only physical health but also mental spiritual and social health. It is the understanding of health that informs the concept of women's health in this study.

2.3 The social construction of health and the social determinants model

The social determinants model of health provides 'an alternative paradigm for understanding health and its mainsprings' (Raphael et al, 2008, p.226). Within this paradigm the notion that health is socially constructed is key. In contrast to the medical model the social determinants model recognises that health is influenced by a range of different factors. In the social determinants model the range of influential factors that dictate health and wellbeing are to be found in 'the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems' (WHO, 1986). The social determinants are the root causes of health and wellbeing and of ill-health and unless policy and practice recognises and understands these root causes their negative impact will be missed.

The commonly quoted rainbow diagram of Dahlgren and Whitehead (Dahlgren and Whitehead, 2006, p.19) is regarded as one of the most effective representations of the social determinants of health. The diagram highlights individual and social factors. Positioned in the core of the diagram are attributes relating to age, sex and hereditary factors, factors that are generally fixed. Moving out from the core there are individual factors and then relationships with family, friends and others in the local community. In health promotion these are referred to as downstream factors or determinants. Upstream factors are

identified in the two outer layers with the inner one focusing on 'Living and working conditions' and the final layer identifying 'General socio-economic, cultural and environmental conditions'. It is usual for policy documents on the social determinants of health to list or provide examples of determinants and related objectives. It is not uncommon for gender to be completely invisible in these influential documents despite the fact that they profess to be based on a social determinants model. A report published by the WHO regional office for Europe which claims to present the 'Solid Facts' (Wilkinson and Marmot, 2003) on the social determinants of health is an example of such gender-blindness. This gender-blindness in such influential documents supports a culture of gender-blindness at practice level.

The suggestion of a gender-blind culture in healthcare policy and practice seems to be contradicted by the almost global adoption of gender mainstreaming policy and accompanying discourse as an approach in public service organizations including healthcare. Gender mainstreaming is a strategy designed 'to counter the gender bias in regular policies, and to avoid the continuous reproduction of male norms in policy making' and to 'address to genderedness of organisations' (Benschop and Verloo, 2006, p.19). Kuhlmann and Annandale (2010) suggest that the impact of gender mainstreaming has been less successful than related discourse suggests as efforts at implementation 'are shadowed by unsolved gender troubles' (Kuhlmann and Annandale, 2010, p3). The obstacles to gender sensitive healthcare and implementation of gender mainstreaming are many and formidable. For example, 'attempts to mainstream gender into healthcare often turn out to be simplified reports of sex differences without taking account of the complex life conditions of men and women and the gendered dimensions of the organization and delivery of healthcare' (Kuhlmann and Annandale, 2010, p.1). A common obstacle is the belief that gender is a simple technical problem that can be addressed by the provision of implementation guidelines and gender training. The lack of understanding relating to gender means that 'there is no real consensus about what the problem is exactly, about why and for whom it is a problem, about who is responsible for the existence of the problem, or who is responsible for solving it' (Verloo, 2001, p.14).

2.3.1 Inequity v inequality

What is valued as evidence in health related research reflects the positivist rational culture of medical science, an approach which looks for clear, specific pathways between cause and effect. Against this background the complex pathways between social factors of health present significant barriers to the development of an integrated evidence base. One significant outcome of efforts to incorporate evidence of the impact of social factors on health is the clear disparities in the health of populations, a development that has given rise to the concept of health inequities and the health inequalities movement.

The terms inequity and inequality are used interchangeably but there are differences between them. Health inequalities, the term preferred in Ireland, 'is seen as referring to value-free observable differences' (Venkatapuram, 2011, p.174) and identifies differences in measured health related outcomes as understood in the field of health, that is incidence of disease and mortality. Where the term inequality is used the cause of the disparity and who has responsibility for addressing it is often vague. The concept of health equity has been used by some who are concerned to reorient the discourse and expand the perspective of health related research. The term, which underlines the unjust and unfair nature of influences that are regarded as unnecessary and avoidable and which constrain the production of health and the ability to live to one's potential, reflects a more philosophical perspective on health and the social determinants. In this discourse health inequities are 'morally troubling' and addressing them is a 'matter of social justice' (Venkatapuram, 2010, p.6). The influence of poverty, or socio-economic disadvantage, is clearly acknowledged as a factor in health inequalities and, although health promoting interventions commonly target economically deprived communities, the focus is generally on lifestyle factors and behaviour change, an approach which places responsibility for change on the individual rather than the structures and systems that lie at the root of poverty. Whatever approach to health inequalities is favoured the discourse underpinning policy and practice is generally gender-blind. As the list below from Braveman highlights (Braveman, 2010, p.32), even when a relatively comprehensive range of factors is identified, gender as a social determinant of health is rarely acknowledged:

‘Social conditions include not only features of individuals and households, such as income, wealth, educational attainment, family structure, housing, and transportation resources, but also features of communities, such as the prevalence and depth of poverty, rates of crime, accessibility of safe places to play and exercise, availability of transportation to jobs that provide a living wage, and availability of good schools and sources of nutritious food in a neighbourhood’ (Braveman, 2010, P.33).

The field of health like any other body of knowledge and practice has its own language and perspective and, despite recognition of the role of socio-cultural factors in the production of health, efforts to reorient health related discourse to the need to produce health rather than curing disease have largely failed. The structures and systems that form the foundation for the social determinants of health have largely remained unscrutinised as ‘The focus on risk factors has tended to lead not away from but back to the health care system’ (Evans et al, 1994, p.43). The reorientation of the discourse is hampered by the medical origins of the concept framework within which health related research is situated. Medical research, including investigations relating to health inequalities is informed by traditional medical reasoning and a positive, scientific approach which ‘strips human realities of much of their social context’ (Evans et al, 1994, p.98).

2.4 Women’s health

‘To a large extent the study of ‘women’s health’ has in fact been the study of women’s illness’ (Lee, 1998, p.3) and women’s health, including the promotion of women’s health has reflected a negative, biomedical influenced perspective. Within this perspective there has been a tendency to medicalise natural events in women’s lives such as menopause and menstruation and to blame any women’s problem on hormonal disturbance. Doyal (1995) expresses particular concern about how women have been damaged by the fact that their higher rates of depression ‘have often been blamed on hormonal disturbance, leading not only to inappropriate treatment but also to a mistaken naturalisation of gender divisions that are essentially social in origin’ (Doyal, 1995, p.16). Diseases of particular interest have included heart disease, cancer and HIV and

the promotion of women's health has emphasised related risk factors and behaviour change. While these issues are important, the focus on 'the woman in a complex, social and cultural context' (Lee, 1998, p.3) has been neglected.

Feminist approaches to health have been inherently social and favoured a more holistic understanding of women's health. The efforts of the women's health movement underline the importance of health and wellbeing to women. Over the past fifty years much of the work of the women's health movement has been about 'women reclaiming power from the paternalistic and condescending medical community' (Nichols, 2006, p.56) and emphasising the importance of personal experience. This male bias affects what priorities are set, how problems are defined and how resources are allocated. It is a perspective that neglects women's needs and concerns. It was and still is a perspective 'that placed women in a secondary position to men's, or that ignored them altogether, using the male experience as the normative experience on which to evaluate health and disease' (Dan, 1994, p.x). The damaging impact of the paternalism in medicine and healthcare on women gave rise to a women's health movement that renounced the dominant, biomedical male bias with its narrow disease focused conceptions of health 'because they leave out, or only nominally consider, the social forces and contexts that shape women's health and women's lives' (Ruzek et al, 1997, p.12). Within the medical model of health the gender-blind, androcentric bias in medical research, which regards the male as norm and excludes women, has been another concern of the women's health movement. A primary concern centres on the ethically troublesome habit of giving treatments to women that are based on men only trials. Research relating to cardiovascular disease, a disease traditionally designated as a male disease, and a priority in health policy has been particularly male biased: 'The underrecognition of heart disease and differences in clinical presentation in women lead to less aggressive treatment strategies and a lower representation of women in clinical trials' (Maas and Appelman, 2010, p.598).

The second wave of the women's health movement was led by a partnership of women's health advocacy groups and professional women. Women's health was seen by many of these second- wave activists as 'a new discipline in the process of creating itself' (Dan, 1994, p.ix). A key development was an upsurge in the

publications on women's health by women's health advocates, mainly academics from a range of academic disciplines, outlining women's perspectives on women's health and proposals for the direction this new discipline should take (Dan, 1994; Ruzek, Olesen and Clarke, 1997). The literature shows that efforts were made to incorporate an understanding of the impact of social factors and women's life experiences on women's health. However, because they were done 'largely with the framework of clinical practice' (Ruzek et al, 1997, p.13) these efforts were only of limited use in broadening understanding of what constitutes women's health. Ruzek et al (1997) were concerned to reframe women's health 'to realise the vision set forth by the WHO', suggesting that the starting point was to rethink 'where health is located' (Ruzek et al, 1997, p.13). The task, they explained, was to 'conceptualise women's health as *embedded in communities*, not in women's individual bodies' and by doing so, to 'lay a foundation for envisioning very different models of women's health from those that now predominate' (Ruzek et al, 1997, p.13).

The changed nature of the women's health movement has hindered the reconceptualising of women's health within a social determinants framework. Increasingly the movement has split into disease focused advocacy groups with the result that women's health has been fragmented into isolated problem areas with a focus on illness. These groups are generally run by professionals who aim to work with the relevant mainstream institutions, rather than transform them. Although the position of such groups is generally embedded in women's rights and issues of justice women do not need to be feminist to support them as they 'don't necessarily take a larger societal perspective that recognises and fights against gender injustice' (Baird et al. 2009, p.121). A number of other factors make these women's health groups acceptable to the mainstream. As the groups can claim to be working for the benefit of all women and generally work with politically safe issues they are often supported by elected representatives, positioning them closer to the centre of decision and policy making: 'President Clinton welcomed the breast cancer activists' petitions, giving them an elaborate ceremony in the East Room of the White House' (Baird, 2009, p.25).

Women's health in this study is based on a more holistic definition of health than that understood in the biomedical model of health. This holistic definition

incorporates wellbeing and includes not only physical health but also mental and social. Increasingly definitions include the idea of spiritual health which encompasses the values and beliefs that provide a purpose in life. The framework proposed in this study combines three essential elements:

1. A holistic definition of health, incorporating a social determinants model of health
2. An emphasis on health promotion and
3. Health as a matter of social justice

These combined elements support a positive vision of women's health which is about women's flourishing and the realisation of their potential and recognises the importance of promoting efforts to achieve that vision. As well as reframing women's health as a positive concept, elements one and two support the promotion of a concept of women's health that moves beyond a negative disease based model and the problem of medicalisation to one that emphasises the importance of the social, emotional, psychological and spiritual aspects of health and wellbeing.

2.4.1 Women's health: a matter of social justice

This study argues for recognition of women's 'a human right to be healthy' (Venkatapuram, 2011.p.3) an argument supported by a feminist analysis which highlights gender. Gender based arrangements in a patriarchal society are 'a central feature of the social context' (Moane, 2011, p.8) and this argument establishes a sound ethical basis for positioning women's health within a social justice framework that recognises the relationship between women's health and social and cultural arrangements. Patriarchy legitimises a power differential that positions women as subordinate, a social arrangement that constrains women's freedom to be and do as they want and as an oppressive regime it constrains women's potential for health and wellbeing. The social determinants of health underlines the significant influence social arrangements have on the potential for health and wellbeing. Incorporating a social model of health with the conceptualization of women's health as a social justice issue highlights how these unjust, socially constructed and avoidable constraints impact on women's

potential for flourishing and the moral error of turning a blind eye to them as primary determinants of health while driving an individualist, lifestyle and behaviour change agenda. Conceptualising women's health as a matter of social justice shows respect for the 'equal moral worth and dignity' of women and 'their freedom to determine, pursue and revise their life plans' (Venkatapuram, 2011, p.3) and supports a goal of reorganisation of social arrangements that reflects a more just society. Turning a blind eye to the impact of social factors on women's potential for health and wellbeing and continuing to promote a biomedically influenced victim-blaming, lifestyle approach is unethical and unjust.

'The centrality of human health and longevity to social justice is so patently obvious to some people that they simply take it as a starting point' (Venkatapuram, 2011, p.2). So, while reframing women's health as a matter of social justice is not common, it is equally not unique. In his rationalisation of the importance of recognising health as a matter of social justice Sen (2002) uses the concept of health equity and explains that 'health equity cannot be but a central feature of the justice of social arrangements in general' (Sen, 2002, p.659). Echoing the importance women attach to health, as evidenced by the development and activities of the women's health movement, Sen describes health as 'one of the most important conditions of human life' and recognises health equity as essential to the 'capability to achieve good health' (Sen, 2002, p.660).

Within the social determinants model of health this study understands women's gender based inequality as an inequitable social construct. This construct constrains women's potential for health and wellbeing by limiting their opportunities to flourish and realise their potential, and are a key consideration in any concept of social justice. Understanding women's health and wellbeing as a matter of social justice confers a responsibility on institutions such as health promotion and community development, institutions that espouse values and beliefs of social justice, to promote women's potential for health and wellbeing and to challenge the factors that constrain that potential.

A critical consideration of the practical application of women's health as a matter of social justice by the relevant institutions requires a feminist analysis

which identifies patriarchy as a discriminatory gender regime that constrains women's 'abilities to be and do things' (Venkatapuram, 2011, p.233) and consequently, their opportunities and capacity to flourish.

There is little evidence in the data in this study that participants consciously challenged patriarchy and its role in women's gender based oppression in their work. According to Aronson (2017) this absence of conscious feminist activism casts doubt on the potency of a feminist identity:

Feminist identity is undertaken when women explicitly identify with feminism as an ideology and/or social movement. When taking on feminist identities, women not only recognise and critique gender inequalities, but develop alternative visions for gender relations. Feminist identities are often, although not always, connected with activism (Aronson, 2017, p.2).

The 'embeddedness of gender in identity' (Meyers, 2002, p.11) can present a significant challenge to a transformative approach to addressing women's gender based oppression that recognises and understands the feelings and behaviours relating to internalized oppression. Without the consciousness that such an analysis provides, activism to address women's oppression will not happen. This need for consciousness is recognized by Ledwith (2005) in her framework for a critical approach for community development, a framework that influences the one proposed in this study. In her framework Ledwith partners feminism with the Freirean concept of conscientisation. Freire explains that the process of conscientisation 'makes oppression and its causes objects of reflection by the oppressed and from that reflection will come their necessary engagement in the struggle for their liberation' (Freire, 1996, p.30). The need to address the issue of the suppression of women's voices and women's passivity and denial in the face of 'everyday sexism' is made clearly evident in the Everyday Sexism project and vividly recorded in the analysis of the project (Bates, 2014). Sexism, according to Bates' analysis, 'seems to occupy a uniquely acceptable position when it comes to public discourse, with a general willingness to laugh and ignore it rather than define it as the prejudice it is' (Bates, 2014, p.29).

This understanding of women's health is, however, hampered by a paucity of relevant literature. Health related literature and opinion is developed and

produced from within health disciplines so it reflects the discourse, priorities and thinking of this professional background. Even the literature linked to health promotion and social determinants of health reflects a preoccupation with the biomedical and with illness and disease.

In this chapter the foundations for this study have been laid out with an analysis of the key concepts and their relevance to this study, gender and health and wellbeing, leading to the conclusion of women's health and wellbeing as a matter of social justice. The analysis provides a clear reference point for the discussion in the following chapter of the two professional disciplines that are relevant to the study, health promotion and community development.

Chapter 3: Health Promotion and Community Development: different disciplines, common issues

In this chapter I discuss the two disciplines pertinent to this study, Health Promotion and Community Development. After a short introduction which presents some of the general connections between the two, I discuss each of the disciplines and associated relevant issues in turn, starting with health promotion. As a women's health officer I worked with practitioners in both disciplines and my ideal research study would have involved both in an exploration of the attitudes and beliefs regarding gender and its relationship with women's health and wellbeing. However, as women's health and wellbeing is identified in this study as a social justice issue, I now argue that it is a matter best tackled through the lens of community development.

After each of the disciplines is discussed, in Sections 2.3 and 3.3, some of the issues common to both disciplines and pertinent to their potential to tackle women's health and wellbeing as a social justice issue are addressed.

3.1 Setting the scene - an introduction to the connections between health promotion and community development

Health promotion and community development share a wide range of commonalities. Both can be a discipline, an approach or a movement, both have a history of struggling for status and recognition, and the role and purpose of both have been and are 'constantly contested and revisited' (Gilchrist, p.115). Espoused values and principles are shared and they both share a vision of building healthier communities, commonalities that suggest a natural partnership. As an approach community development has been recognised as desirable by health promotion since its inception as a new health related discipline in the Ottawa Charter and, in more recent times, the commitment of community development to health is evidenced by the increasing number of organisations specifically linking the two. In Northern Ireland, for example there is the Community Development and Health Network (CDHN) which describes itself as 'the leading organisation championing community development approaches to tackling health inequalities' (<http://www.cdhn.org/>). In Scotland

the SCDC (Scottish Community Development Centre) provides training based on its learning resource 'Community-Led Health for All: developing good practice' (<http://www.scdc.org.uk/>). In the Republic of Ireland 'health issue groups are now a distinct part of the voluntary and community sector' (Combat poverty Agency, 2007, p.8). Some are of the opinion that for community development to meet the many challenges it faces and to enhance its chances of survival there is an 'urgent need' to become 'much more firmly embedded across a whole range of programmes' (Gilchrist and Taylor, 2011, p.118) including health and wellbeing.

The link between health and community development was embedded in the Ottawa Charter (WHO, 1986), the international agreement that officially recognised health promotion as a new approach to health and a new discipline in health service delivery. The need for this new development was an increasing concern about the limitations of the curative, disease focus of the biomedical model and a belief in the need to embrace a social model of health to build health. According to the Charter the basic strategies of those involved in health promotion included advocacy, mediation and enabling (Kokeny, 2011; Saan and Wise, 2011). As advocates health promoters are encouraged to make the many conditions that influence health, social, economic and environmental, favourable to health. As enablers health promotion is focused on equity and is about supporting people to control things that might prevent them from achieving their fullest potential. As mediators, health promoters aim to 'arbitrate between different interests in society for the pursuit of health' (Scrivan and Garman, 2005, p.10). As well as outlining the roles of health promotion the Charter identifies the approaches for health promotion: build healthy public policy, create supportive environments, strengthen community actions, develop personal skills and reorient health services. With the Ottawa Charter, a more holistic definition of health and official recognition of the many factors outside of the health services that influence health, combined with the particular knowledge and skills in community development in community engagement, the foundations are laid for a relationship between community development, both as an approach and a discipline, and health promotion in an effort to build healthy communities. These foundations also provide a base for

the recognition of women's gender based oppression as a health issue and the possibility for both health promotion and community development to address this social injustice within the remit of health, a possibility supported by this research study.

3.2 Health Promotion as a Discipline: introduction and general issues

In any discussion about health promotion it is difficult to avoid the question of what health promotion actually means and what health promotion does. In other words, what is being promoted in the name of health and how as 'health unlike disease has a plurality of meanings' (Labonte, 1998, p.9), it is not surprising to find that 'there is no singularly accepted definition of health promotion' (Laverack, 2007, p.3). Expressing concern about the possibility of the term promotion suggesting 'a propaganda approach dominated by the mass media' (Ewles and Simnett. 1999, p.23) Ewles and Simnett explain that *promotion* in the context of health promotion means 'improving health: advancing, supporting, encouraging and placing it higher on personal and public agendas' (Ewles and Simnett, 1999, p.23). For its definition of health, health promotion refers primarily to the WHO definition which states that health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1946). Cribb and Duncan (2002) find the WHO definition useful when exploring the concept of health promotion as it differentiates between the positive and negative or broad and narrow understandings of health as I have discussed in Chapter 2, Section 3, and helps to explain what the difference means for health promotion. The different models 'give us very different pictures of health promotion:

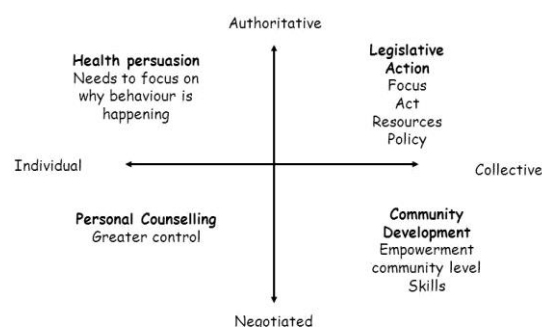
*From the negative model and the narrow definition, health promotion is disease prevention; and
from the positive model and the broad definition, health promotion is wellbeing promotion* (Cribb and Duncan, 2002, p.13).

The different conceptions of health promotion have resulted in a certain elasticity in what health promotion does and what it is understood or expected to do and the different goals of health promotion have led to different approaches. These different goals and approaches of health promotion can be

divided broadly into two camps, individual or structural, reflecting different political perspectives and deep seated beliefs about what health is and what should be done to achieve it. Developments and refinements over the lifetime of health promotion have resulted in range of approaches based to a greater or lesser degree on these different perspectives. The recognised approaches include: ‘medical or preventive, behaviour change, educational, empowerment, social change’ (Naidoo and Wills, 2000, p.91). In practice the dividing line between the different approaches has been quite fluid and efforts to categorise the wide variety of programmes and activities that gather under the umbrella of health promotion have ‘generated a plethora of models and typologies’ (Naidoo and Wills, 2000, p.109).

The principal models of health promotion are Caplan and Holland, 1990; Beattie, 1991; Tones and Tilford, 1994; Tannahill, 1985 and Green and Kreuter, 2000. In agreement with Naidoo and Wills, who regard the Beattie model ‘a useful one for health promoters’, I favour the Beattie model ‘because it identifies a clear framework for deciding a strategy, and yet reminds them that the choice of these interventions is influenced by social and political perspectives’ (Naidoo and Wills, 2000, p.107).

Beattie’s model of Health Promotion



Beattie’s model (Grinnell, no date) consists of four quadrants, arranged on two axes. The four quadrants generate four health promotion paradigms which represent the different ways in which health can be promoted by professionals, governments, and individuals, through health persuasion techniques, legislative action, personal counselling and community development. The two axes

represent ‘mode of intervention’ which can be authoritative (a top down approach) or negotiated (a bottom up approach) and ‘focus of intervention’ which can be individual or collective. The clarity of the Beattie model can be used to contest the often disingenuous nature of the claims made by policy makers and practitioners for many health promotion policies and programmes.

The Tones and Tilford model (Naidoo and Wills, 2000) is sometimes referred to as the empowerment model because of the emphasis it places on empowerment, ‘which is seen as both the core value and core strategy underpinning and defining the practice of health promotion (Naidoo and Wills, 2000, p.108). The principle of empowerment is legitimised by the Ottawa Charter and ‘refers to the process by which people gain control over the factors and decisions that shape their lives’ (WHO, 2009, Track 1, Community Empowerment). Laverack explains that ‘empowerment must come from within the individual and the groups that they form’ (Laverack, 2007, p.14). Within this understanding of empowerment the health promotion practitioner ‘is to catalyse, facilitate or “accompany” the community in acquiring power’ (WHO, 2009). The WHO description of empowerment as ‘co-ownership and action that explicitly aims at social and political change’ (WHO, 2009v) connects it with a community development approach, an approach that is identified as a central tenet within health promotion literature.

3.2.1 Ethics and evidence in health promotion

As health promotion continues to grapple with fundamental issues of identity, what health promotion is, what it does, how it should do it and why, there is a level of consensus among experts that two things are needed to address the problem: a clear evidence base and a strong ethics framework (Carter, et al, 2011; Mittelmark, 2007; Sindall, 2002). The reasoning is that each element will complement the other, ‘evidence based practice may be more ethical and ethically sensitive practice more effective’ (Carter et al, 2011, p.465).

However, despite the stated need for a more robust ethical framework, there is also a concern that there seems to be little enthusiasm or energy for the task and, despite the need for it, ethics is not an issue that health promotion has taken seriously. The topic is not seriously addressed in health promotion courses

and rarely appears at conferences or in professional journals (Mittelmark, 2007; Sindall, 2002; Yeo, 1993). Ethics, which questions if something is right or wrong, good or bad, may seem unnecessary to some, as the moral credentials of health promotion are obvious. Such a view is blind to the unease 'about issues such as 'paternalism', 'social engineering', the 'nanny state', 'privacy and interference with rights and freedoms' or about 'victim-blaming, or of 'failing to engage with the social determinants of health' (Sindall, 2002, p.202). The literature identifies a number of related, significant constraints on the development of these essential elements, particularly the formulation of the ethical framework. The most obvious constraint, particularly in the eyes of the practitioner as opposed to the health promotion academic is, in the culture of New Public Management (NPM), a lack of opportunity as delivering on practice targets takes priority. A second reason is that the absence of attention to the issue in health promotion training means there is a lack of capacity within health promotion to engage in the kind of critical dialogic discussion which is a key requirement for the elicitation of the knowledge and understanding required. A third constraint is a shift in the fundamental values from empowerment and social justice, which have been the cornerstone of health promotion since inception, to an emphasis on health economics in the more recent, 2005 Bangkok Charter. The Charter represents a 'shift from a 'new social movements' discourse of ecosocial justice in Ottawa to a 'new capitalist' discourse of law and economics in Bangkok' (Porter, 2006, p.72).

A number of significant barriers to establishing an evidence base for health promotion have already been identified. The problems are rooted principally in the permanent tensions between the competing paradigms and agendas of medicine and the medical model of health and health promotion and the social determinants model. The characteristics of the different paradigms are identifiable in the different perspectives on appropriate research approaches and what counts as evidence. 'Even in 'hard' medicine, there are 'hierarchies' of evidence for actions and interventions' and 'some models of medical science and its evaluation exist which see it as well defined and grounded, and which seem to be dramatically different to the rather fuzzy and disputed picture of health promotion we have built up' (Cribb and Duncan, 2002, p.89). Pressure on

health promotion to develop a robust evidence base has increased with the rise in popularity of evidence based medicine (EBM). Evidence based medicine is based on the belief that medical practice or interventions should be based on the most appropriate evidence available. The aim of EBM is greater certainty in decision making in medical interventions and in medicine certainty requires hard, scientific evidence. The ongoing commitment of medicine to positivist, objective scientific research is underlined by the existence of the hierarchy of evidence in medical research. The hierarchy identifies the different types of research regarded as credible and ranks them according to strength. The aim of the approved research methods is to establish linear cause and effect relationships between variables and the focus is on disease or treatment outcomes. The hierarchy does not extend to non-traditional research approaches. Randomised controlled tests, which are the gold standard of the evidence hierarchy in medicine, may have their strengths in certain situations. However, the more complex understanding of health found in the Ottawa Charter, one that incorporates the social determinants, in which health is a positive concept that includes wellbeing, requires different research methodologies. These different methodologies need to reflect the theory and values of health promotion.

If the goal of health promotion is, for example, a reduction in morbidity or mortality then the technical efficiency of the positivist paradigm which presumes an objective reality and identifiable patterns of cause and effect and is favoured by biomedical science makes sense. If however the goal of health promotion is improved health and wellbeing based on a social determinants model of health and values of empowerment, inclusion and partnership, values that are part of the cornerstone of the Ottawa Charter 'which advocates a basic change in the way society is organised' (Davies and MacDonald, 1998, p.6), then health promotion needs a different approach. In his outline of what he regards as necessary characteristics of a suitable research approach for health promotion, Buchanan (2000) acknowledges that 'letting go of the idea that health promotion is a science like medicine' is a challenge for some and raises concerns 'especially in an age that puts a premium on power and efficiency' (Buchanan, 2000, p.134). In support of his proposed research approach Buchanan

refers to the work of sociologist Herbert Blumer. Blumer (1954), who was an advocate for naturalistic approaches to research describes a 'legitimate and important' kind of social research as one that aims to 'outline and define life situations so that people may have a clearer understanding of their world, its possibilities of development and the direction along which it may move' (Blumer, 1954, p.3). Following Blumer, Buchanan recommends 'Participatory research as the most logical approach' for health promotion. Characteristics that make participatory research suitable for health promotion include the fact that in such an approach 'researchers and community members would act as co-investigators; the research is more self-consciously and deliberately reflexive; it aims for mutual understanding, in which both parties would be equal teachers and learners' (Buchanan, 2000, p.136). These characteristics reflect a value base which is shared with critical knowledge approaches such as, for example, standpoint feminism which proposes 'asking research questions from women's points of view' and 'making women central to research in the physical and social sciences, as researchers and subjects' (Lorber, 2010, p.173).

Most health issues of social concern are not amenable to simple solutions. In contrast to the perceived rigour of the high ground, the 'swampy lowlands' are where 'situations are confusing "messes" incapable of technical solution' and where, according to Schon, 'the problems of greatest human concern are to be found' (Schon, 1991, p.42). This is where Beattie's radical community development approach to health promotion and a critical feminist approach based on a social determinants model of health are positioned. Those who are willing to enter the 'swampy lowlands' are driven by a fundamental belief that, however challenging the situation, it is the 'right thing to do'. They are willing to work with people to set out or define problems rather than arriving to implement a solution to an externally identified problem. They aim to work in respectful partnerships with people using participative methodologies with the aim of building women's capability for health and wellbeing. Those who work in the 'swampy lowlands' 'speak of experience, trial and error, intuition and muddling through' (Schon, 1991, p.43).

A feminist analysis adds to the gender neutral findings of Pickin et al (2002) and identifies the particular challenges that face those who want to progress a

transformative agenda that challenges the sexist culture of the health sector. The women's movement has long been active in challenging the gender bias in medicine and has been supportive of a social determinants model of health that reconceptualises women's health as 'embedded in communities, not just in women's bodies' (Ruzek et al, 1997, p.13). The congruence between feminist theory and the theory and principles of health promotion suggests an easy alliance. However, 'the funding for health promotion and the dominance of medical approaches have resulted in a narrowing of health promotion approaches' and a 'fixation in Western health promotion with health education and behaviour change' (Keleher, 2007, p.28). The gap between theory and practice in health promotion is also damaging for women as it can reinforce women's gender based inequality.

If any health promotion strategy is to be effective intersectoral collaboration is necessary. Throughout the development of health promotion a community development approach has therefore been recognised as a preferred approach.

3.2.2 Health promotion and a community development approach

Community development 'represents a broad approach to working with people in communities to achieve a greater level of social justice' (Gilchrist and Taylor, 2011, p.9). In health promotion, community development, which incorporates the concept of empowerment, is regarded as a bottom-up approach, one that supports a social determinants model of health and the understanding that 'health and wellbeing are shaped by a wide range of social, economic, political and organisational forces' (Braunack-Mayer and Louise, 2008, p.5). The concept of empowerment supports an understanding of health in positive terms, as wellness rather than illness. It conjures up images of capability, competence, strength and agency and points to the contribution of the social determinants instead of victim-blaming, a discourse that challenges the view of associating levels of health and illness with availability of medical staff and hospitals. The success of a community development approach with empowerment as an aim requires health promotion practitioners to participate 'as collaborators instead of authoritative experts' (Perkins and Zimmerman, 1995, p.570). Collaboration and intersectoral partnerships are not a new idea in health promotion. Such an

approach was ‘a fundamental tenet’ of the Alma Ata Declaration in 1978 (WHO, 1978) and has been an issue identified in every global health promotion conference since. In the 7th Global Conference in Nairobi in 2009, for example, the fourth of five conference themes, was ‘Partnerships and intersectoral action’ (WHO, <http://www.who.int/healthpromotion/conferences/7gchp/track4/en/>).

A community development approach positions health promotion in the bottom right hand quadrant of the Beattie model, where the mode of intervention is collective and negotiated, the mode of thought is participatory and based on subjective knowledge. It is an approach based on a radical political ideology (Naidoo and Wills, 2016, p.84). In reality most health promotion practice is ‘aimed at changing individual behaviour in order to prevent disease’ (Sheill and Hawe, 1996, p.241) and is, therefore, positioned in the ‘Health Persuasion’ quadrant which has an individualist, authoritative mode of intervention, based on a belief in objective knowledge and a conservative political ideology (Naidoo and Wills, 2016, p.84). This discrepancy between theory and practice is particularly evident in the theory and practice relating to community development and empowerment. It is also recognised as having contributed to one of the major tensions in health promotion as ‘many health promotion programmes continue to exert power over the community through ‘top-down’ programmes whilst at the same time using an emancipatory ‘bottom-up’ discourse of the Ottawa Charter’ (Laverack and Labonte, 2000, p.255). These ethically questionable approaches may achieve positive results for the middle classes but are ‘likely to impact negatively on many groups’ (Keleher, 2007, p.28) and actually contribute to inequity in health and wellbeing (Bunton et al, 1995; Goldberg, 2012).

Health promotion behaviour change interventions reflect the emphasis placed on individual responsibility for health and healthcare in contemporary health policy (Boyce, Robertson and Dixon, 2008). Behaviour change interventions are typically targeted at people in lower socioeconomic groups because of a causal link made between a higher level of ‘bad behaviours’ (Boyce, Robertson and Dixon, 2008) such as smoking, excessive alcohol consumption, poor diet and lack of exercise, and a greater level of chronic disease than that found in the more

affluent socioeconomic groups. As well as a lack of evidence of effectiveness and accusations of paternalism, critics question the ethics of these interventions because of the underlying assumption that 'lifestyle choices are truly free in the relevant sense' when they are in fact 'subject to strong influence by cultural, environmental and socioeconomic factors' (Dawson and Grill, 2012, p.102). The inherent victim-blaming of the health promotion behaviour change agenda along with the paucity of evidence regarding effectiveness and appropriateness of such interventions points to a need for more ethically acceptable approaches that recognize the unequal circumstances of peoples' lives. Such approaches will 'involve seeking to discover impediments to health and what makes lives go well' and will 'see justice as being relevant to thinking about these issues' (Dawson and Grill, 2012, p.102).

As Makara states, 'The path of victim-blaming leads nowhere' (Makara, 1997, p.97) especially when it ignores social and structural constraints. The victim-blaming approach of health promotion can be particularly damaging for women. For example, interventions can 'place responsibility for health on women without recognizing their relative lack of power to effect change' (Daykin and Naidoo, 1995, p.59) and often 'position women in relation to heterosexual relationships of cohabitation and marriage, rendering the lives of women outside of these arrangements invisible' (Daykin, 1996, p.339). By reinforcing the notion that women are responsible for the health and health behaviours of others, without taking any account of their relative lack of power in a gender based society, health promotion programmes can be exploitative of women, sustain gendered norms of oppression and constrain women's potential for health and wellbeing. Again, the situation highlights again a clear gap between rhetoric and practice in Health Promotion and is, for me, a substantive issue in the promotion of women's health, one that questions the moral and ethical foundations of health promotion practice.

Against a backdrop of ever changing social, political and economic situations locally, nationally and globally the conundrum of what the goal of health promotion is and how it should go about achieving that goal remains an issue but gaining ground in the efforts to find a solution to the health promotion conundrum is the idea of an ethical framework. The question of an ethical

framework for health promotion needs to be understood in an organisational context, an issue that seems to get lost in the literature but one which I believe is significant.

3.2.3 Barriers to community engagement

Before introducing community development I will close this section on health promotion by considering organisational barriers to community engagement. While the barriers are common to both disciplines they generally present greater challenges for health promotion when situated in the health sector where health as defined by health services, not community, is the primary focus.

Community engagement has become an active strategy of statutory organisations in recent years. In some jurisdictions local agencies are legally obliged to engage with communities. The National Standards for Community Engagement in Scotland, originally drawn up in 2005 were refined and republished in 2016 (SCDC, 2016). The document defines community engagement as: 'Developing and sustaining a working relationship between one or more public body and one or more community group, to help them both to understand and act on the needs or issues that the community experiences' (SCDC, <http://www.scdc.org.uk/who/what-is-community-development/>). The language and purpose of engagement can vary. As well as engagement, consultation and involvement are often used terms. Reasons for engagement include decision making, service improvement, community building and social change. The increase in community engagement has resulted in the development of a 'substantial body of literature on the subject' and the production of resources such as toolkits and guideline documents to support such activities. The toolkits often provide relevant advice pertinent to all parties involved but it is customary for particular attention to be paid to building the capacity of community participants. However, research carried out by public health researchers that looked at what 'constrains the capacity of statutory organisations to work effectively with lay communities' showed that 'Community capacity to engage' is only one of five domains that influence effective engagement (Pickin et al, 2002, p.37). With analysis based on literature, interviews and a workshop, Pickin et al identified the 'main problem' as 'No strategic approach to working with

communities' and a wide range of contributory organisational and professional barriers including: 'Skills and competencies of organisational staff; professional service culture; organisational ethos and culture and the dynamics of the local political system' (Pickin et al, 2002, p.37).

The results of the research by Pickin et al (2002) point to a need to address internal, organisational constraints when planning to engage with communities, particularly with initiatives that have a commitment to empowerment.

Speaking from the experience of having been involved in health promotion as well as a certain level of academic examination I am very conscious that apart from 'being very difficult to pin down for descriptive purposes' health promotion is 'the subject of fierce and incessant disputes among professional practitioners and policy makers (Gabe et al, 2002, p.162). The already identified gap between theory and practice and the tendency of health promotion to advance camouflaged biomedical ideals suggest that getting organisational consensus on any genuine community engagement initiatives could prove problematic. Some of the disharmony in health promotion results from the fact that health promotion personnel commonly come from a range of professional backgrounds and training, a factor identified in Pickin et al's (2002) conceptual model. This can result in different views of health and opinions about the role of health promotion, a factor also identified by Pickin et al (2002). Some differences are rooted in the fact that health promotion is typically situated within a hierarchical health sector and funded as part of the health sector budget, a situation that is potentially significantly affected by a 'professional culture of power and control' (Pickin et al, 2002, p.39), in which health promotion is the weaker party.

In the health sector health promotion is a minor profession or occupational group within a hierarchy dominated by the medical profession, one of the few 'major professions' or 'highly specialised occupations' (Schon, 1991, p.23). These major professions are characterised by such things as rigour, technical expertise and unambiguous ends. They are inclined to opt for the 'high, hard ground where practitioners can make effective use of research based theory and technique', where 'they don't have to be fearful of entering a world in which they feel they do not know what they are doing' and where 'rigour' wins over 'relevance'

(Schon, 1991, p.42). Within health sector organizations health promotion is frequently positioned in public health and regarded as a subset of the public health workforce. Public health specialists are medically trained but are concerned with the health of populations rather than that of individuals. According to Schon's classifications public health professionals arguably belong to the highly specialized occupations. In public health the biomedical model is dominant and a preference for the 'high, hard ground' (Schon, 1991, p.42) is evident in the importance it attaches to 'its scientific functions such as epidemiology, data manipulation and communicable disease control' (Coen and Wills, 2007, p.233). Although the population health interest suggests potential for partnership between public health and health promotion in reality, because of fundamental differences in beliefs and values, health promotion has struggled for professional recognition. In contrast with the relative established professional status of public health, health promotion's struggle with identity along with the 'lack of consensus as to what health promotion specialists do' (Coen and Wills, 2007, p.232) has created tensions in the public health/health promotion partnership. These tensions and health promotion's secondary status in a 'political climate (that) favours quick fixes to defined problems with cost benefit analyses' (Hauge and Hem, 2011, p.80) constrains reflection and innovation and leaves health promotion vulnerable to the dominant viewpoint. These organisational characteristics along with the barriers found by Pickin et al (2002), which include a 'lack of respect and trust for lay views' and 'little recognition of benefits of working with communities' (Pickin et al, 2002, p.40), present a formidable challenge to the development of a community development approach by a health sector based health promotion.

3.3 Community Development as a discipline: introduction and general issues

A community development approach is an essential component of a feminist model of women's health promotion as 'Feminist organizing clearly identifies a worldview that centres on using feminist values and principles to eliminate structural forms of oppression, promote equal rights, and empower women' and uses 'a gender lens to define social phenomena and generate solutions to social problems' (Young Laing, 2009, p.24).

Community development is a global activity but, because the understanding and practice of community development is framed by the context in which it is situated, it is important to note that the specific context for this study is Ireland. Much of the analysis here references the UK and America because both have influenced the development of theory and practice in Ireland. In an Irish review of a guide to community development 'intended for UK practitioners' the reviewer is confident that 'because our definitions and models of practice are so close (the guide) is equally valid to the Irish context' (Lloyd, 2012, p.1).

O'Conneide and Walsh underline the closeness of the relationship between the UK and Irish approaches to community development when they introduce the Community Workers Co-Operative (CWC), a national organisation that supports community development in Ireland, as 'a body which in its approach and policies is very similar to the British organisation, the Association of Community Workers (O'Conneide and Walsh, 1990, p.331).

Ideally an analysis of any concept starts with a definition of the concept. The term community development, as generally understood today has existed in the UK since at least the mid-1960s when its popularity was marked by the launch of the Community Development Journal. The Journal, which has 'occupied a unique and important place in analysing, commenting upon and influencing community development throughout the world' (Poppo, 2006, p. 6):

celebrated the fiftieth anniversary of its launch in 2016. Introducing the anniversary issue the editors point out that elemental questions in relation to community development were still being asked stating that 'the content (of the anniversary issue) raises fundamental questions about the complex and ambivalent relationship between purpose and process in community development (Shaw, and Poppo, 2016, p.464).

The issues identified by the editors in the anniversary issue of the Community Development Journal provide some explanation for the difficulty in identifying a clear definition of what is meant by community development. Throughout its history community development has struggled with its identity, how it defines itself and how it is defined by others. There is no universally agreed meaning of community development and it can be variously understood as an approach, an occupation or a movement. Commentary and analysis over the decades highlight

the highs and lows experienced by community development and, aligned perhaps with the struggles with identity, the 'fortunes and status (of community development) have waxed and waned' (Gilchrist, p.2).

There are undoubtedly common themes to be found in the maze of available definitions, themes that point to community development being a good thing. There is, for example, general agreement on social justice and positive social change as a primary goal. Espoused supporting values and principles include empowerment, participation, collective action, education, inclusion and partnership (SCDC, CDAS, Gilchrist and Taylor, 2011, p.3). Despite the feel good nature of these values and principles 'It is well established that community development is a contested activity' (Robson and Spence, 2011, p.288). The ambiguous nature of the concept and its associated language along with the assertion 'that it will always promote what is 'best' for ordinary people' (Emejulu, 2010, p.3), has resulted in community development being used by a wide range of ideologies for defining and solving contemporary social problems. The Big Society, for example, was a catch phrase used by the then Prime Minister of Britain, David Cameron, for his Government's plans and policies for 2010. The phrase promotes the idea of people and community empowerment, a key principle of community development. Cameron himself explained that 'The Big Society is about a huge culture change where people in their everyday lives, in their homes, in their neighbourhoods, in their workplace don't always turn to officials, local authorities or central government for answers to the problems they face but instead feel both free and powerful enough to help themselves and their own communities' (Knight, 2012). The idea is described by Scott as 'a triumph in articulating and updating the neoliberal settlement' (Scott, 2010, p.132). The impact of neoliberalism and neoliberalist strategies in the public sector is addressed in the following section.

Personal experience leads me to concur with Emejulu's (2010) concern regarding the narcissistic tendency of community development to be 'preoccupied with its own meaning, legitimacy and relevance' especially in its relationships with other related agencies. However the same experience convinces me that clarity regarding the status and purpose of community development in any particular context is essential if engagement is to be genuinely respectful and empowering

for local people. Such clarity would also enhance the chances of success for interagency partnership working.

Confusion about what community development means is often hindered by the use of the term interchangeably with community work. AIEB (2016), for example, introduces the definition as ‘community work/community development’:

A developmental activity comprised of both a task and a process. The task is social change to achieve equality, social justice and human rights, and the process is the application of principles of participation, empowerment and collective decision making in a structured and co-ordinated way (AIEB, 2016, p5).

Dominelli identifies community development as one of four models that are ‘central to mainstream to community work’ (Dominelli, 2006, p.10). Just as there are models of health promotion there are models of community development. Dominelli qualifies her choice of the models of community work proposed by Rothman, with the observation that ‘models are arbitrary constructs that depend on what feature theorists choose to highlight’ (Dominelli, 2006, p.10), and Rothman, for example, has been criticised for ignoring ‘culture as a central dynamic shaping community organising’ (Young Laing, 2009, p.20). In this study culture, organisational, professional and national, is regarded as key.

3.4 Common issues between the disciplines of Health Promotion and Community Development in Ireland

The common issues between the disciplines are divided here into two separate sections. This first section discusses the influence of neoliberalism and new public management. Section 3.5 which follows, discusses gender-blindness and its relationship to the patriarchal national context.

3.4.1 Neoliberalist ideology

‘The rise of neoliberalism has challenged and in many cases subverted the progress on equality and social justice for which those movements struggled. Since the late 1970s, social citizenship and universal welfare has been

undermined through the relentless advance of individualism and free market capitalism. The ideas and practices associated with neoliberalism have in turn supplanted and/or co-opted community development ideas and practices' (Carpenter, M. and Emejulu, A. 2015).

(https://academic.oup.com/cdj/pages/CDJ_50th_anniversary).

The challenges already facing the transformative feminist agenda have been intensified with the rise of neoliberalism. Neoliberalism, which has been the dominant political and economic influence for almost half a century globally, is reflected in the conservative politics of Reagan and Thatcher in the US and the UK respectively. In the western world neoliberalism marked a move away from the social democratic ideology that preceded it to one driven by the principles of the free market. These principles include 'minimal government intervention, market fundamentalism, risk management, individual responsibility and inevitable inequality' (Ayo, 2012, p.99). Neoliberalism is primarily understood and described in economic terms but it is based on a strong social and moral philosophy based on such values as 'prudence, hard work, responsibility and asceticism' (Ayo, 2012, p.101). Efforts to embed this philosophy have been greatly assisted by the expropriation of the language of social democracy and the reorientation of concepts associated with that ideology such as empowerment, agency, community and human rights. This tactic has been very successful in silencing and marginalising the discourse of social justice and discrediting the social justice agenda. The power of neoliberalism has, despite the significant rise in inequalities, had a serious impact on social institutions such as community development and health promotion. The social justice agenda to challenge oppression through building the capacity of citizens and giving voice to the marginalised conflicts directly with the neoliberal agenda and has been replaced with a non-participatory, top-down, authoritarian approach to management, one that focuses on efficiency and accountability.

In her quest for community development to return to a radical agenda Ledwith describes the neoliberal culture as 'a delusional tactic that has resulted in negating dialectic thought, colonising critical spaces and temporarily halting radical practice in a haze of managerialism, professionalism and the elevation of doing over thinking' (Ledwith, 2011, p. 13). Ledwith is referring to community

development, but knowledge based on personal experience and the opinion of respected health promotion commentators, agree that the impact on health promotion has mirrored that of community development. Raphael (2008), for example, wondering why, given the development of knowledge about the social determinants of health, 'so little has been done to improve them?' identifies neoliberalism as a significant influence 'which has little to say about strengthening the social determinants of health' (Raphael, 2008, p.223). Ayo (2012) agrees that 'It is evident that the manner in which health promotion is employed within Western neoliberal societies both reflects and reinforces the political ideology of neoliberalism' (Ayo, 2012, p.100). In an ideology of market fundamentalism and limited state intervention social justice is anathema. It is an ideology that uses the requisitioned language of social democracy to reason the transference of the burden of responsibility to individuals. At the same time mechanisms used, such as public-private partnerships and funding systems, put communities in competition with each other for a limited and a greatly decreased pool of funding.

Neoliberalism has had significant influence on the shaping of policy and practice in relation to the promotion of health. Like any ideology, neoliberalism depends on an acceptance of particular knowledge and ideas to achieve its goals. Various mechanisms, reflecting the ideological values and principles, are developed and incorporated into regimes of practice to drive and achieve the ideological goals. A key focus of neoliberalism is the representation of an issue, the supporting discourse and the identity of the authority in relation to the knowledge about that issue. Technocracy or the technical representation of a problem or issue, in the system of neoliberalism, is informed by the objective, scientific knowledge of the appropriate expert. In the field of health biomedicine and medical doctors are the source of the necessary technical knowledge and the biomedical model, informed by positive science which 'generally avoids dealing with aspects of broader environments' (Raphael, 2008, p.224), becomes the foundation for the understanding of health. Using this science based understanding of health the market orientation of neoliberalism remoulds the concept to one in which health problems are individualised and come from 'individual dispositions and actions rather than resulting from the influence of societal structures' (Raphael,

2008, p.225). As a result solving the problem is primarily the responsibility of the individual 'health conscious citizen' (Ayo, 2012, p.99). Within this discourse illness is a clearly acknowledged cost to society and is, therefore, something a good citizen will avoid. According to free market ideology these responsible citizens are 'facilitated by a burgeoning health industry' to use the power and agency, with which they are credited, to promote their own health and wellbeing. The market supports the efforts of health conscious citizens by supplying the consumer goods deemed necessary by what is claimed to be objective, scientific evidence.

Against this backdrop of individualism the rhetoric of health promotion reflects a continued belief in the social determinants of health. However, the combined influence of neoliberalist individualism, minimalist state intervention and a number of other complementary ideological beliefs and mechanisms 'weakens support for a social determinants approach to promoting health' (Raphael, 2008, p.224). For example, the disease based medical model of health, which favours simple causal relationships, based on the objectivity of medical science complements the market need for technocratic representations of problems. The desire for technocracy is also assisted by the New Public Management approach to the organisation and delivery of public services with its emphasis on accountability and efficiency.

3.4.2 New Public Management in health promotion and community development

New Public Management (NPM) is the term used to describe the application of managerialist ideas and practices of neoliberalism found in the business world in the public sector. How NPM operates in any country depends on the administrative culture of that country, a culture which is, in turn, influenced by the particularities of the cultural context of that country. In setting the foundations for her analysis of the 'key features' of the dominant administrative culture in Ireland, Connelly (2013) references the OECD which observes that 'the creation and evolution of the Irish Public Service has taken place within a specific historical context' and 'is a reflection of national political and administrative cultures, and of past economic and social priorities' (OECD, 2008:

12). Reflecting the analysis espoused in this study, the ‘unique combination’ of historical features that influence the dynamics and practices of the dominant administrative culture of the Irish public sector identified by Connelly are ‘Ireland’s colonial legacy, and the combined forces of Catholicism and nationalism’ (Connelly, 2013, p.88). As a result of the close relationship between church and state throughout the life of the Irish state the Catholic Church has had a significant input into social policy in the country. This influence has resulted in a conservative culture in the public sector and social policy in Ireland. Although this influence has diminished in recent years there is ‘evidence to suggest the persistent influence of traditional Catholic conservative values on wider Irish society’ (Connelly, 2013, p.90).

The persistence of nationalism, the other significant influence on the administrative culture and social policy in Ireland identified by Connelly, is a result of the dominance of two parties, Fianna Fail and Fine Gael, in Irish politics since the setting up of the Irish state. Both parties have their roots in the civil war that preceded Irish independence and represent the rival positions of nationalists in that war. As a result ‘since independence Irish political life has been dominated by the oscillating fortunes of two hegemonic, right-of-centre and conservative, nationalist parties’ (Kitchin et al, 2012, p.1305). Although the left wing, socialist representation has increased subsequent to the recent major economic recession in Ireland and the austerity measures that followed, the traditional left/right political divisions traditionally found in European politics has been absent in Ireland. The Labour Party which would typically represent the left wing agenda with a focus on class and social justice has had little significant influence. Instead, a fusion of Catholicism, nationalism and postcolonialism has been the foundation for the administrative culture of Irish social policy that directs the Irish public sector.

Challenges presented by the unique character of the traditional Irish political landscape which has resulted in ‘a certain species of neoliberalism in Ireland’ (Kitchin et al, 2012, p.1306) are augmented by the spectacular rise and fall of the Irish economy in recent years. New public management (NPM) is often adopted in response to a fiscal crisis and, in the opinion of Kitchin et al (2012), the solutions proposed to address the disastrous costs of Ireland’s economic

collapse clearly show ‘a (re)commitment to neoliberal policies’ (Kitchin et al, 2012, p.1320). In both community development and health promotion in Ireland this commitment to neoliberalism is evident in managerialist approaches and the use of NPM policies. ‘Managerialism is a set of ideas and practices that, under the direction of managers arrange a group’s activities in efficiency minded ways and a doxa that legitimises the need for control in all settings’ (Ward, 2011, p.205). In the guise of NPM the ideas and practices of managerialism were applied to the public sector in Ireland in the name of reform and modernisation and to improve public trust in public agencies. Evidence of the application of NPM include ‘a shift to private sector management practices and their emphasis on improvements in productivity’ and ‘competition to remain employed or surveillance and assessment techniques to spur internal competition’ (Ward, 2011, p.207). In the case of devolution or decentralisation, another strategy of NPM is often that the state becomes the manager and ‘moves the cost of supervision to the local level while maintaining control over the functioning of the agency’ (Ward, 2011, p.208).

Examples of these strategies are to be found in health promotion and community development in Ireland. Against the economic and political backdrop of the economic downturn in post-Celtic Tiger Ireland opposition to the NPM related changes were relatively subdued as the need for cost cutting, rooting out complacency and increasing efficiency in public services was presented as inevitable and necessary.

Documentation in relation to these approaches in Ireland and the impact of them is sparse. However the impact on community development has been critiqued by Connelly (2013) and Power (2014). In her analysis of the impact of such policies Power (2014) uses the example of the guidelines for the National, Local and Community Development Programme. In the guidelines Power noted an emphasis on ‘‘key performance indicators, ‘evidence based data’ and ‘logic modelling’’ (Power, 2014, p.63).

The language of the Pobal guidelines is mirrored in the CompHP Core Competencies Framework for Health Promotion in Europe published in 2011 (Dempsey et al, 2011). The competencies ‘are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively

and appropriately in the field' (Dempsey et al, 2011, p.2). Competency assessment is often regarded as a useful starting point for the auditing and evaluation processes favoured by NPM, processes that challenge the autonomy of professions.

Neither trust nor autonomy is regarded as trustworthy in NPM. According to Power, the Pobal Guidelines show that 'Public or community organisations are viewed as agents in low-trust relationships, which are linked by contracts or contractual type processes so that local projects are expected to deliver on centrally prescribed criteria rather than design and determine their own programmes' (Power, 2014, 63). The belief of NPM is that people need to be managed. As well as being 'unproductive and undisciplined' if people are not managed properly they could also pose an 'indeterminable risk to the organisation' (Ward, 2011, p.211). Trust and autonomy are replaced with performance management and evaluation and auditing systems, approaches that often undermine trust and cooperation.

The boundaries between the private and public sectors are blurred further by the import of NPM approaches to management. In the reorganisation of health promotion that corresponded with the cost cutting and retrenchment exercise that followed the post-Celtic Tiger economic crisis two different approaches to management were used. One approach was that management was 'centralised in the hands of professionally trained and 'objective' managers' (Ward, 2011, p.205). The professional profile of the person brought into manage the streamlining of health promotion, for example, was governance, policy implementation and change management not health promotion. The rationale for this NPM approach is that professional managers have a greater knowledge of how to solve problems than the professionals providing the services. The approach diminishes the authority of the professionals being managed.

The second management approach used in the re-organisation of health promotion was one that requires the managed to become managers. This approach is identified by Ward as another way of diminishing the power of professionals and supports the greater accountability principle of NPM. In this approach workers are 'required to manage and report on themselves either

through managerially created auditing systems or ones piggybacked onto already existing professional peer review processes' (Ward, 2011, p.209).

Ongoing re-organisation is a common theme of neoliberalism and developments in community development since the turn of the century have been similar in character to those that happened in health promotion in Ireland. Reflecting on developments up until 2014 Power observes that 'community development has been radically re-oriented through State managerialism away from community-identified goals and towards delivering on State prescribed policies and agendas' (Power, 2014, p.91). Staff morale was negatively affected as review followed review. Finally, in 2009, despite public protests, community development provision in Ireland was significantly weakened as programmes were either closed or integrated into larger organisations, a move that significantly decreased community development autonomy. A national support agency, the Community Workers Co-operative, (now CWI), which was strongly critical of Government actions and treatment of community development and community development staff, had its funding withdrawn and had to close. A principal state informed goal of the reformed community development was to increase people's work readiness, a goal that grew into SICAP or the Social Inclusion Community Activation Programme. Research into the changes in community development, especially in relation to SICAP, is ongoing by CWI (Community Work Ireland). In a statement in March 2017 CWI observed that the changes had resulted in a move 'away from social change towards service delivery' in community development and had 'refocused energy on compliance only' (CWI, March 2017).

The goal of work readiness is a manifestation of 'workfarism' (Roberts, 2014, p.15), an idea that is compatible with the idea of competency. Workfare promotes the idea that with the right training people will acquire the requisite skills to succeed in work and society. In the neoliberal state, unemployment is the responsibility of the individual and people have a responsibility to make themselves work ready as pay back for state services and benefits that they receive. NPM, the management approach of neoliberalism, 'argues that individuals should draw on their own tangible and intangible core competencies' (Roberts, 2014, p.1) to succeed in life.

The possibility of autonomous community development work and the development of any programmes to address community-identified needs have been significantly curtailed in community development in recent years. Other studies suggest that a number of interrelated factors have influenced these different developments in community development practice. Research carried out in Ireland (Power, 2014) noted that while State agencies, including the health services, had adopted the discourse of community development, using 'terms such as 'community development', 'participation', 'empowerment'' the suggested compatibility was misleading. In reality, as a result of the centre-led re-organisation of community development that has taken place in recent years, the 'purposes and priorities' of community development have become 'centrally prescribed and monitored with reference to State-identified performance indicators' (Power, 2014, p.6). Research carried out in the North-East of England (Robson and Spence, 2011) identified a similarly misleading compatibility between policy and strategy documents and practice and values in community development during a similar period. The focus of the English research was feminism and women's gender based inequality. It concluded that 'the central feminist principle of addressing gender inequality (which) requires specific attention to the female experience' had been 'undermined by prescribed policy agendas which reinforce masculinist structures of power' (Robson and Spence, 2011, p.289). Robson and Spence conclude that these changes have resulted in the broader emancipatory principles of community development practice being distorted within a policy discourse of equality' (Robson and Spence, 2011, p.288).

A gender analysis of the impact of neoliberal influenced developments in the public sector highlight the close relationship between the patriarchal national culture and the culture of the sector. Connelly (2013) observes that although the culture is strongly masculine 'areas of social policy in particular are extremely feminised professions' (Connelly, 2013, p.101). The extremely stereotypically masculine nature of the administrative culture, with its emphasis on results and efficiency, despite the predominantly female workforce, has meant that the impact of pay cuts and job cuts and the embargoes on appointments and promotions have impacted particularly on women. The situation for women has

been exacerbated by the fact that 'these cuts have taken place within the context of wider government measures, some of which, such as cuts in child benefit and increases in the retirement age, have had a particular impact on women' (Fulton, 2011, p.5). The situation for women has been further aggravated by the fact that 'funding programmes for women being sharply reduced in Ireland' (Fulton, 2011, p. 4).

The powerful combination of influences identified in this section means that, despite the rhetoric of empowerment, the primary focus of health promotion in a neoliberal culture is on the development of the health conscious citizen and on creating awareness of the responsibility of citizens to care for themselves. Based on authoritative knowledge, health promotion provides guidance and advice to citizens to 'eat better, exercise more, drink less and give up smoking' (McQueen, 1989, p.342) through education programmes and social marketing. This 'lifestyle' approach 'says little about reorganising society and its structure in the services of health' and even less about how such societal structures should be modified' (Raphael, 2008, p.226). The existence of inequalities is acknowledged through the targeting of 'at risk' communities. In reality, however, these victim-blaming, targeted interventions can add insult to injury by exhorting individuals to build their competence to change their behaviour and to steer their way through the socio-economic, cultural and environmental constraints and barriers rather than working collectively to remove or modify the barriers. This approach continues despite evidence that 'for those in structurally disadvantaged social positions individual behaviour change has little impact on health status' (Bunton et al, 1995, p.51). Among the many criticisms of the lifestyle approach to health promotion is the negative impact it has on women who, because of their caring responsibilities, have traditionally been the target of health promotion programmes and interventions. So, rather than promote the health of women, victim-blaming lifestyle health promotion can actually exacerbate women's gender based inequality.

Health strategies influenced by a New Public Management (NPM) approach typically target cardiovascular disease as a priority. In such a system outcomes have to be relatively swift, easily identifiable and measurable, so initiatives are subject to strict auditing systems and performance indicators. Health based

health promotion has increasingly responded with a lifestyle model of practice, often referred to as a downstream approach. By adopting a downstream approach health promotion inevitably ignores midstream factors. A focus on midstream factors is necessary if discriminatory social inequities such as gender based inequality are to be addressed and gendered policy frameworks are to be developed. In such scenarios the determinants approach of health promotion, based on values of social justice and equity, are effectively marginalised. If the criteria for success as defined by NPM and ongoing funding are to be met, any approach other than the currently favoured of-the-peg, individually focused lifestyle and behaviour change initiatives present significant challenges. Meeting these challenges requires a solid commitment to espoused values of health promotion such as social justice, an understanding of health informed by a social determinants model, thinking more creatively and collaborating with people and other professionals to re-appropriate the discourse of community participation and engagement.

3.5 The Irish cultural context and gender-blind practice

Among the commonalities shared by health promotion and community development in Ireland is that they both operate within a particular patriarchal culture. Because of the unique character of this culture any critical analysis of women or women related issues need to be contextualised ‘in the context of Ireland as a highly patriarchal and religious society where the family (mother) is seen as the proper provider of care’ (Armstrong et al, 2007, p.18). In the particular context of patriarchy in Ireland the policy and practice of both health promotion and community development are generally gender-blind.

Other determinants of health or forms of discrimination or oppression such as poverty, class, race and sexual identity, for example, are recognised by both health promotion and community development. However, as I argue in this thesis, both seem to have a blind spot regarding women’s gender based oppression and the negative impact of that oppression on the lives or the health and wellbeing of women. A key aim of this study is to highlight this blind spot and to gain some understanding of it.

Gender is a social process that legitimises women's subordination and women's gender based oppression. It is an injustice that limits women's capability for health. Health is universally accepted as a good thing and a human right and the social determinants model of health and the principles of the Ottawa Charter (WHO, 1986) support a more holistic understanding of health. This re-conceptualisation of health which recognises the importance of the wider social context as well as people's more immediate context in relation to health and wellbeing provides the perfect rationale for focusing on the influences that impact negatively on women's capability for health, including gender as a social regime. The positioning of gender in the social determinants model of health is significant within the overarching category of socio-economic and cultural determinants, the category that influences all other systems such as education and employment and all the immediate settings in which people interact and live their lives.

'Gender beliefs are hegemonic in that the descriptions of women and men they contain are institutionalised in the media, government policy, normative images of the family, and so on' (Ridgeway and Correll, 2004, p.513). The resulting pervasive and embedded nature of gender, especially in a patriarchal society like Ireland, means that although gender inequality is constantly recreated in our everyday interactions, it remains invisible to many. The simple binary classification of male/female is 'usually the first category that people sort self and other into in social relational contexts' and because 'unlike many other social differences, gender goes home with you' (Ridgeway and Correll, 2004, p.514) even those committed to different, more egalitarian beliefs reinforce stereotypical gender beliefs. As a result, efforts to address women's gender based oppression as a social injustice is fraught with difficulty, and without the benefit of a feminist perspective, can be seen as less of a priority than injustices based on race, class or economic deprivation. It is this very pervasiveness, however, that makes gender discrimination more powerful and potentially more damaging for women as it 'harms psychological wellbeing' and can result in 'anxiety, depression, hopelessness, and lowered self-esteem' (Schmitt, et al, 2002, p.208), outcomes that conflict directly with the espoused values of health promotion and community development.

Health Promotion and Community Development practitioners point to the involvement of women in programmes provided by them as evidence of their interest in and commitment to women and confirmation that they are meeting women's needs. However, an interest in women does not equate with an interest in or an ability to grasp the concept of gender. The gender-blind spot regarding women's gender based inequality is particularly worrying and ethically questionable because activities of both disciplines often 'reinforce the prevailing social belief that women will be the caregivers and that any problems they have in fulfilling their roles can be accounted for by individual failures (Wuest, 1993, p.416). These failings are commonly addressed through non-gender specific parenting and cookery/menu management type programmes. A gender-blind perspective means that the fact that such programmes are overwhelmingly attended by women generally goes unquestioned and a judgement is made that women's commitment to the programmes simply confirms that they are meeting women's needs.

A formative experience in the early days in my new role as a women's health officer and a new member of the health promotion team laid the foundation for what lay ahead regarding the issue of gender-blindness and a discrepancy between my understanding of gender as a determinant of health and the more popular understanding among my peers and colleagues. At our team meeting the agenda for discussion was the new national health strategy for Ireland. The introductory pages of the strategy were promising from a health promotion perspective. The WHO definition of health was referenced. An image of the well-known rainbow diagram illustrating the social determinants of health, accompanied with the acknowledgement that 'achieving full health potential does not depend solely on the provision of health services' and that the development of 'an effective health system the determinants of health must be taken into account' (DOH, 2001, p.15). There was a short explanation of four of the sections in the rainbow diagram. However the outer, overarching section, 'General, Socio-economic, cultural and environmental conditions' was omitted from the explanations. In our discussion I expressed regret, firstly at the omission of the outer layer because of the influence and power these factors have on gender, and secondly, at the gender-blind nature of the explanations of

the other sections. Clearly irritated, my colleagues informed me that my concerns were unfounded as sex was clearly named in the central, core section along with age and hereditary factors, factors that are generally regarded as immutable. The terms sex and gender are increasingly used interchangeably so it is impossible to discern from this exchange with my colleagues what their understanding of the term 'sex' was. They could have been using the term sex to include gender or they could have been reflecting a biological determinist understanding of the term. It is not surprising to find that practice is gender-blind when there is no real distinction between sex and gender and the underlying belief is that gender differences are, like sex differences, natural and innate. The gender-blindness of health promotion policy and practice remained a concern throughout my tenure as a women's health officer.

In this study I argue that, as a result of a gender-blind perspective in health promotion and community development, there is a mismatch between practice and espoused values and beliefs in both regarding the relationship between women's gender based oppression and women's health and wellbeing. With particular reference to Ireland gender-blindness and women's gender based oppression are issues that need addressing, issues this study contends both disciplines have a moral duty to address as there is 'a long way yet to travel before women in Ireland become a 'significant force; and a longer way still before we achieve equality and justice' (Barry, 2008, p.xxii). Undoubtedly, meeting that moral duty presents challenges in a culture where the dominant gender regime is particularly pervasive and where it has been observed that 'among both men and women in Ireland, there appears to be a good deal of cultural unease surrounding the concept of patriarchy' (O'Connor, 1999, p.7). This cultural unease adds to the power differential between women and men in Ireland.

The feminist perspective in this study argues that an approach that raises women's consciousness about patriarchy and how it works as a determinant of their health and wellbeing, has the potential to strengthen women's capacity to support organised efforts to influence social norms, policies and programmes that impact negatively on their lives well as promoting their health and wellbeing. I agree with the observation in relation to sexism that 'it's not easy

to take something invisible and to make people start to talk about it' (Bates, 2014, p.24). However, my experience with women convinces me that involvement in an empathic, dialogic process that encourages a critical consciousness, builds women's agency and their capacity to identify actions to change or challenge the direction of their lives. Challenging gender-blindness and creating such opportunities is a first step in addressing the social injustice of women's oppression as well as the development of a feminist framework for the promotion of women's health. It is also a potential, badly needed, first step in strengthening feminism and the women's movement. Such an approach requires a feminist analysis of women's gender based oppression and that any efforts for change 'must be grounded in the struggles of everyday life' (Ledwith, 2011, p.185).

A critical concern in relation to gender-blindness is the possibility that those with the opportunity and obligation to address the issue of women's gender based oppression are themselves resigned to the situation, perhaps 'feel incapable of running the risks it requires' and are 'fearful of still greater oppression' (Freire, 1993, p.29). The necessary commitment and conviction required to drive a plan for transformative action 'cannot be packaged or sold' (Freire, 1993, p.49). Those who continue to believe that social transformation is possible point out that moving forward requires the building of the necessary foundations with the use of critical reflection in anticipation of 'the creation of a self-conscious analysis of a situation and the development of collective practices and organization that can oppose the hegemony of the existing order' (Weiler, 2009, p.235). So, a vital first step in any such plan requires a process of critical reflection or conscientisation for those who have responsibility for setting the wheels in motion. Involving women in this process and moving forward in 'mutual inquiry and action' (Ledwith, 2011, p.41) is recognised as a key strategy in the feminist-Freirean approach advocated by Ledwith and promoted in this study.

A relatively hidden yet contributory factor to the problem of gender-blindness is the blind spot in the practice and academic literature. In a review of health promotion literature Gelb et al (2012) regard the 'superficial attention to the role of gender in health promotion' (Gelb et al, 2012, p.445) as problematic.

The conclusion of Gelb et al is that 'although gender was at times identified as a determinant of health, gender was never identified and integrated as a factor critical to successful health promotion' and, as a result 'no one had developed a specific women-centred health promotion framework' (Gelb et al, 2012, p.445).

3.5 Conclusions

The 'struggles of everyday life' (Ledwith, 2011, p.185) referred to by Ledwith are significantly influenced by the social and cultural context. 'Policy choices are structured by ideology, institutional arrangements and power, the role of parties and the access of interest groups' (Parsons, 1995, p.610). The power imbalance in a patriarchal country like Ireland between women and decision makers makes it very difficult for women and women's issues, regarded as contrary or threatening to the dominant power and culture, to penetrate the policy agenda. The power imbalance between women, including practitioners, and decision makers, created by this patriarchal culture, additionally informed by neoliberal ideology, certainly presents challenges to efforts to address women's gender based inequality. There are, for example, straightforward practical problems for those who believe in the idea of 'collective practices' (Weiler, 2009, p.235) advocated by Weiler. For instance, the dominant neoliberalist political ideology and the related political and economic measures, typical of those in Ireland, mean that opportunities for women to come together as a group have disappeared 'and it has become less easy to share and name the experience of oppression' (Robson and Spence, 2011, p.293).

A critical feminist analysis is necessary if women's gender based inequality and the potential negative impact it has on women's health and wellbeing is to be made visible and is to be challenged. The political climate in Ireland since the collapse of the Celtic Tiger economic boom and New Public Management approaches has resulted in unprecedented change in both health promotion and community development. An experienced observer of the situation in Ireland noted that one outcome of these changes was 'that there were few independent or autonomous spaces wherein community workers and activists could meet (and) collectively reflect' (Power, 2014, p.7). Ledwith, like Power, is referring specifically to community development and primarily to the UK. However, her

realistically vivid description reflects my personal experience of health promotion. The ‘unprecedented political times’ (Ledwith, 2012, p.1), Ledwith believes, has ‘resulted in negating dialectical thought, colonising critical spaces and temporarily halting radical practice in a haze of managerialism, professionalism and the elevation of doing over thinking. Our focus has been blurred on the real issue at stake and left us as uncritical deliverers of policy, not really understanding why we are doing what we do anyway’ (Ledwith, 2011, p.13).

These changes combined with the traditional power imbalance between women, including practitioners and decision makers, presents undoubted challenges to efforts to address women’s gender based oppression. These difficulties do not, however, remove the moral responsibility of agencies that espouse values of social justice to commit to a transformative agenda that will build women’s capability for health and wellbeing.

In this chapter I explored the potential of health promotion and community development both as disciplines and approaches to addressing the issue of women’s gender based oppression within a health promoting feminist-Freirean framework in the Irish context. Although both disciplines present significant barriers to the development of the necessary framework, ultimately I argue that the espoused commitment of community development to social justice suggests a greater potential to tackle the issue. Prior to examining the wisdom of this position in Chapters 5 and 6 by exploring the understandings of community development practitioners, in the next chapter I describe the methodology I employed to carry out this exploration.

Chapter Four: Methodology

4.1 Introduction

In this chapter I complete the story of the development of this research study. The chapter outlines the significant challenges faced in the research and how they were addressed. The challenges identified include the antipathy in relation to the issue being addressed, particularly by health promotion management, difficulties presented by the original, desired study design particularly the use of Participatory Learning and Action methodology and, partly connected to the attitude of management, difficulties in the recruitment of participants. Before concluding the chapter with a review of autoethnography and its relevance to this study I consider the ethical implications within the study and my approach to data analysis. The research paradigm and its relevance to the study is discussed prior to a discussion about the research questions and how they were reformulated to shape the interview questions. The various aspects of the research process are elaborated on later in the chapter. First I want to set the scene with a short summary of the process.

Because of problems with recruitment the research process was split into two phases which I label simply as Phase 1 and Phase 2. Although six practitioners registered their interest in participating in Phase 1, ultimately there were three participants. In Phase 2 there were four participants. All participants were experienced community development practitioners from different parts of Ireland and the combination of Phases 1 and 2 created a diverse group of age, experience and current practice. The reformulated research questions generated four interview questions. Each question was scheduled for an interview session of at least one hour in duration, using a semi-structured approach.

4.2 Research paradigm

4.2.1 The Radical paradigm

A paradigm contains the beliefs and values that illustrate the particular world view of the researcher and is 'a way of breaking down the complexity of the real world' (Sarantakos, 1998, p.31). A suitable paradigm should 'foster consistency

between the underlying assumptions, theories and knowledge production activities' (Gephart, 1999, p.1) of the research and so provide the researcher with a solid framework, a framework that 'sets down the intent, motivation and expectations for the research' (MacKenzie and Knipe, 2006, p.2). The paradigm, in other words, contains the ontological and epistemological foundations of the study. As well as explaining the intent, motivation and expectations of the study, the aim of the following paragraphs is to outline my particular world view, its relevance to the study, some of what I believe to be relevant influences on that world view and what I believe influences conceptualisations of the world generally. The feminist epistemological perspective which is a significant part of the paradigm framework for this study reflects the concern with the influence of gender on the production and acceptance of knowledge. The emphasis on the relevance of the cultural context, points to a social constructionist view of reality and the feminist epistemological belief that 'knowledge claims are always socially constructed' (Harding, 1993, p.54).

Knowledge and opinion regarding the significance of paradigms in research has grown significantly subsequent to recognition of the limitations of the then dominant positivist paradigm in the 1970s and 1980s with the result that 'the number of qualitative texts, research papers, workshops and training materials has exploded' (Lincoln and Guba, 2000, p.163). One result of this explosion has been an array of categorisations of different paradigms and, while there is general acceptance that no one paradigm is fundamentally better than another, the range of options and 'the use of different terms in different texts and the varied claims regarding how many paradigms there are' (MacKenzie and Knipe, 2006, p.2) can be confusing. Despite the presentation of the research process as linear and identifying the first step as starting 'with a broad notion' of the most suitable paradigm, MacKenzie and Knipe (2006) acknowledge that in reality 'the research process is more cyclical than linear' (MacKenzie and Knipe, 2006, p.1). Having duly considered the array of available options the framework most suited to the intent, motivation and expectations of this study is the radical paradigm identified in the simple trio of options presented in Grant and Giddings' (2002) categorisation.

Grant and Giddings (2002) begin the explanation and description of their relatively unique classification under the heading 'Background assumptions and values' (Grant and Giddens, 2002, p.13). Under this heading critical social theory and feminism, two main bodies of social theory, are, because of their clear commonalities, identified within the radical paradigm.

The partnering of critical social theory and feminist theory creates clear parallels with the intent, motivation and expectations of this research study and underline its suitability as the chosen paradigm. Both, for example, understand that 'we live in an unjust world' (Grant and Giddings, 2002, p.18) and so there is a need for research to have a political purpose, employing paradigms that are committed to social change and challenging social injustices. Uniting critical and feminist theories is also favoured by Martin (2002) who believes that such a partnership creates the potential for 'unexplored synergies' to develop and 'only by combining both will either of these traditions gain the breadth needed' (Martin, 2002, p.32) to achieve their aim of social change. In this study, as in both critical theory and feminist theory, reality is understood as socially created and contextual. Reality is shaped by powerful forces such as patriarchy which, because they have been reified over an extended period, are seen as natural or real. Martin (2002) points out that there is relatively little feminist critique of how women are 'complicit in their own gendered subjugation' (Martin, 2002, p.6). This issue of false consciousness is addressed in the radical paradigm which recognises that 'the 'truth' of everyday experience has been mystified to its own subjects through ideological mechanisms such as hegemony' (Grant and Giddings, 2002, p.18). The development of critical theory connects with the growth of social movements for social justice and the integrated, interdisciplinary approach to knowledge development is a central belief. This integrated approach is necessary to achieve the goal of critical theory which is 'to be *practical* in a distinctively moral (rather than instrumental) sense' (Bohman, 2016), an approach which critical theorists claim distinguishes it from more traditional theory. Critical theories 'aim to explain and transform *all* the circumstances that enslave human beings' and so 'any philosophical approach with similar practical aims could be called a "critical theory"' (Bohman, 2016). The radical paradigm of Grant and Giddings (2002) reflects the connection made

between critical theory and many social movements, including feminism, that 'identify varied dimensions of the domination of human beings in modern societies' (Bohman, 2016) and have a shared goal of social change.

4.2.2 Connecting the Radical paradigm and the theoretical framework of social constructionist feminism

A central tenet of this study concurs with the Thayer-Bacon (2009) view that our knowledge is developed as a result of our experiences of our connections with others, our circumstances and of the world around us. The integrated approach of critical theory, which is put into practice in the radical paradigm, supports Thayer-Bacon's 'pragmatic and relational feminist' approach to epistemology which recognises the fallibility of all social theory and the fact that 'no one of us alone knows the answer' (Thayer-Bacon, 2009, p.2), nor do we develop new knowledge without connecting, not just with other people, but also with 'our social environments, our cultures past, present and futures' (Thayer-Bacon, 2009, p.2). Critical reflection on and interrogation of the socially constructed ideas that are encountered enable people to improve their ideas by 'further developing their understanding and enlarging their perspectives' and 'with these enlarged perspectives people are able to create new meanings for their experiences' (Thayer-Bacon, 2009, p.3).

Critical theory understands truth claims to be prone to distortion as a result of inequalities and oppression. Gender, a central focus of analysis for feminism that is often missed in general critical theory, is an example of such distortion as it rationalises the superiority of males over females in society. Partnering a feminist, gender focused analysis with the critical theory assumption that 'we can and must do something about the injustices we observe around us' (Grant and Giddings, 2002, p.18) challenges the distortion of the androcentric bias of knowledge and recognises gender as a discriminatory social construction.

As discussed in Chapter 2, social constructionist feminism rejects the notion that gender is an innate characteristic of human beings and while it sees gender as 'built into all the major social organisations' (Lorber, 2010, p.244) it also understands that we are not passively shaped by these social institutions but are active in adapting and selecting the dimensions we choose to incorporate, or

not, into our version of gender. Gender is, therefore, not something we are, it is something we do. We all construct gender every day in our relationships and interactions.

‘Doing gender’ was a concept first presented by West and Zimmerman in 1987. However, Deutsch is concerned that this ground-breaking work has been used to develop ‘a theory of gender persistence and the inevitability of inequality’ (Deutsch, 2007, p.106) rather than for the development of a way of improving our understanding of how to undo gender. This study will attempt to improve understanding on the negative impact of gender on women’s well-being and meet the need identified by Deutsch to ‘shift from talk about doing gender to illuminating how we can undo gender’ (Deutsch, 2007, p.107).

What Deutsch sees as the ‘transformative nature’ of the social constructionist approach reflects an emphasis on action for change that is a characteristic of a feminist perspective on social research. Martin (2002) points to this aim for change as a shared characteristic with a critical research approach. She also points to it as a shared weakness as ‘Both are better at critiquing the status quo than changing it’ (Martin, 2002, p.3). This research study is alert to this criticism and incorporates in its design a methodology and methods that aim to address this weakness.

4.3 Research design

The aims of the study and the questions it wanted to address presented a number of challenges that had to be considered in the research design.

The inherent assumptions of the radical paradigm, which combines critical and feminist theories, provide the foundations for the design. One of the first assumptions that needed addressing was my personal bias in relation to the issue being explored, a bias that was evident to me as a result of my experience living as a woman in Ireland, working as a women’s health officer in the Irish health services and as a result of my reflections on those experiences. I was quite conscious that working within a feminist paradigm meant that ‘the researcher has to give considerable thought to her own experiences - she has to ‘place’ herself in relation to the issues she is researching’ (Cotterill and Letherby, 1993,

p.72) and that there is no such thing as unbiased knowledge. As well as alerting me to my particular biases, my experiences and my reflections on those experiences helped me develop, I believe, ‘an acute sensitivity to the embedded values and assumptions in society’ (Morse and Field, 1995, p.16). In the context of this study the embedded nature of patriarchy and the related beliefs and attitudes I experienced when living and working in Ireland, beliefs and attitudes which conflict with my feminist perspective, is one of the challenges that needed to be acknowledged in the research design. My reflections lead me to concur with Morse and Field (1993) who observe that ‘sensitivity is most easily identified when the researcher is exposed to another culture’ (Morse and Field, 1993, p.16). Consideration of how I might address these issues convinced me to incorporate an autoethnographic element in my methodology. (See section 4.8)

The first and most straightforward decision about the research design was that it would be a qualitative study. ‘The mission of qualitative research, as I understand it, is to discover meaning and understanding, rather than to verify truth or predict outcomes’ (Myers, 2000, p.1). Qualitative research does not test hypotheses. It tries to get an answer to the question ‘What is going on here?’ from the perspective of the research participants. I wanted to get an understanding of the reality of the participants in relation to the questions asked that is as near as possible to how they live and feel it and to understand how that reality is influenced by the social, political and cultural context in which they live that reality. Exploring these questions and trying to get a deeper insight into participants’ perspectives required a qualitative approach to the research. The critical character of the research which understands ‘society as a human construction and people as the active subjects of that construction’ demands a qualitative research approach, one which is ‘based on *dialogue* with its subjects rather than the observation or experimental manipulation of people’ (Comstock, 1994, p.626).

The preparatory groundwork for this study has, arguably, been carried over an extended period of almost twenty years. Throughout that time I actively observed and reflected on the society in which I lived and worked. My efforts throughout the years to gain insight into and understand the perspectives of the people with whom I lived and worked in Ireland certainly meet the requirements

to 'be persistent, focused and single-mindedly committed' (Morse and Field, 1995, p.1) when doing qualitative research. Although not formally recorded, my reflections throughout my time in Ireland on a myriad of formal and informal exchanges and observations in both personal and professional situations, ones that generated a range of feelings and emotions, have many of the characteristics of an autoethnographic study.

4.4 Ethical considerations

In social science the issue of research ethics is of great importance and in order to carry out this research I had to apply for permission to the University of Glasgow ethics committee. The application required copies of the Plain Language Statement and Consent Form I intended to use. (See appendices).

In this study all participants were adults and none of the topics to be addressed were particularly sensitive. Nevertheless, a commitment to the values of ethical research required a critical review of every aspect in an effort to ensure ethical integrity of the process.

A key issue in qualitative research is informed consent. Ethical integrity requires that participants have the right to know they are being researched, to understand fully what the research is about and the purpose of the research. Participants also need to be informed that they can withdraw at any time from the process. Ethical integrity also requires that participants are provided with this information in language easily understood by a lay person. Compliance with the intent of the Plain Language Statement in this particular research project required a considered revision of the original information as a result of the switch from health promotion to community development. In an effort to ensure clarity I either met with participants or spoke with them on the phone prior to starting the data gathering. At this stage confidentiality was identified as a concern. Ireland is a small country and the body of community development practitioners within that is small. Anonymity not only of participants but of others identified in the stories and information they shared was a primary consideration throughout the process, including the analysis and discussion of the data. Codes are used as a first step in the process of protecting the

identities of participants and others. Commitment to this ethical principle has meant that some data of value to my argument had to be excluded.

This need to exclude is related to another ethical principle of relevance to this study, a duty to accurate representation of what was said. This commitment to accurate representation of the voices of participants contributes to the validity and reliability of the research.

4.5 Method and recruitment

In this section I address two interrelated and essential elements of qualitative research, method and recruitment. These elements are essential to successful research but often receive little attention in the final presentation. The intention of including the story of my experience and some of my reflections on these elements and the challenges they presented is to ‘provide information from which I and other researchers can learn’ (Nairn et al, 2005, p.223).

Consistent with my commitment to reflection and learning and autoethnography I concur with the belief of MacDougall and Fudge (2001) who stressed the need for research processes to be more transparent so readers can ‘take an honest look at them’ (MacDougall and Fudge, 2001, p.117). In the introduction to their article which ‘addresses the importance of sampling and recruiting’ MacDougall and Fudge explain their concern with the ‘sanitized’ nature of accounts of the research process:

‘A newcomer to research would gain the impression from published accounts that research was generally a smooth, logical process in which little goes wrong and which is immune from the vagaries and politics of everyday life. In practice, it is rare for such immunity to operate’ (MacDougall and Fudge, 2001, p.112).

Because of their unease with the lack of ‘comprehensive descriptions of what can go wrong and detailed hints about how to avoid some common problems’ in their clearly structured article MacDougall and Fudge (2001) present guidelines that have helped them in their work. I use their framework to guide the story of my experience.

In the original, and what I at the time considered to be the ideal, vision of this research study, I planned to work with two groups of five or six practitioners

using a Participative Learning and Action (PLA) approach. PLA was a methodology I had developed and used successfully in my work with women as a women's health officer. I was confident that it was a methodology that could accommodate all the values that underpin this research study and that inform my feminist paradigm. The first principle of PLA that made it an ideal choice for my study was that I would not be the sole beneficiary of the process, or, in other words, that I would not take participants' time 'without recompense', (Chambers, 1999). I intended that the approach would be a transformative, health promoting approach for all involved. The process would involve participants in critically reflecting on and analysing their own practice and would also provide them with an opportunity to critique the 'the institutionally structured situations (projects, programmes, systems)' (McTaggart, 1989) in which they work. A particular benefit of this ideal vision was that the shared learning would potentially act as a catalyst for participants to develop a community of practice which would, in turn, result in a commitment to action and improved practice. It was an approach that, based on my experience, I believed was not only very worthwhile but also very necessary. Health promotion colleagues who knew something of my use of PLA work and were eager to learn more, registered their interest in being involved in the proposed study and generously supported my efforts to make it happen. Ultimately, faced with what looked like insurmountable obstacles, the plan had to be abandoned. The factors that obstructed our plans had a considerable influence on the options regarding the elements of the research being considered in this section so I will briefly outline the relevant events.

Timing was a significant factor. The timing of my efforts to deliver on my ideal vision for my research could not have been less ideal as it coincided with major organisational change. The changes, informed by a new managerialist and austerity-based ethos resulted in a new, tightly managed, centralised health promotion driven by principles of control, efficiency and accountability. The restructuring realistically removed any autonomy previously enjoyed by local health promotion areas. Despite considering a number of creative schemes and strategies to circumvent the new obstacles, a shutdown in communications by the local manager who had previously been supportive of the research, meant

that I had to seek permission from central management. Despite the support of health promotion colleagues, permission was refused. The reason given was that the issue being addressed was not regarded as important by the organisation at that time. The stated lack of interest in gender in health promotion policy and practice was a key influence in my belief in the need for the research. So, the expressed lack of interest combined with the nature of the organisational changes taking place, meant that the refusal was disappointing but not a surprise.

Apart from the lack of interest in the issue being addressed by the research two inter-related characteristics of my proposal made it incompatible with the new culture of organisational efficiency, the time commitment required and the nature of the research methodology.

To facilitate the reflection, learning and planning that are part of PLA the proposed plan included a range of methods typically employed in PLA projects such as the use of images, charts, timelines, shared presentations and interviews, methods that are obviously more time consuming than interviews alone. Four group sessions four hours in length was the anticipated time required for data collection and another two shorter sessions for introduction and conclusion were included in the plan. My contention that the outcomes compared favourably with the participant commitment was refuted by management. Based on my experience of using PLA in the health services I was aware that PLA as a research approach conflicted with the dominant beliefs regarding what constitutes research. In the health sector in particular opinion of what constitutes serious research is dominated by medical science. In the health services, despite the rhetoric in health promotion about the importance of the social determinants of health, disease focused research favouring traditional, objective, positivist approaches is favoured.

4.5.1 Recruitment

In my original vision for the research I had considered the possibility of partnering health promotion practitioners with their regular partners in practice, community development practitioners. My belief was that the mix of practitioners could add another important and relevant dimension to the

research. On paper health promotion and community development are potentially close allies in addressing the social determinants of health. In my experience the promise seldom materialises in reality. The refusal of health promotion to participate in my research study focused my mind and I revised my plans to concentrate solely on community development. I revised my recruitment literature and identified possible key contacts. My efforts closely paralleled the guidance of MacDougall and Fudge (2001):

‘Have you made contact with people or organisations who know the communities (defined by geography or by common interest) to seek *key contacts* (who can make suggestions about possible groups, networks or participants) or, even better, *champions* (who take an active interest and become involved in recruiting either directly or by allowing the researcher to use the champion’s credibility or authority in the community)?’ (MacDougall and Fudge, 2001, p.121).

My participant criteria were quite straightforward. Participants were to be female, currently working in community development in Ireland and interested in the research issue. I contacted a number of relevant national networks where I was known. Although the networks voiced approval for my research I waited in vain for the hoped for practical championing of my research study. When the more direct support in recruiting failed to materialise I reformulated my recruitment literature and accepted the invitation to use the more formal communication systems of the networks by forwarding a short article about the research for one of the forthcoming newsletters. I reformulated my recruitment literature as an article but retained the contact details and invitation to practitioners to register interest in participation. The article emphasised that the research started ‘from the position that potential participants have valuable experience, knowledge and insights that are important for the research and for the community in general’ (MacDougall and Fudge, 2001, p.123). Community referred to women in the community as well as the community of community development practitioners. For reasons unknown to me the circulation date of the newsletter was delayed. Time was now becoming a concern, a concern that was exacerbated by the zero response from my newsletter recruitment strategy.

With the loss of time a new factor needed to be considered when devising my new recruitment strategy. My options were becoming increasingly limited. I had more or less exhausted my reservoir of gatekeepers and networks and more influential key contacts. As my options became increasingly limited the need for pragmatism increased. The revised plan was for fewer, shorter sessions. My belief in the benefits of the group approach to reflection and learning convinced me to retain the group format. On a practical level I shrunk the geographical area of my search, eliminating the need for participants to travel. I would be the only one to travel a distance and would do whatever travelling that was necessary. After more weeks of emails and phone calls and support from local personal contacts I managed to assemble one group of six and decided to proceed. A start date was agreed. However, by the time the start date arrived three of the six participants had withdrawn, one due to serious illness, one as a result of job change and one due to increased work commitments. I was thrown by this but it had taken so much time and effort to get to this point I decided, against my better judgement, to go ahead and start my data collecting.

Time, both in terms of my schedule and in relation the time pressures of the participants, was a significant influence in my decision to continue with my plan to retain the group setting for my data collection. My decision to go ahead without delay and as planned was also influenced by my concern that further changes would result in further withdrawals. All three participants committed to all four sessions and assembled again for an extra feedback session. The demands of everyday life and the need for participants to prioritise other commitments, factors that were out of my control, meant that the initial schedule for data collection was interrupted a number of times and completion took significantly longer than planned. The changes raised concerns for me about commitment, concerns that were increased by my sense of difficulties in the dynamics within the group. The combination of an imbalance in the power dynamics in the group, and a possibly related issue of professional pride, threatened by the challenges presented by the concepts being explored, created, I sensed, sometimes uncomfortable tensions. These tensions and the requested changes to the timetable, changes I had little choice but to agree to, combined with my concerns about my own positionality, certainly evened out

the supposed power imbalance between the researcher and research participants. Despite having many years of experience in classrooms, facilitating groups and interviewing, this uncertainty affected my confidence and I was sometimes disappointed with the level of engagement or connection I had with the participants. At the end I had over twelve hours of data collected but, perhaps because of 'the emotional labour invested' (Nairn et al, 2005, p.236) I was a little disappointed in the quality. I refer to this group as Phase 1 and identify the individual participants as P1A, P1B and P1C. I refer to later interviews involving other participants as Phase 2. Although small, there was an interesting diversity of interest and experience in the Phase 1 group. P1A worked with a Traveller women's project; P1B was an independent consultant who worked across a large geographical area and with a wide range of projects and practitioners; P1C was a very experienced practitioner in a management position in a health related setting.

During the roll out of Phase 1 I was simultaneously involved in organising further interview participants for Phase 2. The practicalities and risks involved in organising a group were, I decided, too great and so I refined the process further and carried out individual interviews for Phase 2. As I moved my search for Phase 2 participants geographically I had to identify new contacts and get their support for my research. Again among the 'no replies' and rejections of my proposal there were also managers and practitioners who recognised a need for the research and helped me identify potential participants. Despite the challenges of recruitment I maintained a strong strategy throughout the process, making sure, for example that participants had a clear idea of what the research was about and what participation entailed. I reformulated the recruitment literature to reflect the change to individual interviews and succeeded in getting five willing participants, although one withdrawal just as I was about to start made a final total of seven participants. A significant difference between the recruitment process of Phase 1 and Phase 2 was that I spoke to potential participants personally and individually. Not all contacts resulted in an agreement to participate but those who did had a positive energy and interest in the questions being asked that I had not experienced in Phase 1. Both Phase 1 and 2 produced good, useable data but the obvious interest and energy of the

latter produced significantly more hours of data than Phase 1. Phase 2 participants are identified as P2A, P2B, P2C and P2D. In Phase 2 I was pleased that there was good representation from what is regarded as more traditional community development settings. Three of the participants, P2A, P2B and P2C were all managers in locally based community development projects. P2D worked in a traveller health project.

Despite the difficulties with recruitment the final blend of practitioner was a very diverse mix which represented many different aspects of community development and generated some very interesting discussion. Participant numbers are small in this study and it is this 'seldom-written-about-but-much-questioned issue' (Boddy, 2016, p.246) that I address next.

'Interview-based studies involving small samples are becoming more common in qualitative research' (Crouch and MacKenzie, 2006, p.484) and, although I probably fit relatively comfortably into the category of 'proponents of this research method (who) may take its value for granted' (Crouch and MacKenzie, 2006, p.484) I am conscious that for others it is an issue that needs addressing. While there is no shortage of discussion on the issue of participant numbers ultimately the guidance in the literature is quite equivocal and experts 'frequently respond with a vague (and actually, reasonable) "it depends"' (Dworkin, 2012, p.1319), but most agree that saturation is the most important issue to think about in relation to sample size.

'Saturation is defined by many as the point at which the data collection process no longer offers any new or relevant data' (Dworkin, 2012, p.1319). The extended data timeframe of the data collection enabled me to become very acquainted with the data when it was still being collected. When I started Phase 2 I was intrigued and concerned to find out if I would find the significant level of congruence that I had found among participants in Phase 1. It was both interesting and a relief to find significant similarities between the two Phases. No new information was being uncovered and I felt confident that more data was not going to produce richer data.

4.5 Data collection - my experience

In the following paragraphs I describe my experience of the data gathering process, the benefits of the approach I used and my understanding of the shortcomings. My decision to carry on with the group situation in Phase 1 (see 4.5.1), despite the small number, was influenced by my commitment to the idea of consciousness raising (C-R) (see Section 2.1). This commitment reflected my belief in the benefits of women sharing their reflections on experiences and feelings, often perceived as private, in the development of a shared consciousness regarding women's gender based oppression and challenging stereotypes. In an attempt to deliver on this commitment I used a life story style approach in the process. I start my account of the process with Phase 1 despite the fact that it fits more comfortably into the category of a 'messy' research process rather than 'serene and orderly' in the belief that this can 'provide valuable insights into a range of real issues that researchers face in the field' (Kevill et al, 2015, p.7).

As well as being suitable for achieving the aims of the research the life story style approach I employed for the data collection supports the feminist principles and aims for good qualitative research, characteristics that overlap significantly with those of PLA, my ideal option. The hope is that by placing the participant and her story at the heart of the research the participants' sense of involvement in the process is increased. By focusing on the participant's perceptions and her interpretations of reality the life story approach emphasises the value of the participant's unique viewpoint and, hopefully, increases her sense of being at the heart of the research.

With Phase 1, I applied good practice guidelines from the start in an effort to build trust and rapport. For example, I met with the group beforehand in a getting-to-know each other session when we discussed the research, the purpose of the research and the reasons for their interest in participating. Ethical considerations, particularly anonymity, were discussed. I talked about the values that informed the research approach and the hope that it would be a learning experience for all. I underlined the importance of critical reflection in achieving this aim by providing each participant with a notebook to record their observations, feelings and any questions that might arise throughout the

process. After contracts were signed dates were finalised. Although relieved to have reached this point at last, I left this introductory session with some concerns. Repeated mentions of pressures of time, especially when the schedule had been significantly trimmed from the one I had proposed, were a concern. Instead of the 'relaxed, comfortable space' (Atkinson, 2011, p.8) recommended for this type of approach the physical space of the meeting room was rather stark, a fact that may have added to the tension that I sensed in the room. My hope was that the story telling planned for the first session would help alleviate these tensions and build a more positive dynamic.

It was in session one that the life story style was most recognisable. In question one the focus is on gender and participants' perceptions and interpretations of their reality in relation to their learning and development as girls and women. The aim was to explore their feelings about those experiences from their current standpoint and how they believe their experiences assisted in forming their identities as girls and women. It was hoped that participant's contextualised accounts would also inform research question three regarding the influence of the wider social and political context of Ireland as a postcolonial nation.

In an effort to ensure participants felt their voices were heard I took steps to support their efforts to construct their stories. Participants already had the notebooks provided for recording their reflections. The next obvious step was to provide participants with the question in advance. The advance information included the rationale for the question and, reflecting Lieblich et al's method, 'I would like you to think about your life now as though you were writing a book. First think about the chapters of your book' (Lieblich et al, 1998, p.25) I provided broad chapter headings for structure. To help balance control of the feedback I suggested that participants bring a photograph or other object to use as a springboard for their story telling. Apart from the broad chapter headings and the springboard object the interview for question one was quite unstructured.

The unstructured format of a life story interview certainly presents challenges and my experience working with women's groups reflects the opinion that 'Your first experience will be your best teacher and from there you will learn more as you go on and try others' (Atkinson, 2011b, p.2). Through experience I was well

versed in the practice of listening to life stories and, by creating opportunities in everyday interactions, I worked to continue to develop the necessary skills. I felt I knew what questions to ask, how to ask them and when. In my PLA projects with women I was fortunate to have had experience of 'a listening that goes far beyond the normal realm of hearing what someone has said, a listening through which both teller and listener are changed ... and what happens at this moment of deep listening is the realisation of a connection that defies explanation' (Atkinson, 2011a, p.11). Despite my qualifications for the task, my experience also alerted me to aspects of this particular situation that caused concern. Working with quite a constrained timeframe for a task that benefits from flexibility was one concern and one that was compounded by my unease regarding the tensions in the group dynamic that I had sensed in the getting-to-know each other session. I had no time, outside of the interview itself, to address the issue and try to create a more comfortable dynamic. In the sessions I knew listening would be key to success. Direct, simple questions, expressions of surprise where appropriate and requests for clarification would hopefully help ease any feelings of discomfort or uncertainty and produce the desired information. Participants took it in turn to tell their story and engage in the interview about the question. There were two rounds of interviews as the question was divided into two halves, a structure that provided opportunity for reflection. Mirroring the format of feminist C-R groups it was agreed that the story tellers/interviewees would speak without interruption from other participants. The task for other participants was to listen. Time was divided equally between the group members.

On the day of session one with Phase 1, although there was no evidence of the notebooks that I supplied for reflections and planning, there were signs participants had prepared for the session. The styles of story-telling varied significantly from a stream of consciousness style to one that was much more stilted with frequently unfinished sentences. There were two outstanding characteristics that presented challenges on the day. One was a resolute resistance to any attempts by me, however gentle and respectful, to ask questions or to help get the story back on track when it ventured into areas not relevant to the question. A second, related, issue was an absence of any

reference to feelings about the experiences described or reference to the impact of the experiences. The difficulties with intercepting the flow of participants persisted throughout the process in Phase 1. My efforts are clearly audible in the audio recordings of the sessions. At first I was very hesitant about adopting a more robust approach to asking questions. However, ultimately I was left with little choice when, after alerting participants to the problem, little seemed to change and I simply had to press quite hard with my interventions. This approach presented further challenges at the transcription stage when my attempts to ask a question often resulted in two of us talking at once which sometimes made the content indiscernible. The situation made me feel uncomfortable and concerned about losing what the participant was saying and on occasions the transcription indicates that I abandoned my effort at intervention. With limited opportunities for relaxed and natural interventions with questions or comments I signalled my interest and encouragement through facial expressions and body language. However, limited opportunities for more active interventions meant that ‘meaning-making work which turns the interview into an active process that is unavoidably collaborative’ (Atkinson, 2011b, p.2) were missed. A collaborative, meaning-making enhances prospects for critical reflection, enabling a deeper level of consciousness and an increased awareness of feelings and impact.

Not everyone is an equally able story teller and one suggestion to assist people is to ask them to make ‘a collage of his or her life on newsprint or poster paper that represents in some creative fashion the important events, experiences, and feelings in words, symbols, and images’ (Atkinson, 2011b, p.2). I agree with Atkinson’s suggestion. The activity he describes closely resembles the most popular and successful activity in my PLA toolbox and, was the anchor in my original and ideal vision for my data collecting. It is an activity I have used extensively. Unlike Atkinson, who suggests doing the activity individually in isolation, I have used it very successfully in group projects with women. Constructing the collage enhances critical reflection and the completed collage provides a visible, accessible structure that greatly aids the articulation of people’s stories and facilitates a more collaborative interview process. It can be a challenging activity and needs a skilled interviewer or facilitator but when used effectively, the collage activity gives people a feeling that they are being

really listened to. In my experience, when listened to without judgement, women in particular feel that they matter and what they have to say is important. It is, however, an activity that takes time, a commodity that was in short supply, particularly in Phase 1. The format in Phase 1 was similar in each session. In lieu of the collage-type activity participants came with their thoughts and took it in turn to tell their stories of their experiences and respond to my interview questions. Each interview question was divided in two, so there were two rounds of telling and interviewing. The one agreed rule, influenced by feminist C-R groups and my experience of action learning, was that, apart from my interview questions participants could speak without interruption. The task for the other participants was listening and reflection.

There were four participants in Phase 2 and, as in Phase 1, there were four interview sessions. While Phase 2 participants were asked the same interview questions, the process was refined slightly. Refinements were driven partly by practical need and partly by learning from the experience of Phase 1.

Coordinating diaries proved impossible so the interviews were carried out individually. The interviews were scheduled to last for one hour but they generally over-ran, significantly on a number of occasions. In Phase 1 particularly, but not exclusively, participants struggled in the interviews with the question of where and how gender was in their work. Wherever possible, I tried to encourage more critical reflection and attempted to probe for richer explanations. However, signs of irritation curtailed my efforts to probe further. I cannot say, beyond what participants say, about what psychological mechanisms stand between participants' awareness and actions.

Although participants were understandably guarded in the early stages meeting and talking with participants individually beforehand and the fact that interviews took place in their own offices, or in a room of their choice on their own premises, resulted in a more relaxed dynamic than in Phase 1. With one participant coffee and scones were included. One of the most significant changes to the process was the template or worksheet I designed for interview question three. The actual structure of the task and the instructions remained the same. The main reason for the change was that although Phase 1 participants came with a wealth of stories to recount about their experiences they struggled to move from story-telling mode to a deeper critique of the

impact of their experiences. In Phase 2 instructions and structure remained the same but, to encourage a more critical reflection, participants were provided with a template or worksheet (See appendices) to record their experiences, including their feelings about their experiences. The completed worksheets provided a strong anchor for the story-telling and reflections of the participant and a clear frame of reference for interview questions.

4.6 The Research questions

As a feminist research study the overarching characteristic is attention to gender as a form of oppression in women's lives. The research is borne out of my experience of the gender-blind or gender neutral practice of female colleagues in health promotion and community development and the absence of a feminist perspective in their work with and for women when I worked as a women's health officer in the health services in Ireland. The overall purpose of the questions asked as part of this study is to develop knowledge that can lead to more critical awareness and understanding of the issue being addressed and can contribute to a framework of action for change and improvement.

My own experience as a woman working and living in Ireland influenced my belief that the impact of gender based oppression on women's health and wellbeing is an important social justice issue that needs addressing. This study is informed by that experience and by my subsequent efforts, in my role as a women's health officer, to develop a feminist vision of and approach to women's health, one that recognised gender and women's gender based oppression as an overarching determinant. In my experience a principle barrier to achieving my aim was the lack of opportunity for the development of a shared feminist standpoint among potential allies or co-workers. From my standpoint the absence of a critical feminist perspective among female colleagues in health promotion and community development resulted in gender-blind or gender neutral practice in their work with and for women. From my critical feminist perspective I see such practice as potentially damaging to women and women's health and wellbeing because it generally ignores the impact of the daily drip, drip of everyday sexism and reinforces traditional gender based discriminatory understandings of women, their roles and capabilities. From this perspective I

believe women's everyday experience of gender based oppression is a social injustice that is detrimental to their health and wellbeing and is an injustice that needs addressing.

In my role as a women's health officer and within my feminist paradigm I believed that I had a responsibility to address this social injustice. This feeling of responsibility is what drives this research study and inspires the radical paradigm that informs it. In agreement with Grant and Giddings (2002), my belief is that in the face of social injustice the change oriented objectives of a critical feminist perspective believe the task of the researcher is to 'illuminate social structures and their oppressive effects in order to raise his/her own and the research subjects' consciousness of them, and as the basis for collective action and struggle' (Grant and Giddings 2002, p.19).

The study presents a number of potential challenges that require consideration in the question design in relation to what I consider necessary and possible to ask. One challenge to be considered is that two concepts central to the study, health and gender, are social constructions. A second related challenge is the embedded nature of the dominant definitions of both concepts. So, a necessary aim of the questions asked is clarification of participants' understanding of these key concepts. A more extensive discussion of the research process will take place later in the section on research design. Suffice to say, reflecting the critical feminist epistemological position of this research, the questions are not designed to be part of a one way information exchange. The feminist roots of this study assume that 'those who are researched should be treated like people and not as mere mines of information to be exploited by the researcher as the neutral collector of "facts"' (England, 1994, P.243). In support of this principle the questions and the questioning process were designed to encourage reflection on the issues and to raise the consciousness of both researcher and participants.

As socially constructed concepts, both health and gender, and subsequently the relationship between them, are understood differently in different cultures and contexts. Throughout my time as a women's health officer in Ireland, despite my ongoing observations and reflections on the issue I was never confident that I understood why a feminist informed understanding of the relationship between gender and patriarchy and women's health wellbeing seemed such anathema to

practitioner colleagues in health promotion and community development. This research study presents the opportunity to directly examine this conundrum by asking participants directly about their perceptions regarding the different concepts, the relationship between them and how they think their understanding influences their practice.

The aim of the question formulation is to progressively build and extend a shared consciousness and understanding. The starting point is an exploration of the key concepts, how participants view them, what they believe informs this understanding and, with reference to a social determinants model of health, how they understand the relationship between the two. This initial exploration leads on to an examination of the relationship between practitioners' beliefs and their professional practice. In the postcolonial analysis of this study the cultural context is of interest, so, building on the knowledge gleaned from previous discussion, the third question attempts to explore the wider social context. Hoping that earlier discussions will have resulted in the sort of 'changed consciousness' (Grant and Giddings, 2002, p.19) that is an aim of critical feminist research, the final question focuses on what changes in practice and possible future actions participants might consider as a result.

The research questions are as follows:

1. What are the perceptions of Community Development Practitioners (CDPs) in relation to:
gender
health and wellbeing
the relationship between the two?
2. How do the CDPs' understandings of these concepts relate to their own past and present practice and experience?
3. In what ways, if at all, are these perceptions, experiences and practice related to their wider social context, in particular by the wider social, historical and political context of Ireland as a postcolonial nation?

4. What are the implications for future strategy, policy and practice in this area, from a critical feminist perspective?

In the four interview sessions with participants these research questions were operationalised into four main interview questions:

Interview Question 1: What are your memories of growing up as a girl and young woman in Ireland? This question was designed to ease participants into the process and to build the relationship between me, the researcher, and the participants. The question anticipated the challenge of defining a complex concept such as gender by encouraging participants to talk initially from and about personal experience. In the discussions, as well as recounting stories of their experiences, participants were asked about the messages they recalled about gender and gender differences, where these messages came from and how they felt about them.

Interview Question 2: What is your understanding of health and wellbeing? My approach to this question was influenced by the fact that, like gender, health is a difficult concept to define. To make the task more manageable for participants I again encouraged them to begin by reflecting on personal experiences. Concerned that, in the context of the interview, participants would be inclined to favour the medical, disease based explanation, with the possibility that the discussion would end up in a cul de sac, when necessary I planned to encourage participants in this discussion to describe in positive terms what they understood by health and wellbeing.

Interview Question 3: What did you observe about gender, how it manifested in your everyday life, how you responded to experiences and describe associated feelings? In this question the focus moved from memories of gender to contemporary, everyday experiences and understandings of gender. In recognition of the possible challenge presented by the request to describe their understanding of a complex concept of gender the process of responding to this question was facilitated by the use of 'doing gender', a concept introduced by West and Zimmerman in 1987 (See Chapter 2). In the week preceding interview session three participants were asked to apply a gender lens to their everyday experiences, both personal and professional. The question and task were

designed to encourage reflection and promote greater involvement of participants in the research process as discussed in Chapter 2.

The observation task (See appendices) was assigned in the hope that ‘an understanding of how gender is produced in social situations will afford clarification of the interactional scaffolding of social structure and the social control processes that sustain it’ (West and Zimmerman, 1987, p.147). The task assigned to participants in preparation for Question three was to encourage them to look critically at their perceptions of gender. Following West and Zimmerman this critical observation of everyday actions would shed light on how gender is manifested, the part played by participants themselves in doing or undoing gender and what they believed influenced those decisions. The exercise reflected the belief that ‘only by asking how, when, where and by what means gender is actively practiced can we gain insights into “saying and doing” dynamics’ (Yancey Martin, 2003, p.359).

The reality of gender inequality is generally accepted wherever there are readily accessible statistics, for example, the gender pay gap or the absence of women from politics or other positions of influence and leadership such as company boards. However, women’s experiences of ‘everyday sexism’ (Bates, 2014) and gender based prejudice in everyday interactions and the impact of those experiences, however commonplace, remain largely invisible. The instructions for the assigned task specifically asked participants to include experiences of interactions in the domestic sphere, in the family and other social situations in their observations. This instruction reflects my agreement with Lorber (2000) that ‘gender so imbues our lives’ that to just focus on their professional experiences would give a very limited picture of reality. In the professional context the possibility of a restricted or partial view owing to the presence of gender related policy or legislation was a consideration. The rules of the gender regime are often more evident in the home and among relatives and friends, so observation in the relative comfort of interactions in the home and family environment and other social settings was necessary to ensure a suitably comprehensive study of the reality of gender. Including the personal sphere in Question three presented the possibility of highlighting the omnipresent nature of gender in the social relational context, a characteristic that, according to

Ridgeway and Correll (2004), distinguishes it from other systems of inequality and difference. The constancy of gender makes it 'a significant feature in nearly everyone's daily experience' and 'that, in turn, reinforces the role of gender as a significant definer of self and other in all social relational contexts' (Ridgeway and Correll, 2004, p.512).

Another challenge of Interview Question three, like questions generally in a feminist study, was to 'maximize the research process as a change-enhancing, reciprocally educative encounter' (Lather, 1991, p.72), one that would boost the development of feminist consciousness. In an effort to meet the challenges presented at this stage of the process Question three and the subsequent interview questions were positioned within a critical reflection framework.

Critical reflection has become increasingly regarded as an essential component in professional education and training, particularly adult education, because of its ability to unsettle individual assumptions and support transformative learning. It is regarded as being particularly compatible with professions with aspirations for social change (Lishman, 2015). Critical reflection encourages a review of self-knowledge in particular the deep seated values and beliefs which can hamper capacity to consider other perspectives:

A good critical thinker understands the limitations of her individual perspectives and the value of other perspectives (and thus the value of dialogue) as a way of opening her mind (Hanscomb, 2017, p.57).

The critical reflection approach promotes the active involvement of participants in the research process in encouraging them to carry out their own research by exhorting them to notice what, how and why they practice or challenge gender in everyday interactions in their private and professional lives

Interview Question 4: How, if at all, do you think women's gender as a determinant of women's health and wellbeing might be addressed in community development policy and practice? The main factor to be considered in relation to Question 4 was that the nature of the discussion in the session would be significantly influenced by the discussions in the previous three sessions.

My analysis of participants' responses to these questions is presented in Chapters 5 and 6.

4.7 Thematic analysis

My approach to organising the data closely resembles that outlined by Braun and Clarke (2006) and Green et al (2007). The process began with my 'immersion' (Green et al, 2007, p.547) in the data. Really this process began as soon as the data collection began. It continued and became more focused during the transcription stage. Once the thirty plus hours of data was transcribed and in hard copy I read and re-read it in preparation for the first step in structuring the data. Ideas for codes were developing throughout the immersion stage. I began the actual sorting process by identifying general points of interest relating to each particular question. Initially notes in the margins identified the relevant sections of interest. The next stage was categorisation and grouping of the segments and applying descriptive labels to them. Although the influence of theory is undoubtedly ever present in this process, because of my aim to give voice to the thoughts and opinions of the participants my coding was principally data driven. I began the coding process using a manual approach with coloured markers and cut out segments of text or quotes in large print and grouping them at first using a table and then moving to the floor. Eventually space, or lack of it, became a problem but by transferring to CAQDAS, specifically HyperRESEARCH, the process became much more manageable.

Throughout the process of organising the data I was guided by what I was asking from it and each question was analysed separately. In the final stage of the process I collected the codes together and combined them meaningfully under a small number of suitable themes which gave a greater depth of meaning to the codes. There were clear distinctions between the themes in each question, although Questions 1 and 3, both of which explored the concept of gender, generated the same principle themes, Manifestation, Impact and Response.

Reflecting the struggle participants had with the concept of health beyond a disease based medical model, the principle themes in Question 3, which focused on understanding of health and wellbeing, were Harmful Contributory Factors and Positive Contributory Factors. In the fourth session participants were asked

about how they might in practice progress a feminist framework for the promotion of women's health and wellbeing which addressed the issue of women's gender based oppression. The reality of the challenges inherent in their responses was clear and is reflected in the resulting themes, Barriers and Constraints, Concepts of Health and Gender Myopia. Themes tell the story of the data and the use of Gender Myopia as a theme rather than gender-blindness highlights one of the key contradictions found in the data. Although it is evident in the data that participants had a consciousness of gender as a social construct and, although not universal, a level of feminist awareness, there was little evidence of the feminist identity which is regarded as necessary for activism. So, the theme denotes the fact that, while they could see gender inequality, because of a narrow or constricted vision, they failed to see it as a matter that needed prioritising as a social injustice.

4.8 Autoethnography

Primarily because of a pressure on space, as the study developed the planned autoethnography component was trimmed. There are brief autoethnographic snapshots included in the body of the study, for example in Chapter 5.5.

Throughout my time in Ireland I actively observed and reflected on the society in which I lived and worked and how the patriarchal nature of that society impacted on me and on other women. My efforts throughout the years to gain insight into and understand the perspectives of people I lived and worked with during those twenty years certainly meet the requirement to 'be persistent, focused and single-mindedly committed' (Morse and Field, 1995, p.1) when doing qualitative research. My efforts over the years to understand also provide potentially rich data that I believe can inform the issue being addressed in this study. In this section I explain how I intend to use this data by including an autoethnographic element in the methodology. I will look at what autoethnography is in the context of this study and how it will be used. I will also outline the benefits of autoethnography and some of the issues relating to the method.

As with most doctoral dissertations the topic of this study was not a casual or random choice. A level of personal motivation drives the study and has

influenced the understanding of the issue the study addresses. The relationship between researcher and research as understood in this study supports Ngunjiri et al's perception that 'Scholarship is inextricably connected to self, personal interest, experience and familiarity' (Ngunjiri et al, 2010, p.1). As I explain in the section on my positionality the research is, in other words, an extension of my own life. The autoethnographic component of the study uses relevant personal experiences from that life with the aim of helping to advance knowledge about the issue under investigation. The myriad of formal and informal exchanges, the observations in both personal and professional situations, the range of feelings and emotions these experiences generated and the reflections on these experiences provide a potentially rich data source pertinent to the research issue.

The self-focus element of autoethnography endorses Gannon's (2017) inclusion of feminist research in the 'multiple lineages of autoethnography' (Gannon, 2017, p.1) and reflexivity, a method that is particularly respected in feminist research, is a particularly well regarded method in the development of new approaches that passed through the door opened by postmodernism. Reflexivity provides researchers with a tool to critically examine how personal values and experiences impact on the research process and outcome. The influence of reflexivity is not always clearly evident in research reports in which it claims to have an influence and, over the years, concerns grew about the tokenistic use of reflexivity, when it 'is often included as a paragraph in an otherwise neutral and objectively presented manuscript' (Wall, 2006, p.148). With autoethnography there are no such concerns.

The ability of autoethnography to acknowledge and make meaningful to otherwise hidden or unheard experiences is an active demonstration of the personal is political, a favourite mantra of second wave feminism. Enabling the researcher's voice in this way is particularly valuable in serving social justice and adding to the transformative power of the research in situations where the voice in question has struggled for insider recognition or acceptance.

Autoethnography has transformative potential as an approach when, because the narrative engages with the personal experience of the reader, it manages to bridge the gap between reader and research. Building the bridge makes the

research more accessible, opens hearts and minds and increases people's capacity for action, making it an attractive option for feminist research. The characteristics of autoethnography as a methodology have led it to be recognised as 'one way of doing feminism in society' (Ettore, 2016, p.1). In her analysis Ettore (2016) places particular emphasis on narrative and her summing up of the importance of narrative to feminist methodology resonates with this study: 'Narrative shifts or pushes us from notions that there is a single cultural perspective revealing an irrefutable set of truths that all cultures claim about themselves' (Ettore, 2016, p.1).

Because of the inclusion of personal narratives, autoethnography has the potential to open hearts and minds to a different way of seeing the world and creating the potential for the generation of new questions that in turn produce new knowledge that can inform people's efforts for social change. Increasing capacity for change is also made more possible if the related experience resonates with the reader's own experience. While the inclusion of the personal data allows for a more comprehensive analysis and understanding of the world being explored, Anderson (2006) warns against the danger of 'self-absorbed digression' (Anderson, 2006, p.?). The self-reflection and interrogation is necessary for the task of making sense of a complex world which the researcher is part of, but only part of. Although autoethnography involves the researcher writing about herself the autobiographical element is not the same as autobiography in the literary sense. In autobiography compiled for autoethnography the 'I' is firmly situated in the cultural context with the aim of developing insights from that perspective whereas the 'I' in literary autobiography is positioned within the personal.

4.9 Looking forward

This chapter describes how this study was brought together, some of the challenges faced along the way and how they were overcome. In the following chapters, 5 and 6, the fruit of these labours, the analysis of participants' responses to my research questions is outlined. In Chapters, 5 and 6, I describe my analysis of participants' responses to the interview questions 2 and 1 respectively. In Chapter 5 I present my analysis of participants' responses to

Question 2, 'What is your understanding of health and wellbeing?' In the following chapter, Chapter 6, the focus is on interview Question 1, 'What is your understanding of gender?' In both chapters the analysis is supported by some useful contextual analysis which refers to the literature in Chapters 1-3. After the analysis I finish with a Discussion and Conclusions Chapter.

Chapter 5: Participants' Understanding of health and wellbeing

5.1 Introduction

In the following two chapters the analysis and presentation of the findings are supported where necessary with some contextual analysis which connects with the literature referenced in the earlier chapters. The chapter provides a platform for the broader discussion and conclusions chapter which follows. In Chapter 7, the concluding chapter, I review the findings in relation to my overall argument and research questions. The data analysed in this section focuses on Interview Question 2 and participants' understandings of health and wellbeing with regard to women in the communities they serve and how, if at all, this understanding influences their practice.

Community development and 'the practice of a more just society starts in the personal everyday experiences that shape people's lives' (Ledwith, 2011, p.3) which is where a positive, social determinants model of health and wellbeing is also situated. An aim of this study is to explore with participants their consciousness of everyday experiences of gender and how, if at all, these experiences influence their views about the scope to promote women's health and wellbeing by acknowledging and targeting the social injustice of women's gender based oppression. The data indicates that to address such a feminist agenda potentially poses a significant challenge.

The findings highlight the struggle participants had with operationalising a social model of health and wellbeing in relation to women in the community. Analysis suggests that this struggle is associated with the gender-blind practice which results from the absence of a critical feminist analysis, one that understands patriarchy as the root of 'women's oppression and exploitation within the family, at work and in society' (Subotic, post-2015, p.2). Such an analysis recognises the need for consciousness-raising (C-R) to challenge the pervasiveness of patriarchy. It recognises women's gender based inequality as an issue of social justice which requires transformative not just social action.

A level of gender or feminist awareness is evident in the acknowledgement of the inequity of the pressures of women's gender prescribed roles and responsibilities. However, the analysis highlights a degree of conflict between this awareness and an accommodation with the situation characteristic of internalised oppression or subordination.

None of the participants expressed a view that the sexism experienced by women is a social injustice that could or should be addressed by community development. In contrast, the data suggests that there is a general agreement in community development that men's needs should be prioritised. The data also implies that this agreement is partly influenced by women's relatively high level of participation in community development compared to men. The subsequent belief is that women's needs are being met and, in those circumstances, gender equality requires that men's needs are prioritised. However, the data suggests an inconsistency in the thinking about gender equality - while men-only initiatives are positively regarded, the need for women only initiatives has to be continually defended. Evidence of an accommodation with traditional gender social arrangements is particularly evident in the findings relating to Travellers and Traveller women. The Chapter concludes with discussion of the challenging issue of adolescent pregnancy.

Throughout the chapter I use the identifiers I described in the Method and Recruitment section of Chapter 4, the Methodology chapter, P1A, P1B and P1C for Phase one participants and P2A, P2B, P2C and P2D for Phase two participants.

5.2 Accommodating gender as a determinant of women's health and wellbeing

Feminism is not an inert concept or static term. Beyond the fact that all feminisms acknowledge women's inequality there are, as I have discussed elsewhere in this study, many different feminisms which define the problem of women's inequality differently and subsequently propose different solutions. As Aronson's (2017) continuum explains (see following chapter), gender awareness

or feminist consciousness does not always result in activism or active involvement in feminist politics. For example, not all feminisms attach particular importance to the prioritising of women's perspectives and experiences to make 'women's "voices" salient in the production of knowledge' (Lorber, 2010, p.173), knowledge required to inform gender aware policy and practice. Such approaches are valued in feminist practice because of their capacity to shed light on the often invisible impact of the pervasiveness of patriarchy and everyday sexism in women's lives, thus making the connection between gender as a determinant and women's health and wellbeing.

Although not universal, there was general consensus regarding the inequality created by the care burden placed on women as a result of prescribed gender based roles and responsibilities:

I mean there isn't a Traveller woman I know, and actually a lot of women in the community do the work of carers, the invisible work. It's not just rearing children. It's the sick relatives. It's the checking on somebody who isn't well and it's the interfacing with services on behalf of family. P1A

You know we are in a post-feminist era now because we're all so equal but I still see that it's women that are the ones chasing, collecting the child. And you know how health services are delivered - a lot of it is that women are going to appointments but they're not always suiting the user. P1B

There was similar consensus among participants of the negative impact on women of these unequal care demands:

I think women carry an awful lot of guilt. I think that if women have free time for themselves if they have children and are married women feel more guilty about having that time to themselves. I think men fare better around making sure you know that they're going to the hurling match with their friends, or going to golf and they're full time maybe but they do all of that. Women who are working fulltime do that and they also then look after the household and look after the children and

then try to squeeze in time for themselves. So I think there'd be enough statistics around I think that would say the gender issue definitely impacts poorly on women. P1B

In her reflections P1B recognises the inequality created by the sex related polarisation of characteristics, behaviours and responsibilities. Despite this awareness, in practice this gender based inequality and its impact on women's health and wellbeing was not supported by examples of how it is problematised by practitioners or identified as a potential area for intervention (see below for comments from P2C and P1B). Although they had a good level of awareness of the importance of being proactive in relation to their own personal health and wellbeing, particularly in relation to psychosocial aspects, participants struggled with their responses when asked about their professional practice regarding the promotion of women's health and wellbeing.

Participant commitment to the idea of promoting women's health and wellbeing varied across the group.

Some of the barriers to including a women's health promoting programme were identified in the session on health and wellbeing but it was not until the final session, in which the focus was on thoughts about future practice and following much discussion and reflection, that the essential problem was identified. P2C stated it clearly:

You see when you said community development practice in addressing gender as a determinant I think at the very end of the last session we really reached the conclusion that gender wasn't on the agenda at all. P2C

P2C's clarification suggested the situation was compounded:

I think if you were to take it a step further you would actually see that in my opinion that there's been more of a drive to have equality for men in community development in recent times and that's a direct result of men haven't traditionally participated and it's very hard to engage men in community projects. P2C

Different shades of feminist awareness are threaded through the data. However, there is little evidence of personal feminist awareness translating into gender sensitive practice for women.

When I asked P2C directly for her thoughts about the connection between community development and women's health and wellbeing she emphasised the level of women's involvement in community as an obvious and presumed benefit:

Well women are far more engaged with community development as both service users and practitioners than men. We do put on a lot of community education classes here and if there were twelve places on it ten would be women. It's very difficult to get men in so women are doing much better out of it I think.

P2C

When asked specifically about women's needs in relation to health and wellbeing P2C again painted a positive picture, one positioned within a framework that supported a strong medical model bias, with health understood as freedom from disease. P2C regarded as positive the fact that women '*statistically go and seek medical help more readily than males do*'. When asked about the influence of gender as a determinant of women's health and wellbeing P2C identified women's childbearing and related gendered responsibilities as a '*positive thing*':

Women are the people who take children to public and developmental checks so women are exposed more to what's out there both in diseases and health than men are so I'd say that's a positive thing. P2C

P2C's optimism suggests a high degree of environmental mastery that is unrealistic when set against a backdrop of 'a structural and cultural reality where power and authority are largely concentrated in the hands of men' (O'Connor, 1999, p.138) and which ignores the socio-economic context and social marginalisation of the caring role and undermines the need for active intervention to promote women's health and wellbeing.

In my discussion with P2C about the programmes and projects she managed and what, if anything, was the role gender played, I gained some insight into the ease with which women become invisible as a result of a gender-blind analysis. The programme was, P2C explained, a challenging one for the men. One issue was men's unwillingness to take direction from women programme leaders:

They're not used to being directed by women and they kind of find it a little bit offensive and have a 'she's not going to tell me what to do' and 'the last women who told me what to do was my mother' kind of an attitude. It's completely outside their experience to take direction from women and it can lead to quite a number of conflicts and I think the management of those can be quite difficult as you have to be very wary. P2C

Listening to the story about the difficulties the men had and how the women programme leaders could feel intimidated by their behaviour I wondered if women participated in the programme.

Yes, there are women as well. They just want to put down their time, do four hours or whatever. They want, and I'm generalising here, to put it down doing as little work as possible and follow the path of least resistance. They do enough to keep themselves out of trouble. Women are cleverer if you like about how they do it and how they present themselves at work. They'll do, as I say, enough to keep themselves out of trouble. P2C

P2C's description of women's approach to the programme could be described as an example of the 'environmental mastery' element of Ryff's scale of wellbeing. This could also be an example of 'adapted preference formation' in which choices and preferences are accommodated to oppressive social conditions' (Stoljar, 2016, p.2). Is the experience a positive one for women, one that builds women's resources, builds their potential to flourish and has a positive impact

on their health and wellbeing? Or, is it a ‘forced trade-off’ (Khader, 2013, p.213) that further contributes to women’s own oppression? Although these are fundamental questions within any social justice agenda they are going to remain as unanswered questions if programme leaders do not ask them.

P2C concluded our discussion with a statement of the mission of community development as she understands it:

Just to say in a nutshell, what we’re trying to achieve is a more fair and equal society which is a very noble mission. P2C

It is difficult to see how this fair and equitable society be achieved in the absence of a feminist analysis that problematises women’s relationship with their gendered social world? Take for example P2C’s description (reported above) of the sexist attitudes and, discriminatory behaviour of the men participating in the programme in her project. These same men are the fathers, brothers, husbands, partners in the local community. These attitudes and behaviours reflect and support a culture of gender based inequality and oppression and are clearly not conducive to P2C’s vision. As mentioned earlier, P2C herself noted the absence of gender in the community development agenda. If women in their own right are to be included in the vision, a feminist analysis is necessary, a feminist analysis that recognises that ‘addressing gender inequality requires specific attention to the female experience’ (Robson and Spence, 2011, p.289) and the impact of that experience on women’s health and wellbeing.

In the final moments of the group interviews, after many hours of discussion, P1B made an insightful observation regarding community development practice, stating that gender as an issue had been superseded by other injustices. P1B acknowledged the need for gender analysis to be part of community development but expressed doubt about the level of current capacity within community development, in the form of self-awareness or reflection, to take action on the social injustice of gender. P1B concluded that practitioners have a responsibility to check and reflect on their awareness of personal prejudices and values in relation to gender, especially women’s gender based inequality:

Gender analysis should be part of community development work more than class or race and I think we did years ago start with a more gendered analysis of ourselves as women as workers. I think that's kind of gone down the pecking order. You need to have that self-awareness to challenge and I think that has dropped down a level ... the level of self-awareness or regular reflection on gender, in my world anyway. P1B

The introduction of gender mainstreaming and the development of a gender equality discourse in Ireland has led to a less politicised discourse in which the specificity of women's gender based oppression is lost: 'Gender mainstreaming has rendered women invisible, effectively situating women at once 'every and nowhere' (Thomas, 2006, p,3). One example of this less politicised discourse relates to the issue of violence against women. The term violence against women (VAW) has been replaced by the more neutral term gender based violence (GBV). The term GBV includes violence against men and boys, sexual minorities or those with gender-nonconforming identities. With the change in terminology the heightened vulnerability of women and girls and the profound impact on women's and girls' lives is erased.

In this discourse equality and inclusion are good things and any efforts in relation to them are also good just as any criticism is regarded as rocking the boat. The increased institutionalisation of potential agents of social action and change has also made dissent or disagreement more difficult. One result of these changes is that 'feminist politics in Ireland has become (has arguably been forced to become) increasingly polite and decreasingly radical (Smyth, 2006, p.13).

5.3 Women, health promotion and a deficit model of health

P2B talks positively about women's participation in health promotion programmes:

I'm just thinking of the programmes ... like if there's health programmes run here it's very much women coming together as a group and you hear the women afterwards saying it was really

good because everybody speaks and they all realised that everybody feels exactly the same. P2B

P2B's recognition of the particular stress women have to cope with could be regarded as a welcome recognition of women's inequality and therefore an issue that requires the 'specific attention' advised by Robson and Spence (2011):

I think women are the ones who have to cope a lot more with the stresses of life maybe. I think there can be a lot more stresses put on women by society than maybe there would be on men. P2B

Viewed through a feminist lens, however, it could equally be seen as a potential rationale for a deficit model of woman whose capacity to cope could be helped by improving the skills she needs to fulfil her prescribed responsibilities. The role of women as mothers and carers make them particularly vulnerable to the victim-blaming approach of the deficit model of health promotions interventions. The 'classic example here is that of the 'guilty' mothers who have long been the traditional target of health education' (Bunton et al, 1995, p.51).

Based on my experience I believe that a feminist alternative to the deficit analysis is one that is rooted in women's reality and validates their experiences. It is built on respect for the potential strengths and resourcefulness of women and their capacity to adapt to the pressures they face daily as a result of gender based oppression. It is an approach that understands women's experiences as carriers of 'both the seeds of radical change and the burden of oppression' (Popple, 2015b, p.80) and reflects Freirean as well as feminist values and principles. This problematising approach means 'immersing oneself in the struggle of disadvantaged communities (Popple, 2015b, p.80) and collaborating in a consciousness raising process of ongoing critical reflection and action.

Despite widespread scepticism about their value, deficit models of health promotion are presented by those who support them as being proven to being essentially a good thing. P2B was proud of organising a smoking cessation programme, one specially designed for women, for women in her community area:

I know it's a proven fact that cancer is a huge thing in Ireland and smoking is connected to that. There's still a hard core of people who are smoking and it's primarily from disadvantaged areas. The coverage in the media and all is that it's so bad for your health. P2B

P2B feels a moral imperative to do the right thing for women in the local community. But she does also express some awareness of the morality of the imposing healthist, middle class values in disadvantaged communities because, despite the messages in the media:

For women in disadvantaged areas, because of the pressures they are under smoking is almost - it helps them get through the day kind of thing. Some people just need it. So it's a difficult one. P2B

Although my analysis does not include a full autoethnography as originally planned, I include a brief autoethnographically-informed personal experience here to support my analysis and augment the discussion. It relates to my experience as a leader of a particular health related programme with women.

My experience of using such an approach with women in the Feeding Families project proved to be a memorable and transformative experience. The starting point for the health services was the issue of obesity and the type, quantity and nutritional quality of the food consumed in families, particularly in families in disadvantaged communities. The starting point for me, viewed through my feminist lens, was women's experiences of delivering on the responsibility of feeding families and the impact of that experience. The project was informed by feminist and Freirean values. The use of Participatory Learning and Action methods produced expansive colourful and informative charts, used photographs, images and other objects, role plays, personal accounts and discussion to support the process of critical reflection. As well as critical reflection there were tears and laughter and actions. The actions were generally small but significant in the women's lives and chosen to impact positively on their health and wellbeing. The actions were identified by the women and were what the women themselves felt confident to manage.

I have two particularly abiding memories of what I learned during the project. The first lesson was about the many tasks involved in feeding a family and the many invisible challenges women had to face to carry out these tasks. Tasks included planning, shopping, putting shopping away, cooking, catering for different tastes or dietary requirements, timetabling, reading food labels, interpreting food labels, childcare and budgeting. The second lesson was the inverse relationship between criticism and affirmation connected the responsibility of feeding families. Criticism was very common while affirmation was, the women acknowledged, rare. Not surprisingly the issues identified by women in the Feeding Families project bore little resemblance to the issue identified by the health services. Equally obviously the difference between my priorities (as defined by women themselves) and the priorities of the health services created problems in my role as a health service based women's health officer.

5.4 Traveller women's health and wellbeing - the intersection of sexism and racism

Like women from other minority ethnic groups, Traveller women experience an intersection of oppressions and experience both racism and sexism (Pavee Point, 'Traveller Women', 2015). Traveller women can be subject to a high level of sexism in their own community as well as racism from settled communities.

P2D, who had a specific remit for health in her work with Traveller's voiced a commitment to a social determinants of health. However, she expressed concern and a certain confusion about the suitability of the behaviour change style of programmes that are advocated to promote health in disadvantaged communities. 'It is those who are in structurally advantaged positions who benefit most from the changes in individual health behaviours' (Bunton et al, 1995, p.51) and in her personal life P2D was comfortable with the relationship between lifestyle and positive health and wellbeing. However, she recognised the context for Traveller women was very different. P2D acknowledged that in the very different context experienced by Traveller women that a simplistic, victim-blaming, behaviour change approach was inadequate to meet the needs of Traveller women and ethically questionable:

I'd be really conscious about running up to a halting site and waving my 'you need to lose weight' programme invite. I wouldn't do that. P2D

Her concerns were well founded. Travellers live with a burden of triple discrimination, race, class and gender. Addressing this multi-faceted discrimination is very challenging and feminism has been criticised for ignoring race and class in favour of gender. However, Casey, (2014) observes that there is 'a tendency to give primacy to race and discrimination issues which on their own fail to reveal the added 'gender burden' which pertains to Gypsy-Travellers, in particular women' (Casey, 2014, p.827). In the settled community factors such as internalised oppression, adaptive preference, the personal nature and embeddedness of gender means it is a social justice issue that is generally avoided or sidelined by agencies despite espousing values of social justice. In the Traveller community gender presents an even greater challenge if only because of 'the 'gender-blindness' of much contemporary Gypsy and Traveller literature' and the fact that 'there remains the tendency to underplay the effects of gender in the reproduction of racial inequality within Gypsy-Traveller communities' (Casey, 2014, p.5).

The significant level of discrimination against the Traveller population in Ireland strengthens the need and desire for Travellers to have a strong sense of identity and a commitment to the protection of Traveller culture. However the traditional ways of Traveller culture are based on a strong system of patriarchy in which women's role is dedication to family. P1A, who works specifically with traveller women, described women's role:

Traveller women, like women in the general community do the work of carers, the invisible work. It's not just rearing children. It's the sick relatives. It's the checking in on somebody who isn't well and it's the interfacing with services on behalf of family and directing other people who are part of part of your family or community to maybe access those services. It's a raft of

invisible work that society would collapse without and it's mainly unpaid. P1A

Commitment to family is everything, and was something that frustrated P2D's efforts to support women in identifying their own needs:

They are looking for something for their daughter, for their son, for their husband, for the wider community and not asking for themselves. P2D

Traveller women's prescribed gender roles and responsibilities amount to significantly more than maintaining the home and caring for family. Along with the general emotional and domestic responsibilities 'women's gendered position is related to the need for cultural continuity' (Casey, 2014, p.826), ensuring that it is passed down the generations. Maintaining the culture is a responsibility that further increases the burden on Traveller women but it is also one that gives them a certain level of power and authority. As a result, it is a responsibility that they are generally reluctant to relinquish. However, this commitment to cultural norms and practices that are 'used as justification or camouflage for the oppression of women within their community' (National Traveller Women's Forum, Gender Position Paper, p.6) also means a commitment to their own subordination and oppression. As a result, Traveller women who want to challenge this injustice 'may find themselves in a position of divided loyalty' (National Traveller Women's Forum, Gender Position Paper, p.6). This commitment explains why gender is a sensitive and complex issue for Traveller women and in development work with Travellers and requires a thoughtful and respectful approach:

The gender imbalances in the Traveller community are very different to the wider community. So it's about using the resources in here. So we would have other Traveller women in here working with Traveller women sensitively around these issues. P2D

P2D described the traveller community she worked with as particularly conservative. She described the reality and invisibility of women's experience of

oppression in this situation as they engage in their everyday, traditional gender prescribed responsibilities:

They're holding everything in their community and they have to be particularly strong because they're the ones who have to mind the kids. They're the ones that have to do the house stuff. They're the ones that have to in many instances put up and shut up when it comes to their men and what their men want to do.
P2D

Measured using the indices of the dominant disease based model of health

Travellers have significantly poorer health than the general population.

'Travellers are particularly disadvantaged in terms of health status and access to health services. Generally speaking, they suffer poor health on a level which compares so unfavourably with the settled community that it would probably be unacceptable to any section thereof' (Department of Health and Children, 2002). Typically the approach to tackling such inequality is the delivery of health promotion interventions focused on lifestyle and behaviour change. There were hints that P2D wanted to work within a more positive concept of health, one that emphasises wellbeing and replaces the 'measuring of negative health elements (for example illness and inability to cope) with something of a positive valence' (Knight and McNaught, 2011, p.24). There was also some evidence that P2D's positive approach was one that did not judge women but instead encouraged women's flourishing and promoted their capabilities rather than their inadequacies, elements found in Ryff's Scale of Wellbeing:

Maybe they have it right and I have it wrong. Maybe going to the gym is not so important. Maybe what is more important in life is having a really big family and having children to mind. P2D

I think it's about creating opportunities. It's about giving them the floor a little bit to discuss and explore that stuff, to look at their lives with a view to what's happening and supporting them with that stuff so that they can get that understanding. P2D

Such a consciousness raising approach, one that focuses on wellbeing rather than illness, reflects a gender sensitive perspective, one that could facilitate

consideration of gender as a determinant of women's health and wellbeing. It is an approach that feminism and the women's health movement have promoted: 'Feminists have consistently played a key role in movements challenging the biomedical approach' and 'according to the comprehensive feminist approach, in order to improve health, the social determinants of health must be taken into account; these are the factors that have the greatest impact on health' (Canadian Women's Health Network, 2009). While P2D's comment indicates an intention to start from women's experience and values it does not imply a critical awareness of how Traveller women's lives are constrained and controlled within a very traditional patriarchal culture and that 'the qualitative experiences of men and women vary significantly and women may bear an especially heavy burden in many aspects of their lives' (Casey, 2014, p.5). Because of her reticence to employ context blind, deficit model health promotion programmes in her work P2D needed to find an alternative. However, the desire to develop a plan to promote a positive model of health, one that would explore gender as a determinant of women's health and wellbeing, is not supported in the pertinent literature. 'Despite this mainstream theorisations have been slow to incorporate the relevance of gender issues. Until recently, Gypsy-Traveller women have been ignored or subsumed into accounts of Gypsies and Travellers more generally and the difficulties they face regarding a wide range of issues' (Casey, 2014, p.5). Neither the Position Paper on Women's Health from the NTWF, a body that actually has a position paper on gender, nor a submission paper to a new national health strategy from a Traveller health unit, for example, identifies gender as a determinant of women's health. In the latter it was acknowledged 'that 'social determinants' were the main cause of the poor health status of Travellers - accommodation, education, employment, poverty, discrimination, lifestyle and access to/ utilisation of services' (<http://npf.ie/wp-content/uploads/2017/09/0294-Traveller-Health-Unit-HSE-Mid-West.compressed.pdf>). Gender, despite being arguably a more persistent discrimination than race because of its presence in the domestic as well as the public sphere, remains invisible in health related documents.

Sensitivities around the issue of gender discrimination within Traveller communities and keeping gender and health in separate silos are definite barriers to the development of a gender conscious understanding of Traveller women's health and wellbeing. However Towards the end of my discussion with

C there appeared to be some evidence that P2D's reticence to address the issue of gender based oppression with Traveller women may also relate to a reticence to address gender discrimination in her own life. P2D used an example from her personal life which highlighted her beliefs about the pressure on women to conform to stereotypical gender roles. When asked about the impact of this pressure P2D, drawing on her personal experience, talked about feelings of powerlessness. When then asked about the potential impact of conforming to discriminatory stereotypes P2D made a connection with internalised oppression. She distanced her personal experience from her response and replied using the third person:

It affects women because I think they just go with it and this is kind of like a bit of a mirror of the internalised oppression stuff that I'm talking about in the Traveller community. You just kind of go with it. You accept it. You go with the stereotype and you don't ask questions because if you do your life is going to be harder. Or, it could become harder and it's too much of a fight. So people do what they think is expected of them. Because if you don't you will not be the norm and that could lead to a whole other set of questions and pressure from society. Women do what's expected of them and that's it. So life is hard for women. P2D

P2D therefore believes addressing the issue of gender discrimination within the Traveller community in relation to women and their health and wellbeing could be more damaging than the discrimination itself. It is also reasonable to conclude that such an analysis stands in the way of Traveller women (and men) achieving their full potential.

5.4.1 Responses to Research into Traveller health needs

Developments in relation to groups working for Traveller rights and providing community projects are regarded as relatively well developed in Ireland: In Ireland, the National Traveller Women's Forum (NTWF) has a membership consisting of representatives from 70 different Traveller groups as well as a significant number of individual women, reflecting the degree of organisational,

financial security and political importance of Traveller groups in that country' (Cemlyn, 2009, p.225). As with P2D, the discussion with P1A hinted at a level of confusion in relation to addressing the issue of Traveller women's health and wellbeing. That P1A recognises health and wellbeing as an important issue for Traveller women is evident in the fact that she '*was delighted when the All Ireland Traveller Health Study came along*'. The study P1A refers to is regarded as a seminal document in relation to Traveller inequality in Ireland, marking it out as a priority area for Government and health services and providing a framework for future practice:

'The purpose of the Study is to examine the health status of Travellers, to assess the impact of the health services currently being provided and to identify the factors which influence mortality and health status. It will provide a framework for policy development and practice in relation to Travellers' (<http://www.paveepoint.ie/wp-content/uploads/2013/10/AITHS-Summary-of-Findings.pdf>).

The study introduced her to the social determinants model of health for the first time and confirmed her belief about the importance of factors in relation to health and wellbeing other than biology, health services and lifestyle:

I was delighted when the All Ireland Traveller Health Study came along. We were all working on the ground and they used the social determinants of health, because it was the first time I had seen that depiction. But the women I was working with on the ground were making those connections. P1A

As a specifically Traveller women's organisation P1A claims that there is an acknowledgement of gender in her work. However, her search for women and gender in the Traveller health document left P1A feeling disappointment:

There is a little section on Traveller women but it's more statistical rather than looking at the dynamics of what impacts directly. P1A

The 'section' to which P1A refers is a short single page in a document nearly three hundred pages in length. The page provides statistics on contraception, folic acid and multi-vitamin consumption, uptake of breast and cervical screening and health provider of choice in relation to menopause. It reflects the priorities of a concept of health defined within a medical model and health service provision. The study is a 'mine of information' (p.157) of disease, illness related statistics. It has comprehensive detail on levels of smoking, alcohol consumption, diet and exercise that support the case for behaviour change, health promotion interventions. As P1A points out however, there is no reference to what she considers to be the factors that impact on women uniquely.

Racial discrimination is recognised as a significant issue for Travellers in service delivery, for example. However, gender based discrimination experienced by Traveller women *within the Traveller community itself*, is not identified as a determinant of women's health and wellbeing. Perhaps reflecting the sensitivity around the issue of gender in the Traveller community P1A does not use the word, preferring instead to refer to Traveller women's 'particular' and 'specific' experiences. In one such reference P1A expresses a sense of irony that men fare worse than women on a particular measure. She wanted more from the document:

There are other parts going through it that talk about gender you know, where ironically the life expectancy gap for Traveller men is longer, but Traveller women certainly have a particular experience that needs to be taken into consideration. P1A

In her frustrated search for issues that she considers pertinent to women's health and wellbeing as she understands it in such a seminal document relating to health P1A refers briefly to the sort of things that she thinks are relevant. She mentions the lack of voice women have when in the company of men, the lack of freedom women have relative to men, the level of domestic violence and the lack of necessary services, the invisibility of women's mostly unpaid work and, generally, a lack of choice in relation to anything. Finally P1A concluded, just as P2D did, that in order to understand the impact of Traveller women's

‘particular’ and ‘specific’ experience there is a need for the women to define their own issues and to make their experiences more visible:

The starting point for equality to happen is for women to have the space to define their issues and experience of issues. P1A

P1A also explained that her organisation had already undertaken relevant projects:

There are projects that we have done around trying to make women’s experiences a bit more visible, giving women space to talk in a safe and comfortable way around issues that uniquely affect them. P1A

However, what the women talk about and how they talk in these safe spaces may make all the difference and have more or less impact on women’s health and wellbeing. The starting point of a social justice or feminist perspective is that health and wellbeing defined by disease and illness based indicators is a very narrow, negative and limited understanding of health and wellbeing. By incorporating wellbeing into the concept of health the focus is altered to being about women’s flourishing and registering good levels of the elements of the Ryff (2008) scale. There are risks involved in such an approach but if the injustice of gender based inequality of Traveller women is to be respected, as the injustice of racial inequality is, it is necessary first of all to recognise it. Otherwise the wellbeing of Traveller women continues to be compromised.

5.5 Reflections on local women’s networks

To open our discussion on her understanding of health and wellbeing and how she thought that understanding impacted on the priorities in her community development practice P2A expressed a particular commitment to a holistic, social determinants model of health and wellbeing:

I suppose in our work here in this centre we would always have a strong emphasis on the overall health of the whole person and

how living in this community impacts on people's health and wellbeing. P2A

As we explored her understanding P2A fluctuated between her more holistic understanding, which emphasised various aspects of wellbeing such as engagement and achievement, and more medical model informed examples of disease prevention programmes such as screening.

As with P2C's examples, although the activities in her centre were not specifically designed with women in mind, participants were primarily women. It was obvious that P2A was eager to support a positive definition of health and wellbeing, one that supported women's flourishing. She identified developments in recent years that she believed supported her positive vision of health and wellbeing:

I think over that past 15-20 years there's been a lot more focus providing training and support networks to empower women. Things like the 'Training for Transformation' programmes and local women's networks working with women to kind of recognise their own agency and their own power. P2A

The period of time to which P2A refers covered the period of the unprecedented economic and social change in Ireland. During the 'economic miracle' (Centre for Economic and Social Rights, 2012, p.5) that became known as the Celtic Tiger, funding for initiatives and organisations addressing social inequalities and injustices, including community development and women's groups, increased significantly. However, the subsequent dramatic economic downturn which also happened in the period P2A refers to, led to harsh cuts to the same budgets. The austerity cuts affected women and other vulnerable groups disproportionately and, at a time when support was more needed than ever, the type of networks and support agencies P2A celebrated as a positive development in relation to women's health and wellbeing had to close their doors or drastically reduce their capacity. The increase in women's groups over the years in Ireland has been construed by some 'as an indicator of the vibrancy of the Irish women's movement' (Ward and O'Donovan, 1996, p.1). In my experience women's groups do not necessarily prioritise tackling gender based discrimination or women's

oppression and 'to surmount the situation of oppression, people must first recognise its causes' (Freire, 1996, p.29). Women are thereby denied the opportunity to reflect on the causes as well as the consequences of the gender based discrimination they experience daily. They miss the opportunity to realise that the sexist discrimination and women's oppression is as a result of the prejudice of others rather than due to their own inadequacies. Such consciousness has been shown to have a positive impact on women's self-esteem which is 'widely recognized as a central aspect of psychological functioning and is strongly related to many other variables, including general satisfaction with one's life' (Crocker et al, 1991, p.218).

Discrimination experienced by women in the community in which P2A works is likely to be more severe than that experienced by women in more advantaged situations and lead to lower levels of self-esteem. P2A paints a clear picture of the experience of women in the local community:

There has been a history of sexual violence against women in the community, women on their own, people coming into women's houses. That's probably something people think more of in the winter when it's dark and you're afraid to open your door and being afraid of going out and doing stuff. P2A

In such circumstances it is easy to understand that women's reasons for joining a group were 'to meet other women, to make and build on contacts and to establish a friendly and sociable space outside of the spheres of family and home life' (Ward and O'Donovan, 1996, p.1). P2A agrees that such participation supports a positive health agenda:

It's other things like the arts and crafts groups that a lot of older women in the community seem to enjoy. It's the mental activity of doing something with their hands and focusing on it and just the social space as well and just allowing those friendships ... looking at the whole person. P2A

It is also easy to understand that in the absence of a feminist analysis that recognises the causes of women's gender based oppression, as Freire (1996) suggests, the positive impact of such provision is going to have a limited impact

on the adverse consequences of damaged self-esteem. Women with low levels of self-esteem generally view themselves in a negative way, believe others view them in a negative way, put themselves down and doubt their abilities. Such feelings and beliefs are an antithesis to flourishing and drain the resources needed for wellbeing. The Freirean (1996) suggestion to ‘create a new situation, one which makes possible the pursuit of a fuller humanity’ (Freire, 1996, p.29) would support P2A’s positive vision of health and wellbeing. a social justice based agenda through critical consciousness informed by a feminist analysis leading to transformative action is required.

5.6 Reflections on adolescent pregnancy

P2A then turned to the subject of adolescent pregnancy, an issue that she identified as a priority in the community:

So how do we empower young women to recognise that they’re in charge of their bodies and nobody else is? P2A

This question came after P2A had explained that the current approach to the issue was the provision of a sexual health programme:

We run a sexual health programme at least once or twice a year with young girls. We’ve done it with young boys as well but it’s mainly young girls that we work with around that. But one of the things we do with it every year is that they do an overnight residential with programmable robot baby dolls that cry at night and ... just a bit of an eye opener. P2A

Sexual health programmes are a common response when there is a concern about adolescent pregnancy. However, rather than being empowering, the individualist nature of such programmes, especially when targeted primarily at young women, put the entire onus on young women themselves. Such programmes tend to ignore the gender norms and attitudes within the context of the lives and situations of both the young women and young men concerned. A narrative that adolescent pregnancy is always a bad thing predefines pregnant or parenting adolescents as deficient individuals and is certainly not conducive to the empowerment hoped for by P2A. Contemporary Ireland continues to present

challenges to P2A's aspiration, challenges that should reflect the context of the lives of the young women concerned and to inform the discourse regarding adolescent pregnancy.

In modern Ireland contemporary discourse relating to sex and gender reflects the neoliberalist free market ideology that has been embraced by the country. In stark contrast to the gender equality that is supposedly evident in the rise of 'girl power' there is the extreme gender coding of absolutely everything to do with children, a development that reflects an essentialist, bio-determinist concept of gender identity and difference. This regressive development which prioritises biological differences, challenges social construction theory and validates gender stereotyping is supported across all forms of media. In this new discourse 'girls are becoming increasingly sexualised and passive, while boys are depicted as rejecting emotion and engaging in exaggerated performances of aggression and bravado' (Ging, 2009, p.63).

The potential of this validation of sexist stereotyping combined with the traditional attitudes that are typically found in marginalised, disadvantaged communities suggest that P2A's concern about the issue of consent in relation to the young women in the community are well founded. Research shows that 'With regard to sexual coercion, while only a tenth of boys reported that they felt pressured to have full sex, a third of girls reported that they at some time felt pressured' (Drennan et al, 2009, p.245). These statistics are thought by Rape Crisis in Ireland to under-represent the issue, 'The Rape Crisis Network of Ireland has expressed concern that the sexual exploitation of teenagers by their peers is greater than reported' (Cherry and Dillon, 2014, p.408). Unfortunately the solution suggested by Drennan et al was more sex education 'to improve young people's knowledge of reproductive physiology and the risks they pose to themselves by having sex without a condom' (Drennan et al, 2009, p.245). As I have pointed out and as P2A intuitively understands the complexity of the issue of sexual health and the health and wellbeing generally of the young women P2A is concerned about requires a more insightful and critical approach than one that simply educates young people about reproductive physiology. Programmes need to acknowledge the issue of coercion and the possibility of aggression in relationships and explore attitudes about gender. However, an analysis carried

out by Rogow and Haberland (2005) indicate that programmes ‘still do not reflect what has been learned about the fundamental role of gender in shaping sexual attitudes and behaviour’ and that in popular sexuality education programmes ‘gender issues’ (if addressed at all) tend to be included in a superficial manner’ (Rogow and Haberland, 2005, p.335).

A significant factor that is of concern in a feminist analysis of adolescent pregnancy and one that generally gets overlooked is how the discourse around it is constructed. Young women may have a different understanding of the purpose of families and how families function. For example ‘young mothers tend have a better access to the familial caretaking nexus than older women, and people living in poverty have a foreshortened healthy life expectancy, which means that early childbearing is functional in the sense of providing longer healthy parenting’ (Cherry and Dillon, 2014, p.133). A feminist analysis that understands and respects the different possible realities would help young women to feel empowered.

When there was a booming economy in Ireland, the argument for delayed childbearing may have made more sense because the availability of new opportunities for education and employment made a different reality a possibility. However, the reality of new opportunities for people, including young women in disadvantaged communities in Ireland, is that austerity related budget cuts in public spending have had a devastating impact on possible sources of support. As well as erasing opportunities for advancement that may have previously have been dreamed about, austerity budgets mean that the provision of health and education services advocated by those concerned about adolescent pregnancy has also been shrunk. In the circumstances the prioritising of age and the deficiencies of young women as the principle factors in adolescent pregnancy needs reviewing.

5.7 Conclusions on health and wellbeing

Some of the contradictions and conflicts in the reasoning and understandings of participants evident in the findings underline the level of influence of the dominant discourses in relation to health and gender. Understandings of health and wellbeing were particularly affected. The dominance in the data of the

disease based understanding of health and wellbeing meant that capacity to operationalise the social model of health was very limited. While there were fragments of an awareness to operationalise a social model of health these insights were underdeveloped in relation to practice. Although there was evidence of gender and feminist awareness and glimpses of a feminist identity it was not sufficient to counteract the influence of internalised oppression and level of accommodation with the patriarchal status quo. In the following chapter these findings will be developed further. Chapter 6 will focus on participants understandings of gender and will consider evidence that suggests that participants 'have adapted to the structure of domination in which they are immersed, and have become resigned to it, (and) are inhibited from waging the struggle for freedom so long as they feel incapable of running the risks it requires' (Freire, 1996, p28.)

Chapter 6: Participants' understandings of gender

6.1 Introduction

In this chapter the analysis of the data from Interview Questions 1 and 3 is presented: Question 1: What are your memories of growing up as a girl and young woman in Ireland? and Question 3: What did you observe about gender, how it manifested in your everyday life, how you responded to experiences and describe associated feelings?

Question 1 focuses on participants' recollections of learning about and experiences of gender as they were growing up. Question 3 concentrates on current understandings of and practice in relation to gender, particularly their experiences in relation to challenging the injustice of gender based discrimination with particular reference to women. The analysis of the gender related data identified three main themes, Manifestation, Impact and Response. Each of the themes and their significance will be presented separately and in relation to each question in turn. The chapter is organised into the following sections: Introduction, Growing up with gender considered within the themes of Manifestation, Impact and Response and Current experience of and attitudes to doing and undoing gender, also considered within the same themes of Manifestation and Impact/Response. Memories of gender in 6.2 records and reflects on many examples of traditional, patriarchal attitudes and messages exhorting young girls to be more ladylike. Section 6.3 looks briefly at evidence of gender and feminist consciousness and feminist identity. Section 6.4 outlines the impact of an observation task set in support of Question 3 to stimulate participants' sensitivity to gender. I begin the chapter with some introductory comments, firstly to explain my thinking behind the question order and then to offer a caveat in relation to the responses obtained.

Because of the range of possible definitions or conceptions of gender (see Chapter 2), the task of explaining what is meant or understood by the concept can be experienced by some as a daunting undertaking, especially if it is from a standing start. I began my exploration of participants' understanding of gender in Interview Question 1 by focusing on their childhood memories and what they

recalled about learning about being female. My objective was to help provide some momentum for participants' thinking as well as a level of safety by giving them the opportunity to tell stories of past experiences from the relative security of their chosen aspects of their own history. The intention was that the story telling would ease them into the process by giving them a clear starting point. The hope was that this approach would relieve any prospective pressure to provide what participants might regard as the kind of cogent, knowledgeable and insightful explanation of gender that they might think would be expected from an experienced community development practitioner in the interview situation. An additional hope was that any connection between values adopted growing up and professional practice would be identified. I judged that the approach had the added potential benefit of helping to build the relationship between myself and the participants. Finally, I hoped that the reminiscing would encourage a level of reflection on their experiences and beliefs that would be continued and developed throughout the process. To promote the practice of reflection participants were provided with the question a week in advance.

6.2 Memories of gender

6.2.1 Memories of gender - Manifestation

In this section I concentrate on one of three themes identified in the responses to question one, 'Manifestation' or how gender manifested itself in the episode recalled. The manifestation theme contains a range of categories providing instances of gender being enacted and examples of participants' conceptualisations of gender. Overall the content of the autobiographical narrative of participants recounting memories of gender socialisation is family centred and generally, although not entirely, reflects the dominance of a patriarchal or traditional gender regime. The story recounted by P2C presents a particularly clear and stark example of how a simple domestic scene is shattered when male authority and identity feels threatened. Viewed through a feminist lens the injustice and unfairness of the situation is obvious:

My brother made a mess and my mother was making him clean it up. He fell into a muddy trench and he came home and got mud all over the house and I remember my mother. She picked my

brother up by the scruff of the neck and she put him in the bath and hosed him down and when he came out of the bathroom she gave him a scrubbing brush and a bucket of water. She told him to start with the step and work all the way down through the hall. When he was doing it my dad came home and said 'what are you doing?' and my brother said 'Mam said I have to wash the floor'. My father wouldn't let my brother clean up the mess because 'that's women's work' and he made me do it. P2C

The gender related messages manifested in this anecdote are clear. The story illustrates how easily patriarchal dominance can feel threatened and how, in order to protect that dominance and to reassert male authority, women can be undermined, diminished and discriminated against even by those closest to them.

In this section the focus is on the theme of 'manifestation' with the two other themes identified in the analysis of question one, 'Impact' and 'Response' discussed separately in later sections. There is no clear description of impact on or response of those involved in the incident. However, the anecdote concludes with a suggestion that the immediate fallout from the event was conflict and discontent in the home:

There was a big row then between him and my mother. P2C

The simple domestic incident described here is one example of the gender related discriminatory messages girls and women receive throughout their lives in a strongly patriarchal culture. Oppressing females by positioning them as subordinate in this way may create a barrier to their flourishing and the development of the core dimensions of health and wellbeing such as autonomy, personal growth, self-acceptance or environmental mastery identified by Ryff (Ryff and Singer, 2008, p.20).

I have found in Ireland that gender based discriminatory messages are not confined to family or the domestic sphere. I believe they are deeply embedded in social structures and other social institutions. For example, control of education by the Catholic Church has been and is an elemental factor in sustaining a strong patriarchal culture. All of the participants in this study

attended Catholic, single sex convent schools at both primary and secondary level:

I was in an all-girls school. It was a reasonably large school, Catholic, a load of nuns in terms of their view of what us girls should be and look like. So there was a very strong ethos in the school around girls and their role and even though they promoted education they promoted it to a point. Ultimately you were to settle down, get married and look after a family. P1B

I would have gone to a Catholic, all-girls school, which was actually a grammar school and run by nuns. So we were brought up you know to be a lady. It was all about you know ladies do this and ladies do that. It was very much like that - quite regimented. P2B

Although packaged in comic irony, Flynn's (2014) observation that 'being a lady is one of the top Irish compliments' (Flynn, 2014, p.228) suggests that things have not changed as much as some people believe. In reality the gendered term ladylike is a means of controlling women's behaviour and appearance and positioning her as the other. The many admired qualities that define a lady include demure, modest, obedient, polite and nurturing. Ladies do not complain and are pleasing to men. Ladylike qualities positions women as the weaker sex physically, mentally and emotionally. Participants found that opportunities to compete in sport were limited by the expectation of being ladylike. Competing in sports or sweating or grunting as a result of involvement in physical activity was frowned upon and limited:

They didn't want anybody playing camogie because it wasn't ladylike. So you could play a little bit of hockey because you didn't raise your stick. But you couldn't play camogie. It was to do with that it wasn't ladylike and you know girls should be doing things that were not rough but were more genteel. That's what they wanted for the girls. P1B

The reminiscences of participants illustrate a clear awareness of the unfairness of the imposed ladylike behaviour regime and of the constraints it imposed on their

opportunities for fun. While girls were indoors doing sewing and knitting boys were outside doing gardening, which because it offered an opportunity for running around and having mud fights, was much more attractive choice for girls who preferred the outdoors. The story of the playground fight in an all-girls school highlights how the concept of ladylike was used for control and regimentation:

I definitely remember being told that I was a lady and must behave like a lady. There was a fight for want of a better word in the playground when I was a child in school and we were all called in the following day. This is my first memory of the real behaviours that were expected. It was an all-girls school. There was a fight and some of us that weren't involved in the fight but were watching were called in. We were all called in and were told that we weren't ladylike and we weren't fit to be ladies because we were watching a fight between two other girls. P2C

This story also highlights an awareness of the social constructionist nature of the ladylike concept which, despite the evidence, denies that girls can be attracted by the fun and excitement of a playground fight:

Now I don't remember that we were watching it because we were girls or because we were boys. We were watching it because it was exciting. It would have been alright for boys to be out watching the fight but it wasn't alright for us. P2C

The conclusion of the playground fight story provides a brief insight into the importance attached to the control of girls and women within the Irish context. Consternation regarding the breach of the ladylike code of behaviour did not end with the girls being verbally chastised in the school. The seriousness with which the behaviour was viewed is demonstrated by the fact that parents had to be informed. By their behaviour the girls had not just brought shame on themselves but also on their families:

We were all instructed to write letters to our parents apologising for our non-ladylike behaviour and how we shamed them basically by egging on this fight. P2C

The reaction of the school reflects the ethos of the Catholic controlled school and a commitment to its role as a key socialising agent in Ireland not just in enforcing and reinforcing Catholic ideology but in the development of the post-independence Irish state in partnership with the State and Irish nationalism. From its inception gender and women's subordination has been integral to the conception and discourse of the new nation and Irish culture. Both the Church and nationalism extol the importance of family and revere women in their role as mothers and as the producers and protectors of both Church and society and therefore indispensable to the prosperity of the nation. This essential role of women 'which denies women an identity beyond the role of mother' (DeWan, 1997, p.35) remains protected in the Irish Constitution. In reality this reification of womanhood is, I would argue, an expression of an oppressive patriarchal regime that limits the choices and capabilities of girls and women. For one participant growing up in Ireland the message was quite clear:

We were second class citizens, you know in sport at club level and school level. You know we got the corner of the pitch. The boys got the big pitch. People turned up for their games. They didn't for us. We had no money for any equipment or for jerseys and the boys always had things provided for them, helmets and gear. We'd none of that. P1B

All of the participants attended all girls schools, an option that is generally argued as being beneficial for girls for a number of reasons: 'This study identifies several areas in which single-sex education appears to produce favourable outcomes for female students, especially in terms of their confidence, engagement and aspirations, most notably in areas related to math and science' (Sax, 2009, p.11). They are more likely, for example, to be able to study the subjects and participate in activities of their choice. In these circumstances it is argued girls are able to be more confident and assertive, capacities conducive to flourishing and positive health and wellbeing. This vision contrasts sharply with one participant's experience of the manifestation of gender recounted in the following excerpt. The girls in this example had to avail of the facilities in the boy's school in the town because of the lack of suitable facilities in their own school:

There were three of us in first year. We were sent to the boy's school to do science. It was way down the other end of town. We had to walk up to do science three times a week. So I did get to do some bit of science with all the boys which was very intimidating, very unnerving to be in a huge class of boys. It was not the most comfortable place to be for three girls. That was a very stark feeling. I didn't like the feeling because they would spend most of their time laughing at us. It was not a nice place to be. There was nothing enriching about that experience. P1B

When asked about what she learned about being female from that experience, an experience that happened nearly three decades earlier, I noted a quiet anger in the tone of P1B's response. Her response is evidence of the possible impact of one experience of the manifestation of gender in a young woman's life. Reflecting the in-grained prejudice influencing gendered choices discussed by O'Connor in chapter 2, the experience clearly impacted negatively on her health and wellbeing, limited her subject choices and potentially her career choices:

(I learned) That science was not for girls. Science was for boys. It was serious in terms of learning and we should have not been there at all in the first place. We were complete misfits and I took that on in a way. I took it on not to take science too seriously and I didn't do science ultimately. You know you were really just pushed to the side. P1B

Another common gender narrative in Ireland is the post-feminist narrative of objectification as empowerment. This is clearly evident in the recollection of P2D, the youngest of the participants who explains that young women who chose to celebrate their supposed new found freedom and sense of empowerment were branded as promiscuous or immoral:

Girls can get a reputation very easily. When I was growing up there was always this group of girls in school who were sleeping around and you know ... and they were very much known as the slappers and sluts in school really. P2D

The situation described also highlighted the continued currency of the traditional double standard regarding sexual behaviour for women and men. This double standard maintains that men have to respond to their biological urges whereas women, especially respectable women, do not experience similar intense feelings or desires:

But you'd have guys that who would have ... who I would know as sluts and slappers, but they're not. They don't get the reputation. Instead they get a positive reputation. P2D

Although she seemed to recognise the unfairness of the situation P2D was not going to take any chances:

So maybe that kind of stuck with me a little bit in terms of how you are or how you behave. I was very conscious of these things. P2D

Being more ladylike was the smarter option. Ging (2009) suggests that the manifestation of gender in the post-feminist, neoliberalist culture of modern Ireland presents different but equal challenges to the health and wellbeing of women in Ireland as the traditional culture of pre-Celtic Tiger Ireland:

‘The double-speak is one of the most confounding paradoxes of the new liberalism. Irish women may be finally freed from Catholicism but they must now negotiate the dual forces of bio-determinism and commodification, which have equally high stakes in the regulation of their bodies’ (Ging, 2009, p.59).

The following section explores the second of the three themes identified in the analysis of the data from question one - ‘Impact’. The theme focuses on the feelings generated by their experiences of gender as they grew up and developed their female identity.

6.2.2 Memories of gender - Impact and Response

Initially the focus of this section was to be exclusively on Impact, the second theme identified in the analysis of Question 1 about participants’ understanding of gender. Almost inevitably, however, given the guardedness of participants in their responses to Question 1, the amount of content identified in the Impact

theme is limited. In my exploration of the data I was curious to know not just what was being said but about how it was being said. In Section 6.2.1 I outlined the idea of a cultural disposition to ‘guardedness’ as a credible explanation for the general responses to the autobiographical narrative approach of the interview question about memories of gender when growing up. ‘Guardedness’ understandably became even more apparent when participants were asked about feelings about events. In being asked to explore an experience further by describing the impact or internal feelings and how they responded to those feelings participants were being asked for even greater access to their lives. Such access would shed light on their inner selves and greater insight into their values and beliefs, particularly about gender and gender based discrimination. What factors influence the recollections they choose to share?

In choosing one event from the multitude of possibilities when recounting autobiographical memories it is reasonable to presume that the specific event is distinctive or significant in some way. In P2C’s introduction to her story about being directed to clean up her brother’s mess she described the event as ‘significant’:

There was a very significant thing at home around that time. P2C

Events that fail to generate an emotional response of some sort, either positive or negative are clearly less likely to be recalled in autobiographical memory. Events that are recalled are distinctive in some way and can be presumed to have generated some kind of emotional reaction, either positive or negative. If an event is significant it somehow stands out, possibly because it is unexpected and the person does not have a script for such a happening or because the event interrupts an already existing script. Life scripts are created in childhood and provide the framework for an idealised life story that anticipates a series of events in a specific order regarded as ideal in that particular culture. Starting school, going to college, starting work, getting married and having children is a typical life script in modern Western societies. Life script theory (Bernstein and Rubin, 2004) is regarded as an extension of autobiographical memory theory because it broadens the focus from the individual to acknowledge the cultural influence:

Theories of autobiographical memory generally focus on the level of the individual and minimize the impact of culture on the content and structure of autobiographical memory (Bernstein and Rubin, 2004, p. 429).

In this section I set out how participants describe the impact of their experiences of gender in Ireland and how they respond to those experiences.

The best example is P2B who acknowledged that reflection on childhood memories took some effort:

When I looked at the question last week I realised, I suppose, that it takes some time to go back to your childhood. P2B

It appeared to me that there was a connection between P2B's initial rejection of any experiences of sexism or gender based discrimination in her life and her acknowledgement that reflecting on the question required some effort. It was, however, illuminating to share her increasing awareness as she reflected on her memories. P2B was clear about the feelings generated by her first experience of gender discrimination. Within the security of her family the message regarding gender placed a strong emphasis on equality, choice and capability:

I had a very contented upbringing. It was very accepted in our family to be a strong woman. When I say strong I don't mean physically strong. I mean we're all healthy thank God. But I'm not talking about sport or anything like that. I'm talking about like that in ourselves we would always consider ourselves very equal to men and be able to do pretty much the same roles as men. P2B

The choices available to her in her single sex convent school supported this equality based life script:

In fairness there was a lot of subject choice that maybe wasn't there for other girls of my age at that time. Like we would have had physics, chemistry, biology and honours math if you wanted it. P2B

Between the ages of fifteen and eighteen P2B was a member of the mixed sex Catholic youth club organised by a religious order in the parish. As a member of this group she had her first experience of the gender discrimination inherent in the Catholicism and her first practical experience of the Church's view of women. In this particular example it was 'woman as temptress'. In Catholicism the conviction of woman as temptress is based on the parable of the Garden of Eden when Eve committed what is regarded by some as the first sin when she tempted Adam to eat the forbidden fruit:

I got involved with the youth group and so there were guys and girls in that and that was the awakening of the whole sexuality thing. It was a way to meet guys and I remember having many crushes at that time on different guys. But the young lads in the group they would always have seen them as potential guys to go into the order (become priests). So there was always that underlying thing where if you got great with some of the lads ... like don't take him away from us. You know what I mean? There was the whole temptation thing. That was the beginning of the message. P2B

In our very first meeting P2B explained that she had a strong Catholic faith and was very active in her support of her religion. As she told the story of the Catholic Church's attitude to women nervous laughter and a number of unfinished sentences suggested that her words were being chosen carefully. However the fact that her equality based life script was interrupted at this point and her reaction to it are clear:

This was the first time I began to realise that the particular role of being a priest was something that women couldn't do. And I really began to feel ... Suddenly this was where the whole ... I suddenly began to feel really angry about it. You know, why is this blocked off? And then the whole temptation thing ... women aren't a temptation. P2B

The significance of this interruption to her life script was underlined by the fact that she chose to return to it when at the end of the interview I asked if there was anything she wanted to add:

I suppose because my family was very solid, deep down in myself I had no doubt that men and women were completely equal. But I was beginning to meet the world at large which didn't feel the same way and my reaction was anger. The emotion I would tend to display is anger if I thought something was unjust. P2B

In later interviews there is clear evidence in participants' responses of a positive impact as a result of the reflection and discussion that was the foundation of the research process itself. In these later interviews there is an increased gender consciousness and an acknowledgement from a number of participants of the state of gender in practice. It was tempting, therefore, in the presentation of the second theme identified in participants' memories of gender to skip to the presentation of what appears as a more informed comment on the issue.

However, my decision to include the analysis of this stage is consistent with Inglis' assertion that 'analysis of a fragment of social life can reveal the nature of the social whole to which it belongs' (Inglis, 2010, p.509) and the 'fragments' in the responses to Question one help to frame the picture that develops more clearly as the research process builds. In an effort to present a more fluent and coherent narrative in this section, I merge the two remaining and closely related gender themes, Impact and Response.

The entrenched nature of the patriarchal narrative in Ireland makes it a difficult ideology to challenge. The gender regime is supported by all social institutions, family, church, education, state and in the national narrative of what constitutes being Irish. Against the backdrop of this wall of power, challenging the dominant narrative has been and continues to be a testing undertaking in Ireland, although change is slowly happening. For one participant the absence of a clear feminist discourse remains an issue and has, she believes, an impact on her sense of self as a woman in Ireland:

I suppose why I'm not coming here with a stronger sense of who I am as a woman, rather than as a mother or a community

development worker is that you know gender analysis or women's movement or feminist discourse isn't all that prevalent in Ireland. P1A

In this already testing situation the difficulties faced by feminism have increased as 'the language of feminism is being replaced by anodyne gender speak' (Smyth, 2005, p.9). The impact of a weakened feminist discourse means, as Smyth suggests, that dissenting voices in relation to gender and patriarchy have been relatively scarce and easily dismissed. In the absence of a compelling discourse Irish women have been relatively ambivalent about feminism, choosing instead the option of adapted preferences and internalised oppression, choices that inhibit any thoughts or intentions of the pursuit of justice or fairness and making such intentions seem like too risky an option (Freire, 1993). O'Connor (1999) concurs with this judgement, suggesting that 'in a small society such as Ireland the social, economic and psychological costs of resistance are considerable' (O'Connor, 1999, p.4). There was an evident range in levels of commitment to feminism among participants but as all did identify as feminist it is reasonable to assume a general openness to feminist consciousness.

All participants were raised as Catholic and were educated in Catholic schools at both first and second level. However, P2B had a particularly strong commitment to her religion. In her late teenage years, despite her shyness, she felt compelled to respond to her feelings of anger in the face of obvious discrimination and injustice and would get involved in '*heated arguments*'. Although she became known within her youth group for her clearly feminist stance in relation to the Catholic Church's attitudes to women, P2B admits that she did not identify as feminist. As a lone voice her feelings and opinions, while apparently respected, were not taken very seriously:

I was great with one of the guys who was a priest and he would say - jokingly - 'you're so big into women's rights and all of that' and 'well now, P2B, we all know where you stand'. So he was obvious getting the sense of my beliefs and I had obviously taken a stand even though I would never have considered myself feminist. P2B

Undaunted, P2B continued to pursue her chosen path which led to studying a joint degree which included theology. Her experience highlighted further the hierarchical and paternalistic attitudes which she had made her so angry and which she had challenged in her youth group. The disingenuous nature of a respect and regard for women became more obvious:

There was one module that shows how much they valued women. It was feminist theology but it was one of those optional modules. You were never examined. It was optional, an extra curriculum but I opted to do it. As I said I was interested in all that but people would ask why I was doing it. So it was very much seen as a waste of time. I was beginning to see that women were not taken seriously. P2B

In her concluding remarks about this period in her life story P2B acknowledges again the feelings of anger and sense of injustice. Despite her consciousness and the feelings she experiences however, she resigns herself to the situation of oppression:

So there was always anger about it. There was always a feeling of injustice. But I suppose there's part of me that if I feel I can't change something because it's too big then I tend to ignore it. I might feel very angry but then, if I feel I'm not going to get anywhere I'll tend to just retreat and just get on with my life as if it wasn't really there. P2B

P2B's resigned response was not unique among the participants.

There is an admission by some participants that gender was not something that they thought much about as they were growing up. A mix of awareness and acceptance of gender based discrimination is evident in the comments. When asked about the conversations she and her female friends had about their gender related experiences as young women this participant was clear:

We didn't really that I remember. I don't remember it (gender) being central to anything. We would have been aware of the fact that we felt a bit discriminated against but it was kind of

well that's the way it is. There was an acceptance about it. I suppose we were conditioned by society to accept it P2C

The adaptive preference option is even clearer in this response:

Well it's pretty straightforward you know. To be honest it's something that I don't think I have really reflected on during my life. It's just stuff that you kind of go with, that you take for granted and you put your own little boundaries in place in terms for what's acceptable, what appropriate behaviour in your surroundings or your network. P2D

How women are affected by gender differs from woman to woman and, in contrast to the acceptance of the situation by some, one participant spoke excitedly about the impact of her experience of feminist consciousness as an undergraduate:

For the module on gender we had to go away and read a feminist text. It was the first time in my life having any avenue for that type of discourse and I really liked it. But then you had to go into the class and debate it. We were a small, fairly left wing all women group of community development workers and we were put in with the social work class for gender. They were a mixed group, men and women and were, I suppose, more mixed in outlook. But I remember the first class. There was one guy with some really mad ideas about gender, a really essentialist view of gender and women. He was challenged by a gay guy 'Look as a gay man I really don't agree with you. My partner and I we're the carers for our kids, his kids' and after class we were saying 'wow this is going to be a great class' and it went on from there. P1A

However, as Meyers (2002) observes 'it is not within one's power as an individual to expel gender from one's life' (Meyers, 2002, p.7), especially in the absence of a supportive discourse and when 'among both men and women in Ireland, there appears to be a good deal of cultural unease surrounding the concept of patriarchy' (O'Connor, 1998. P.7). Later in her interview there is a suggestion of

frustration and disappointment in the voice of P1A at the impact of her failure to expel gender-based inequality at least from her personal domestic domain. In this excerpt she describes her thoughts when she realises that, despite her education, her gender consciousness and her active efforts for gender equality in her home situation, she has not been fully successful:

We're socialised into it. But I would have loved to think that well I've had all this education and chances to travel and a husband who cooks and agreed to go part time like me when we became parents so we could have equally shared parenting. I remember realising ... the bubble burst. All this gender stuff is happening to me. P1A

In this comment P1A has moved the focus from reminiscences about childhood and young adulthood to her contemporary self as an adult. As her adult self the feelings of frustration and disappointment she expresses contrast sharply with the excitement described earlier when, as an undergraduate, she was introduced to feminist thinking and the concept of gender. Her active efforts to change unequal gender relations suggest a feminist identity. Feminist identity 'is undertaken when women explicitly identify with feminism as an ideology and/or social movement' and 'develop alternative visions for gender relations' (Aronson, 2017, p.2).

When, in an earlier comment, she intimated that her feminist identity was not as developed as she would like, P1A named the absence of an evident feminist presence and discourse in Ireland as an influence. This connection between feminist identity and a feminist movement concurs with Aronson's observation that 'it is often only with the presence of an active social movement that women come to see themselves as feminists' (Aronson, 2017, p.9). So, seeing themselves as part of a collective identity distinguishes those with a feminist identity from the more individualistic feminist consciousness. As people generally engage in behaviours associated with their chosen identities positive perceptions of feminism and, as P1A's comment suggests, feeling connected increases the desire to participate in collective action and self-identifying as feminist is regarded as a predictor of feminist activism.

The focus of the next chapter is participants' experience of and attitudes to taking action to address the social injustice of gender. In the concluding section of this chapter I review something of what the evidence suggests at this stage about the reliability of the feminist self-labelling and how it relates to the feminist identity that is understood as a precursor for the feminist activism that is necessary if participants are to challenge the social injustice of gender.

6.3 Gender consciousness, feminist consciousness or feminist identity?

There are many different feminist positions and different ways of theorising about and measuring feminist identity. Here I have referenced Aronson (2017) who positions feminist identity at one end of a continuum that has gender consciousness at the other end and feminist consciousness in the middle. Her use of a continuum rather than fixed categories allows for 'the diversity in women's viewpoints' (Aronson, 2017, p.2). The development of and a commitment to feminist ideology, like any values profile, is shaped by a range of influences with potential to either support or impede understanding, development and definition. The assortment of feminisms that result mean that the label of feminism can mean different things to different people in different situations and at different times. So 'although deciding if an individual woman is feminist or not seems simple, in practice it has proved complex' (Yoder et al, 2011, p.9). All of the participants self labelled as feminist at some stage of the research process. However, there is evidence to suggest that participants' conceptions of feminism do not always position them in the feminist identity end of the Aronson's continuum.

The conditions in Ireland have not, historically, been favourable to the presence of a strong feminist movement or to a culture that might contribute positively toward an individual adopting a feminist identity. Against the backdrop of the historically conservative nature of Irish society and a culture, heavily influenced by nationalism and the Catholic Church, feminism and women's activism have ebbed and flowed. When women have mobilised and have had a periodic public presence, the focus has usually been on a single issue related to basic human rights such as the right to employment, divorce, contraception and abortion. All the participants shared in this cultural experience.

The impact of the absence of a feminist discourse that has historically been a characteristic of the 'gender-scape' of Ireland and the invisibility of gender as an influence in women's experiences is evident in P1B's recollections. She remembers being angry and rebelling against the obvious unfairness she experienced as an adolescent. For example, she played camogie in secret because it was banned in her school. However, she acknowledges that there was no sense of a gender consciousness, which is 'defined as an awareness and critique of gender inequalities and patriarchy' (Aronson, 2017, p.1), informing her rebellion:

To me it was about rules. I didn't have a gender analysis. It was more about breaking rules because it didn't seem fair. I mean not just breaking rules just for the sake of it. It didn't seem fair that we couldn't do these things. It just didn't make any sense to me. So we needed to do them and we did. P1B

While there is clearly evidence of gender consciousness in discussions with P2C there is also some evidence to suggest that her natural position on the feminist identity continuum is closer to gender consciousness than feminist identity. Like P1A, P2C reverted to recounting stories of her experiences as an adult as part of her response to Question 1. I have already referred to her acceptance of and resignation to gender discrimination simply as part of life as a young adult. Young adulthood is identified as a particularly formative time in the development of political identity and at that time P2C, who comes from a family of political activists and has always been politically active herself, aligned herself with other social inequalities, particularly class, and other political movements. Her choice of a women's studies module as part of her course when she returned to education as a mature student does not necessarily indicate a commitment to feminism but it does, at least, suggest a gender consciousness. P2C's reaction to the experience shows that no theory is infallible or that exposure to feminism guarantees acceptance. Her reaction challenges the belief that '*exposure to favourable information about feminism in learning about feminism through women's and gender studies coursework*' is one of the main conditions that '*may contribute positively toward an individual adopting a feminist identity*' (Zucker, 2004, 425). Among the reasons women reject

feminism are feelings of 'exclusion or lack of relevance or feminist goals to their own lives' (Aronson, 2017, p.8). Although P2C acknowledged that her studies gave her a broader knowledge of inequalities but her negative reaction to the course creates undoubted impediment to progression to the feminist identity that drives activism:

I did women's studies in first year. I hated it, absolutely hated it. I thought it was very abstract. I thought about the twelve years I had spent at home and it bore no relation to any life that I have lived in what they talked about and the issues they were concerned about. You know we were studying people like Simone De Beauvoir and you know all very fine women in a way but just not the real world at all. No connection whatsoever. The whole subject just left me cold. P2C

The diversity of experiences within the group, the impact of those experiences and the responses to them is clearly evident in the very different reaction from P2B to her introduction to feminist texts and feminist thinking as part of her post-graduate community development studies. In her description of her experience other possible sources of support for the development of a feminist identity including positive related experiences on campus and being friends or connected with others who identify as feminist (Zucker, 2004), are identified by P2B in her description:

It was where my whole mindset changed. It was a really mind blowing time. It was very much about empowerment and very much I suppose about women. There were a lot of very strong women on that course and a lot of the lecturers were women. So I think my whole attraction to I suppose gender equality and feminism and stuff really began on an academic level to take off from there. I read a lot of books around it at that time. P2B

I have referred previously in this chapter to the anger P2B felt when faced with the gender inequality and sexism in the Catholic Church and her introduction to feminism and feminist texts produced that feeling again:

I remember thinking 'why are women putting up with this'. I could understand it all but again it was making me so angry. Why should we have to ... why am I in this half of the human race that isn't equal? So that book, I still have it. That was huge for me. P2B

P2B's feelings of anger about gender inequality generated by her introduction to feminist texts, is a stark contrast to the feelings described by P2C. For P2B the experience was a liberating one:

I think it was a lot more freeing really, freeing for me. But there was also a sense that you could do a lot about it as women. P2B

In this statement P2B hints at becoming a 'we' with other women, a collective identity that supports activism, two things that are part of feminist identity and distinguish it from feminist consciousness. However there are significant contradictions in the beliefs and attitudes expressed by P2B that reflect the influence of and a commitment to a more dominant identity, her catholic religion.

For P2C class and other social movements were priorities. For P2B it was her Catholic religion. Highlighting the diversity within the group a number of other priority perspectives that have the potential to hamper participants' capacity to actively challenge women's gender based oppression were found. These other perspectives include respect for traditional traveller culture and LGBT rights. Attitudes to gender related activism, or a feminist approach to practice, the factors that influence those attitudes and the choices made as a result, are the focus of the following chapter.

6.4 Doing and undoing gender in adult life

6.4.1 Introduction

In Question 3 the focus extends the exploration of participants' understanding of gender by building on the foundations established in Question 1. While the uniqueness of each participant means that there were differences in their

responses to Question 1 there were considerable similarities in their accounts, particularly in their responses to sexism and gender oppression. The foundations established in Question 1 include evidence of a feminist consciousness ‘defined as an awareness and critique of gender inequalities and patriarchy’ (Aronson, 2017, p.2). Deciding if a woman is feminist or not is not simple but the evidence from Question one suggests that identities other than feminism were more dominant among participants, and responses to experiences of gender oppression were primarily of accommodation, resignation and denial.

While participants acknowledged feelings of being devalued and anger and frustration at their experiences of gender discrimination they made no connection between these feelings and experiences and their sense of health and wellbeing, a connection that is of particular interest in this study. Schmitt et al (2002) observe that ‘a growing body of empirical work supports the idea that perceptions of discrimination are harmful to the psychological well-being of disadvantaged groups’ (Schmitt et al, 2002, p.199) and that women are included these groups. The responses described by participants are consistent with the concept of ‘subordinate adaptation’ identified by Scwalbe (2000) as a coping mechanism when faced with discrimination or ‘the deprivations of subordinate status’ (Schwalbe et al, 2000, p.426). A negative consequence of subordinate adaptation is that it plays ‘an essential part’ (Schwalbe et al, 2000, p.426) in reproducing the inequality that is being adapted to, accommodated or denied.

In Interview Question 1, about memories of gender socialisation as girls and young women, awareness of gender discrimination did not feature strongly, a situation that presented a potential challenge for Interview Question 3. Unless their thinking could be somehow unsettled and become more critical participants’ ongoing denial or sense of resignation to the reality of gender based oppression would almost inevitably hinder the aim of more in-depth exploration of their attitudes and beliefs.

6.4.2 Manifestation

In preparation for Interview Question 3 participants were asked to carry out an observation task in the week preceding interview session number three. The task, inspired by the idea of ‘doing gender’ introduced by West and Zimmerman

in 1987, required participants to look critically at how gender is manifested in everyday interactions. More details of the task and the rationale for it are outlined in Chapter 4.

In the feedback from participants it was clear that the non-professional interactions often afforded the most affecting insights and experiences. P1A, for example, who was quite excited by the refocusing of her gender lens, discovered that she and her friends did not necessarily agree on the basic issue of women's gender based prescribed roles and responsibilities:

I've had loads of examples. I think my gender lens has just gone into very sharp focus. So I've had a lot of really interesting discussions. You know about internalised oppression and how women collude in the oppression of other women around gender roles. I had examples of that just in the personal sphere around assuming the caring role is mainly women's responsibility and how women in my close sphere were making assumptions. Just conversations. P1A

For P1B the realisation that the doing of gender was so pervasive and prevalent made an impact. The observation task really opened her eyes and once she started noticing gender it was as though she could not avoid it. It was a discovery that generated an emotional response. There is also evidence in this comment of an increased feminist consciousness and a sense of recognition of the importance of a collective feminist identity which 'means seeing oneself in relation to a larger social movement' (Aronson, 2017, p.14):

You know like it is constant. It is everywhere, whether it's the interaction at home or it's interactions on TV, in my work. It is constant. Some days I just despair. I just think I despair with some of the stuff I do. Most of the time I'm cross. I was thinking, in light of this work that maybe I should be challenging that more as a woman on behalf of women. I should be stepping up to the mark more as a woman in terms of me representing myself and representing women. The jury's a little out on that but this work has made me think. P1B

As the above responses imply, participants found the observation task to be an interesting one that had a positive impact on their gender awareness and which caused some unsettling of assumptions. These responses acknowledge the usefulness of reflection and the resultant increased consciousness:

Yeh, I thought it was pretty interesting to name things and put it down on paper. It was really good from a reflective point of view and made me think. So I thought it was really good. What was good about it as well for me was that it made me think about what I need to do in the future and made me really question myself like 'why am I ...' and 'why do I do these things?' P2D

Because I was trying to do it as part of my daily life I sometimes forgot about it but then I'd think about it at other times and then it was quite reflective. You know this weaker sex, this fairer sex thing is engendered into society and if you sit back and watch you can actually ... I really took time to see that. You go along and that's how things are and you don't question it. Because I had to do this, because I had your question in my mind and what I had to do came back into my head so I started reflecting on things that had happened in situations I had been in at work or whatever. P2C

The comment from P1B, expressing her anger at the constancy and pervasive influence of gender, was triggered by the story she chose to recount regarding an incident in her professional life as an example of doing gender. In this story P1B described an event where she was to present an important research report highlighting a serious community issue. The attendance and venue for the event underlined the importance of the report and the interest in it:

A big affair. It is a select venue and there are quite a few academics in the room as well as the Mayor and other dignitaries. There were people from the community, mostly women, people whose personal experiences contributed to the work. P1B

P1B was assisted at the event by a male colleague who, at her request, had made a relatively small contribution to the report. She was proud of the report, *'a particularly nice report in terms of the time and effort that was put into it'*, and which was produced by her own company. It was after she presented her report that P1B witnessed the interactions that made this the experience she chose as her example of doing gender:

They made a beeline for him. Just a beeline as though I wasn't there. I was the assistant. They only wanted to talk to him about this important piece of work. It was all to do with being a man in this piece of work. P1B

What she witnessed was an exhibition of a culture of gender essentialism that denied her status and competence because she was a woman. As discussed in Chapter 2 gender essentialism is the 'notion that men and women are innately and fundamentally different in interest and skills' (England, 2010, p.150). It marginalises women and positions men as 'more status worthy and competent overall at the things that count most' (Ridgeway and Correll, 2004, p.513):

P1B acknowledged that her male colleague tried to point out the mistake, but was unsuccessful:

In fairness he was embarrassed. He was trying to say 'this is my colleague. This is the person who led this piece of work'. P1B

P1B's own response in this situation is reminiscent of the internalised oppression that was evident in the group responses to Question one. The response of the academics and local dignitaries constituted a dismissal of P1B, her work and her competence based solely on her sex. P1B's response, talking instead to people from the community, describes a resigned acceptance by her of the obvious gender based discrimination and did nothing to challenge the discrimination.

The outcome of P1B's reflections on the experience, as a result of the observation task assigned for Question three, underlines the potential of critical reflection to increase awareness of and challenge oppressive consciousness and feelings of resignation to the gender system, which, in turn increases the possibility of activism.

6.4.3 Impact/Response

The scenario described by P1B has many parallels with the findings described by Katila and Merilainen (1999) in their exploration of gender discrimination in academia and the world of research, and the experiences and responses of female academics. One parallel between the attitudes of female colleagues and the tension between their self-labelling as feminist and their hesitancy about engaging openly in discussion of the issue or challenging gender discrimination themselves. The hesitancy was, perhaps, as a result of fear:

The fear of not getting a job or losing the one you have, the fear of losing your credibility as a researcher, and the fear of conflict in the work place are just too great for many feminist academics (Katila and Merilainen, 1999, p.164).

The context described by P1B, her public presentation of a serious research report, is one typically associated with masculine authority and requiring masculine characteristics such as a scientific, rational mind, capable of clear thinking and decision making. Against the background of this gendered discourse women are regarded as lacking and therefore *'constructing oneself as professional researcher and as a woman appears to be a contradiction in terms'* (Nentwich and Kelan, 2014, p.14). The internalised way of behaving evident in P1B's resigned response to being marginalised in the way she described is another parallel with Katila and Merilainen's study where, in the face of marginalisation and exclusion, female academics sometimes had a 'tendency to keep a 'low profile' even in cases of 'apparent discrimination' (Katila and Merilainen, 1999, p.164). It is possible that by doing gender through choosing to be silent the female academics in Katila and Merilainen's study and P1B give tacit support to the discriminatory gender system and contribute to the constancy of oppression identified by P1B in her story. P1B's observation, subsequent to the critical reflection task, that she *'should be stepping up to the mark'*, suggests that, despite an ideological disposition to equality and social justice, prior to the critical reflection task, gender was not an active interest for P1B. Her acknowledgement, subsequent to reflecting on her experiences through a critical gender lens, that gender injustice is important in her life and something she should be challenging on behalf of herself and other women intimates, perhaps, the re-igniting of a dormant feminist identity. It also

highlights the potential of that process to support the development of a feminist identity that increases the possibility of women taking responsibility for fighting against their own oppression.

While personal resistance can contribute to the erosion of essentialist gender beliefs and behaviours, to effectively challenge the behemoth that is gender means embracing this feminist identity. To translate consciousness into action means *‘seeing oneself in relation to a larger movement that articulates an alternative to gender inequalities’* (Aronson, 2017, p.14). Cultivating a collective feminist identity means making connections with others. These connections are also necessary to counteract the cumulative damaging impact of gender such as erosion of confidence and sense of competence and the feelings of demoralisation and isolation that result from oppression. The previously referenced response of P1A to Question 1 regarding the absence of *‘gender analysis or women’s movement or feminist discourse’* in Ireland suggests that efforts to make these necessary connections may present a separate challenge to women in Ireland. Further examination of participants’ experiences of and reflections on the doing of gender will help to develop a better sense of the accuracy of P1A’s observation.

In the stories related by P1C the pervasiveness and omnipresent nature of gender and the doing of gender were again evident. The particular connection with P1B’s example considered here is the imbalance of power and influence between women and men as a result of the dominant essentialist gender script. The discriminatory attitudes displayed by the dignitaries in P1B’s reflections were again clearly evident in P1C’s stories. Essentialist gender perceptions judge women, however competent, to be unsuited to decision making or leadership and women can be, as a result, silenced, devalued and made invisible:

It was an ongoing piece of work for a number of years. You know I’d make a suggestion but anything I’d say was completely unheard and at the end of the meeting this man would say ‘I think we should do this’ and it would be done. It was totally frustrating because like I’d said that at the beginning of the meeting. There were more women at the meeting but when the

man said it they'd agree 'That's a brilliant idea' and it would be done. P1C

Unlike P1B, P1C had an opportunity to consider her response to the matter. It took her a number of months to decide what to do. Like P1B, She almost resigned herself to the inevitability of the situation and considered walking away. Considering that comment P1C's description of the impact of the sexist interactions seems a little understated before she explains her decision to be proactive:

I was so frustrated you know coming back from these meetings and saying 'Oh I'm not going back'. In fairness you know it took me a few months of thinking about what I needed to do. But I had to get over all my emotions around it and then look at it and then say 'Right, what am I going to do about this? P1C

In the end P1C decided to discuss the matter with her colleague, her co-facilitator. The man in question, who was the joint facilitator of the group, was someone P1C knew quite well and had a good working relationship with. She described him as '*very gender conscious and very clued in*'. In her telling of the story P1C makes little of the fact that when she broached the issue with her colleague and co-facilitator although he acknowledged that he had noticed what was happening and could in fact '*see it clearly*', he did not identify it himself as an issue that needed addressing. For P1C the outcome was a positive one, resulting in a happy and successful collaboration. They used the opportunity to address the gendered attitudes and behaviours within the group. There is a hint of satisfaction in her description of the response from the group when they realised what they had been doing:

You could just see all the light bulbs going on and the women got embarrassed. P1C

The belief that women's oppression is a problem that has been sorted is greatly influenced by the development of a framework for equality and non-discrimination since Ireland joined the EU in the 1970s. Both the 1970s and the 1990s are identified as 'distinct periods in Irish equality policy' (Armstrong et al, 2007, p.12). The EU and the UN Platform for Action in Beijing are identified as

significant drivers in the development of gender equality policy in Ireland. Having outlined the different policies Armstrong et al conclude that ‘Ireland now has a distinctive equality policy where there is a focus on equality generally rather than a specific focus on gender and where there has been a strong legalistic approach with considerable influence from EU directives and regulations’ (Armstrong et al, 2007, p.13).

Despite this framework *‘Ireland stands out among EU-28 countries with its severe underrepresentation of women in national political structures’* (Barry, 2015, p.7). Kaufman (1999) shares P1C’s belief in the need for men to work collaboratively with women in making the ending of patriarchy a reality. However, he also recognises that this vision faces significant problems. A commitment by pro-feminist men to actively support efforts for a change in gender relations requires men to realise that such support is not simply about *‘scoring academic or political debating points, or to feel good about our pro-feminist credentials. It means more than supporting institutional and legal changes but also requires personal changes in their own lives’* (Kaufman, 1999, p.73). The starting point for such collaboration has to be *‘a recognition of the centrality of men’s power and privilege and a recognition of the need to challenge that power’* (Kaufman, 1999, p.74). The gap between the vision of the desired collaboration and reality is evident in the attitudes and beliefs of men’s movements groups. The men’s movement developed in response, some would say, a backlash to feminism, the privileging of women and the feminine and the consequent suffering of men and the devaluing and of masculinity. A significant impediment to collaboration between the men’s movement and feminism is the reluctance of men to address the issue of male power, a fundamental principle of patriarchy which pre-supposes the natural superiority of male over female. This superior status is evident in characteristics such as independence, confidence, being in control and, when necessary, aggression. The Men’s Sheds project is a particularly successful example of a men’s movement related project and is present in all the Community Development Projects linked with this study (<http://menssheds.ie/>). The popularity of Men’s Sheds in Community Development reflects the fact that working class men have been particularly badly affected by economic developments in recent years that have resulted in a

loss of low and semi-skilled jobs that have been traditional masculine sources of employment. These jobs were a powerful source of identity for working class men and were a source of pride for them. Having a job gave the men a sense of power and status that defined their masculine identity. The loss of these jobs has been described as a crisis of masculinity for working class men. The crisis is caused by the replacement of these traditional sources of masculine identity with service jobs that require skills and attributes that are stereotypical feminine such as patience and deference to the customer. These skills and attributes are antithetical to working class masculinity. This clash has meant that many men in communities served by Community Development Projects are unemployed and unemployable and the legitimacy of their superiority has been undermined. In the newly centrally controlled community development in Ireland the gender-blind solution to the problem is job activation schemes.

The conflict of a 'clash of mind-sets' between male participants and female managers on such a scheme provided the material for P2C's response to Question 3. One mind-set is that of local men on the job activation scheme who *'are not used to being directed by women and find it a little offensive'* and attempt to exert their masculine authority in the situation. Hostile sexism was the weapon used by the men to exert what they believed to be their legitimate masculine right to command respect and to expect others, especially women, to defer to them. Hostile sexism aims to punish women if they challenge that male dominance:

No woman will come in here and tell me what to do. I'm not taking orders from her. Who does she think she is? The last woman who told me what to do was my mother. P2C

The other mind-set was that of the, generally younger and much better educated, female manager who, as manager, had coercive power in the situation and, according to P2C was *'very aware of her rights and entitlements and is well aware of what she has to listen to and what she doesn't have to listen to'*.

Hostile sexism, unlike benevolent sexism, is clearly sexist and disrespectful in nature and therefore is typically in contravention of workplace gender policy and practice. P2C was well versed in employment and workplace equality policy

and legislation so I was surprised to hear that this situation was ongoing and wondered what action was planned to address the situation. In the ensuing discussion I was interested in her gender analysis of the situation and her thoughts on how the impasse might be resolved. In her response there was obvious empathy with the men in the situation. Age, poor education, type of work experience, long term unemployed, poor awareness of gender equality policy, difficulty in articulating their feelings as well as the possibility of mental health issues or a problem with alcohol or relationship difficulties and feeling intimidated by the better educated, younger, female managers were all identified as explanations for the men's behaviour. She talks sympathetically about the men's unwillingness to participate in education about gender equality:

They're products of their environment and the only way you're going to address that is through education and it's very difficult to get people who do manual work to sit down in those kind of educational settings even if they are informal and it's a group of people sitting around on chairs.P2C

While class inequality was clearly identified as a primary cause of the discord, the influence of gender, despite being the issue under discussion, was notable for its absence.

In contrast to the empathic connection with the men working in the scheme, P2C was critical of the managers' competence to handle the situation and the sexist hostility directed at them. In passing she acknowledged that the managers were often right:

They're often quite right in what they are saying. This is the nub of it. They're right in what they say but it's not necessarily the right way to deal with what the problem is. They have a different education. They almost have a different language and sometimes you have to be conscious to bring yourself down to the language that they (the men) understand. I think there's a lack of capacity. A lot of managers are good coordinators and they might be good community development workers but

they're not necessarily good HR experts. You know people management is a skill in itself. P2C

Later in the discussion when there was acknowledgement of a gender aspect to the situation the competence of the female managers was again identified as a contributory factor:

I think the gender thing for women in this scenario is that women are often tougher supervisors if you like or managers. When they're managing men in particular they're more into micro-managing because I think there's a little bit of a fear that they won't be taken seriously. You know they have to be continuously asserting their authority. P2C

As the interview progressed I continued my efforts to uncover any gender or feminist awareness in P2C's reflections. I wondered, for example, if P2C considered how the culture of hostile sexism she witnessed from men might impact on women in the community. I moved the focus to women by asking about women participating in the job activation scheme. Women participants were not a problem. They simply got on with their work on the job scheme and then went home to get on with their prescribed gender responsibilities of caring for their families:

The women are here and they just want to put in their time. They don't want any hassle. They do enough to keep themselves out of trouble. They want to do it doing as little work as possible and follow the path of least resistance because I think women have far more going on in their lives. So they are always busy and have somewhere to go. They seem to be very much in touch with and very much involved with family life and grandchildren. P2C

In P2C's analysis women's identities, unlike men's, do not seem confused or damaged. Their prescribed gender responsibilities are still in demand, perhaps more than ever. Because of the changed nature of the increase in service jobs women's identities have actually been extended to possibly include a role outside the home. The relatively brief analysis of the lives of women in the local

community echoed the comic irony of the concept of 'I'm Grand' (Flynn, 2014), the irony suggesting that the reality is opposite to the literal description:

'What every Irish woman instinctively knows is that, no matter how bad things get, sooner or later everything will be Grand' and 'Every Irish girl has been trained not to lose the run of herself. She's raised to be diligent, hardworking and even try to do well, but never to believe that she's got there' (Flynn, 2014, p.79).

As the interview continued and there was an increased focus on gender P2C shed some light on her more evident empathy with the position of working class men and their experiences and the absence of women's experiences from her analysis. Her summary provides some explanation for the popularity of Men's Sheds projects in Community Development:

There is gender based inequality without a doubt. I would almost go so far as to say that it's turning around and there's male based inequality as well but I think the male stuff is relatively new. The women's stuff is inherent and it's so embedded if you like that we don't even see it happening. P2C

Throughout the interview I observed that P2C struggled to focus on gender from a professional perspective but that her awareness seemed to increase as the interview progressed. My observations were confirmed when, as I drew the interview to a close, I checked with her how she felt:

I think I had to give it a lot of thought. It was work. I feel quite tired after it. I had to dig deep and had to think very hard about what you were asking. Because it's not on any agenda. It's not on any agenda at all. It wasn't on the agenda in Leinster House last night when they were having that vote and it's not on the agenda in the community because it's subsumed, buried if you like. It's not discussed or mentioned. I've only come to this realisation through the process of talking with you. P2C

The very different examples that resulted from the 'doing gender' observation and reflection task highlight the persistence of gender inequality and women's

oppression and the hesitancy and reluctance among practitioners to address this particular issue of social justice. Each example, in its different way, shows how women, women's lives and experiences remain largely invisible and how, along with women's competence, they can be dismissed and devalued. Meanwhile male power and authority are taken for granted. The stories show that the belief of a steady march forward to women's equality is misguided and that interrupting the belief of patriarchal male superiority can result in an aggressive and intimidating backlash. If gender is an issue, the idea that it is men's inequality that is now the priority goes unquestioned. P1C highlighted something of the gender related challenges faced by women who break the patriarchal mould and challenge the ideology of male power and women's lesser competence that has been evident in the scenarios presented thus far. Included in those challenges are the hesitancy, reluctance and lack of confidence in the possibility of success.

P1C was a member of a group representing Ireland abroad. The group represented different interests in Irish life including social and public services, private enterprises and public/political representatives. Many of the group would fit into the category of 'dignitary' identified in P1B's story about the presentation of her research report. The ratio of women to men in the group was heavily weighted in favour of men. Given the underrepresentation of women in positions of influence and politics in Ireland the group was unusual because the highest ranking dignitary in the group was a woman. The group was together for an extended period of time and it was a very interesting experience for all. However, what should have been, in P1C's words, an '*incredible*' experience was in reality tarnished by the repeated sexist comments directed to the woman leading the group. In this account I will refer to her as 'director'. The sexism at play in this example was not of the very obvious hostile sexism (HS) employed by the unemployed, working class men in the previous example to exert their masculine power.

One outcome of the development of the legislative measures that makes such overt sexism inappropriate and potentially illegal in a work situation is that people in public office and with professional responsibilities have a sense of the need to comply with and support equality and shun discriminatory attitudes and

behaviours. Despite this P1C describes the sexism as *'It was constant. I could see it so strongly'*. Her heightened sense of feminist awareness enabled her to see this doing of gender where others might have been blind to it. The reason was that P1C was witnessing well developed practice in benevolent sexism (BS) rather than hostile sexism (HS). The interactions were benevolent in nature. Like HS, the aim of BS is to underline or realign the authority and superiority of the male.

BS reflects and is based on the paternalistic belief that women as the weaker sex need protection, a role carried out by men. It conveys the idea that women are wonderful but only as defined in the context of traditional stereotypical gender roles. BS contrasts with HS in that *'it is positive in tone and because it is subtle enough not to be identified as sexism'* (Dumont et al, 2010, p.546) and is, therefore, more difficult to discount or challenge. The subtlety of BS makes it difficult, even for those with a feminist awareness and competent in gender analysis, to challenge the doing of gender. The subtlety and positive nature of BS makes it difficult to recall explicit examples of it in practice. However P1C was confident about what she witnessed:

She's in a very powerful role, you know. You could see a woman who's in a significant leadership role but they interact with her in a way that shows that because of her gender she is less important. I was clear that if this was a man this would not be happening. There was the whole thing around her clothes like 'Isn't your suit lovely' or 'Isn't your dress lovely' or how she looked like 'Aren't you looking fabulous today'. You could see it in a number of these kinds of comments that were made. Lots of time in the interactions it was clear that the male testosterone had to be more important than the director. P1C

These comments, seen by many as harmless or even complimentary, work to make the woman more aware of her female gender, an awareness that can elicit thoughts of being unsuited for the role and responsibilities of public leadership. BS can contribute to controlling women and can be more damaging than HS which is so obviously disrespectful. When a woman is, as in this example, in a minority the emphasis on her sex is particularly salient and without support and

positive feedback women, when confronted constantly with these subtly undermining comments, can begin to question their ability and competence. The result can be a decrease in self-belief and in performance. They have to fight against the intrusive thoughts that such comments can generate. The challenges for the 'director' were made more acute by the traditional cultural attitudes and beliefs of the foreign dignitaries she was meeting as:

They went automatically to the nearest male as the leader and bypassed her. They would automatically assume that she wasn't in charge. It was fascinating'.
P1C

P1C observed all of this doing of gender and was alert to the potential impact on the woman concerned and worked to support her. In one particular example of support the choice was to do gender because of the potential dangers inherent in attempting to undo it:

I remember we were back at the hotel on night and there was a big gang of the men and they were all going to this bar. I remember looking at the director and she said 'I'm not going' and so I said 'and I'm not going'. I remember saying to her 'There's a gender aspect to this. If you went out tonight and had a few drinks with the lads the only thing they'd talk about tomorrow is you. All those guys, they can go out every night and do this but if you, a female director, did it they'd be talking about you the next morning. P1C

The point being made by P1C was that participation in the social evening with the group of men would help stimulate more opportunities for BS. P1C's concern was that the talk subsequently would be a continuous flow of BS remarks that emphasised the 'director's' difference and separateness rather than an in-group member of the party of Irish representatives of which she was the leader. The 'director' was the most senior in a professional sense. However, as a woman in the overarching gendered hierarchical structure she was disadvantaged as she was not a member of the more privileged group of male dignitaries.

It might be judged that the 'director's' awareness of prejudice could have a positive effect if it helped her to understand that the problem was the

discriminatory attitudes of the men as opposed to her own incompetence. However, research shows that the experience of being devalued and excluded in the way the 'director' was in this example of doing gender, and the realisation of the pervasive nature of that discrimination harms self-esteem and 'is negatively related to psychological wellbeing among women (Schmitt, 2002, p.199). The problem of women getting heard has already been identified in this analysis and, while the context looks completely different the underlying problem is the same. BS is related to conservative attitudes about women's roles and how women should behave. So, despite her status, in the dominant patriarchal culture that the BS reflects, men 'have the structural power to define who is and who is not accepted and valued in society' (Schmitt, 2002, p. 199), particularly in a domain that is generally regarded as a male domain. These factors affect whether others ignore her or listen and can affect feelings of control and sense of competence.

6.5 Concluding remarks

Chapter 6 has been dedicated to presentation of my analysis of participants' responses to Interview Questions 1 and 3 which focused on their understandings of gender. The early sections of the Chapter focused on Interview Question 1, participants' early memories of gender socialisation. Before moving on to participants' contemporary experiences of gender which was the focus of Interview Question 3, I include a short section on participants' experiences of and reflections on feminism in Ireland. The sections dedicated to Interview Question 3 mirror the organisation of Interview Question 1, with the discussion focusing on the themes of 'Manifestation' and 'Impact/Response'.

6.5.1 Opportunities and limitations

The diversity in the group of participants in this study is in direct contrast to the size of the group. Participants identified as lesbian and heterosexual. Some were mothers, both lesbian and heterosexual, some came from working class backgrounds, some from middle class and there were differences in educational levels and experiences. Some participants were married and some single, while ages of participants spread across three decades, from late 30s to late 50s. Concerns about anonymity mean that I am unable to be more specific about

participants and particular markers of their identities and how these characteristics may have influenced their opinions and beliefs about gender and practice. While there is little evidence of notable differences in thinking among participants in relation to the key issue being explored in this study, there was general consensus that gender as a social justice issue was absent from the community development agenda.

Women represent a majority in the community development workforce in Ireland, and ‘women, especially those with young children, are traditionally the key constituency for community development work’ (Popple, 2015, p.65). While there was clear evidence of practitioners awareness of the importance of, and something of the burden of, women’s caring responsibilities in their communities, there was little evidence of agreement with the popular, often quoted mantra, of both community development and health promotion that good practice means ‘starting where people are at’. According to Popple (2015) ‘if community workers are to ‘start where people are at’, they need to take account of and relate to the experience of women’s oppression’ (Popple, 2015, p.65).

In this study, which is informed by my experience in Ireland, the primary focus is on gender, specifically women’s gender-based oppression as a social justice issue, and particularly the gender consciousness of community development practitioners. Equality legislation in Ireland clearly recognises gender as a ground for discrimination. However, like many feminist commentators before me, I am aware of the limitations of gender as a single analytical category. I am, however, equally aware of the potential for gender-blind analyses, and the marginalisation and devaluing of women’s experiences, as other inequalities and social injustices are foregrounded, a reality experienced by P1C. (See Chapter 7.4.2).

Popple (2015a) suggests that the solution to the problem of foregrounding single analytical categories and creating a hierarchy of social injustices is to view them as ‘intersecting’ (Popple, 2015a, p.66). This ‘intersectionality’ approach means that the different categories of oppressions ‘can be studied in a way that brings greater understanding of those experiencing these disadvantages’ (Popple, 2015a, p.66). One benefit of an intersectional approach from a feminist

perspective is that it helps to address one particular paradox in feminism, a paradox that is evident in responses to interview question three in this study. Question three focused on participants' experiences of doing and undoing gender and highlighted a reticence to adopt a more assertive position regarding feminism and gender, in either their personal or professional lives. The paradox in question refers to women who mediate their views on gender and have a level of accommodation with experiences of everyday sexism, as the participants do. Often identified as 'I'm not a feminist but ...' these women are reluctant to identify as feminist despite, on occasions, espousing feminist beliefs perhaps because of a fear of the stigma and negative stereotypes associated with feminist ideas and opinions. The development of a more integrated or intersectional approach to social inequalities is seen as a possible way of addressing this paradox. Intersectionality, by refuting the accusations of feminism being a single issue, hierarchical movement, provides practitioners with a more acceptable foundation for the adoption of a more assertive position in promoting gender as a social injustice.

Kimberle Crenshaw, who is credited with coining the expression 'intersectionality' was a key theoretician of black feminist thought and introduced the concept because 'although racism and sexism readily intersect in the lives of real people, they seldom do in feminist and antiracist practices. And so, when the practices expound identity as woman or person of colour as an either/or proposition, they relegate the identity of women of colour to a location that resists telling' (Crenshaw, 1991, p.1242). In academic feminism the concept of intersectionality 'has seen itself raised to the status of being the most important theoretical contribution to date of feminism' (Bilge, 2010, p.58) and, since its introduction, it has gained recognition globally as an approach to analyse how different discriminations combine to produce a specific form of oppression. Since its early days, when the focus was on race and gender, intersectionality has developed to look at the links between feminism and other liberation movements. The basic original principle, to make visible those who have been excluded from mainstream theory and practice and give a voice to those whose voices have been ignored, has remained.

Applying an intersectional perspective, and starting where people are at, means theory and practice ‘must start at the fringe, by considering the experience and oppression of the most excluded women, in order to become an inclusive and transformative space for all women’ (National Union of students/Women, no date, p.5). Feminism is, as the feminist initiators of intersectionality recognised, is not just for white, middle class women. It is also the right of marginalised women. ‘At any moment race, class or gender may feel more salient or meaningful in a given person’s life, but they are overlapping and cumulative in their effects’ (Hill-Collins, 2007, p.5/6). Adopting an intersectional perspective can help to highlight not only the absence of other categories of injustice or oppression from any social justice agenda but also of gender, where applicable. Excluding gender from any analysis or theorisation of social justice risks ‘reproducing structures of domination’, structures that include patriarchy, and helps to ‘contribute to the exclusion of marginalised women’ (National Union of Students, no date, p.5). Feminist standpoint theory, part of the framework of this study, underlines the epistemic value inherent in the perspectives of marginalised women ‘when crafting a normative vision of a just society’ (Nash, 2008, p.3), the just society that presumably mirrors the ‘fair and equal society’ that P2C describes as the ‘noble mission’ of community development. In his critique of how community development can contribute to a more just society Popple favours a return to consciousness raising, a characteristic of second wave feminism and valued by this study, ‘as a means of encouraging the reflection and action necessary for personal change and possible political transformation’ (Popple, 2015a, p.67).

There are a number of possible explanations for the fact that the focus on autobiographical narrative did not produce the level or quality of data that I had hoped for. Recounting personal reminiscences is more than simply telling stories. The teller of the stories is giving the listener an insight into their inner selves and to their personal self. As a listener to autobiographical narratives ‘we gain access to individuals’ construction of their own identity’ (Fivush and Haden, 2003, p.145). These autobiographical narratives are not static. People make their own decisions about what to tell and what to withhold and these choices are influenced to varying degrees by situational and cultural factors. I believed

that the opportunity to reflect on what to choose and what to omit was one of the safety elements of the process and would have a positive influence on participation. There is no direct evidence of what factors influenced participants' responses. However, personal experience leads me to concur with Moncrieff's conclusion that the 'guarded' nature of Irish people makes them 'near impossible to get to know' (Moncrieff, 2015, back cover). As evidence of his theory Moncrieff refers to his own mother's tendency to silence in relation to her autobiographical narrative. 'She was so Irish. We rarely had any glimpse into her interior life' (Moncrieff, 2015, p.238).

Moncrieff's theory regarding the 'guarded' nature of Irish people is supported by the postcolonial analysis that is part of the conceptual framework that supports this study, particularly in relation to the question of gender. As well as recognising the integral nature and powerful influence of nationalism in Irish culture and identity, feminist postcolonial analysis recognises the pivotal nature of gender to nationalist culture and identity. Feminism and nationalism 'have an uneasy, if not antagonistic relationship because of their often conflicting social and political goals' (Tyagi, 2014, p.46). Nationalism is gendered and the construction of gender is a primary concern of Postcolonial feminism. It is common for nationalism to see women's role in the building of the nation as key to 'the reproduction of the nation (ethnically and culturally)' and to define women's role as 'mothers and nurturers, keepers of the home, national tradition and spirituality' (Subotic, post-2015, p.3). The power of the nationalist discourse in Ireland presents a particular challenge for feminism. In this context it is possible that participants may have felt concerned that an autobiographical narrative that supported a feminist position on gender could be construed as anti-Irish.

Participants found that once you look for gender it is everywhere. There were recollections from their professional lives of being side-lined or seeing female colleagues side-lined. Question 3, in particular, opened participants' eyes to multiple examples of sexism in everyday interactions, both personal and professional. Responses to Question 3 also highlighted the near perfect conditions participants feel are required when considering whether or not to

challenge sexism or gender based discrimination, conditions that make it much more likely that the challenge will be abandoned.

Chapter 7: Discussion and Conclusions

7.1 Introduction

A key aim of this study was to explore the potential within community development practice in Ireland to promote women's health and wellbeing using a feminist framework to address the social injustice of women's gender based oppression. As discussed in the introduction, the envisioned framework consists of a triangle of three essential elements, community development, health promotion and gender. To meet the aim of the study I explored with participants the different elements of the framework, the relationship between the different elements and the possibility of combining the different elements in practice. The questions I wanted to address in the study were:

1. What are the perceptions of Community Development Practitioners (CDPs) in relation to:
 - i. gender
 - ii. health and wellbeing
 - iii. the relationship between the two?
2. How do the CDPs' understandings of these concepts relate to their own past and present practice and experience?
3. In what ways, if at all, are these perceptions, experiences and practice related to their wider social context, in particular by the wider social, historical and political context of Ireland as a postcolonial nation?
4. What are the implications for future strategy, policy and practice in this area, from a critical feminist perspective?

The tools for the exploration were four interviews extended over four sessions with community development practitioners with the research questions reformulated into four Interview Questions. The interview questions focused on participants' understandings of the core relevant concepts of the study, health and wellbeing and gender, how the core concepts relate to each other and the potential in community development to merge these concepts to address the injustice of women's gender based oppression.

In this discussion/conclusions chapter I begin by identifying some of the key findings from the interviews. This is followed with a discussion of the research findings regarding participants' understandings of the key concepts, gender and health and wellbeing, and the relationship between them. I close each section with some conclusions regarding the findings. Finally, I close the chapter with some reflections on possibilities and challenges on the road ahead.

In an effort to breach the barrier created by professional specialisation the conceptual framework that guides this exploration connects theory and opinion from a number of different disciplines including health promotion, community development and psychology. All are viewed through a feminist lens, a perspective which is poorly represented in both health promotion and community development literature.

7.1.1 Key findings

1. For me and the issue of interest in this study the outstanding finding was the absence of a feminist identity, generally regarded as necessary for activism, among participants. There was clearly a level of gender and feminist consciousness but only brief and intermittent evidence of feminist identity. Feminist analysis, which is dependent on feminist identity is recognised in this study as the essential link in the triangle of community development, the promotion of women's health and wellbeing and gender, the necessary framework to address the social injustice of women's gender based oppression.
2. There was a significant level of accommodation with and/or resistance to the continued oppressive influence of patriarchy on women and women's position in Ireland, especially in the lives of marginalised women.
3. Professional specialisation was identified as a clear barrier to addressing women's gender based oppression through the inclusion of the promotion of women's health and wellbeing in community development practice.
4. While there was evidence of a consciousness of the relationship between social determinants of health and emotional and psychological health and wellbeing in relation to participants' personal experiences, this did not

transfer to practice. Practice was guided by the dominant, disease based, narrative of health promotion.

5. A high level of accommodation of gendered cultural norms combined with a low level of confidence in relation to challenging gender, particularly with and behalf of marginalised women, resulted in gender being ignored in favour of other social injustices.
6. Participation in the research was clear evidence that participants were disposed to reflecting on the issue of gender and its relationship with women's health and wellbeing. The consciousness raising impact of Interview Question 3 suggests that there is potential in combining participants' commitment and a critically reflective approach to practice, as advocated in this study.

7.2 Discussion: participants' understanding of gender

7.2.1 Introduction

Gender inequality and discrimination in Ireland is supported by a raft of statistics, reports and legislation and, in theory, it is identified in community development and society generally as an issue. In legislation Equal Status Acts 2000-2015 prohibit discrimination on nine grounds including gender and statistics show that women's representation in decision making positions in both the public and private spheres continues to be poor. The gender pay gap, having narrowed slightly during the economic boom years, has widened again. Gender based violence continues to be a significant problem with nearly a third of Irish women having experienced psychological violence by a partner (https://ec.europa.eu/ireland/node/684_en).

In the data analysis chapter the emphasis was on remaining sensitive to what participants actually said in response to the questions asked. It is in this discussion section, by going beyond the data, and viewing it through relevant theory I move beyond the particular cases to a more generalised understanding that directly answers the research question regarding women's gender based oppression. The principle tool for this exploration is a critical feminist postcolonial lens.

7.2.2 Gender as a social construct

As outlined in chapter 2, social constructionist feminism proposes that gender is a socially constructed concept which, as it positions the male as dominant and the female as subordinate, is a social injustice that oppresses women (Beauvoir, 1949; Haslanger, 1995; Lorber, 2010; Mikkola, 2011). This gender based regime of institutionalised discrimination which is known as patriarchy, accredits characteristics as male or female according to sex differences and prescribes roles and responsibilities in society based on these supposedly innate characteristics. In Ireland the influence of patriarchy has been and remains, although gradually but slowly weakening, a persistent and pervasive social and political influence.

Participants' responses to questions relating to gender represented different positions on Aronson's continuum of awareness or consciousness (Aronson, 2017) but rarely registered at the feminist identity end of the continuum, despite participants self-labelling as feminist. Participants generally concurred with the understanding of gender as a socially constructed concept. Participants shared stories and identified incidents of gender inequality and discrimination, incidents in which they were disrespected and positioned as subordinate. In their stories they describe having to play sports in secret because such activity was regarded as 'unladylike', being very conscious of needing to behave appropriately in mixed sex company to safeguard their reputation, being ridiculed and treated as stupid in a mixed sex educational setting and receiving a poor quality education at undergraduate level relative to male students. However, there was little evidence of a critical feminist analysis of the influence of patriarchy on their experiences as women. In almost thirty plus hours of interviews the term patriarchy was not used once. The limited analysis, while disappointing, was not entirely surprising. The reticence to recognise patriarchy as a feature of Irish society has been identified by O'Connor (O'Connor, 1998, p.7). Given the ever unfolding stories of mistreatment of women in Ireland, the 'X' case, Amy Dunne, Ann Lovett, Savita Halappanavar the Magdalene Laundries, the mass grave of baby and foetal remains in Tuam, many people, including the participants, accept a patriarchal influence in the past but believe that modern Ireland has moved on and women's equality, with help from the EU, is now a

reality or very close to it. However, the a Government publication has warned against ‘the mistaken impression that women’s equality has been achieved (Department of Justice and Equality, 2017, p.19). The Strategy expresses concern that the belief that women’s equality has been achieved ‘has served to sap energy and attention from the issues still needing to be addressed and there is a renewed need to make the case ... for continued action on gender equality’ (ibid). Equally, most people, commentators, participants and citizens generally, (Moane 2011 and O’Connor, 1998) associate the traditional patriarchal ideas that identified Ireland as a particularly conservative country, with the influence of the Catholic Church, an influence that is understood as significantly diminished. Participants talked about the differences in their lives compared to their mothers and grandmothers. They told stories of grandmothers asking the local priest for permission to use contraception or to sleep separately from their husband because further pregnancy would be a serious risk to health. One story told of a grandmother dying in childbirth after the requested permission was refused. With the social developments of recent years it is reasonable to presume that most women would now regard such control of their private affairs as outdated and unacceptable. One participant described being aware of the ‘abortion bus’ that transported women from her local area to England to access abortions that were illegal in Ireland. It took thirty years, the incredible commitment of a group of women dedicated to the cause, the strenuous efforts of people, particularly women driven by their own and others’ tragic stories in the face of the distortions and vitriol of the anti-abortion lobby and the votes of the youthful Irish diaspora who returned to Ireland to register their support, to repeal the law that has had such a detrimental impact on women in Ireland.

The Eighth Amendment took its place in the Irish constitution when the Catholic Church was a recognised powerful influence in Ireland. The repeal of the Amendment suggests a significant development in discourse and thinking in relation to women’s agency and rights as citizens and can be seen as another success of the women’s movement in Ireland. Feminism, in the form of the women’s movement, has been a significant agent of social and cultural change in Ireland (Connolly, 2003). The women’s movement, by mobilising primarily around single issues has helped significantly in bringing about practical changes,

such as family planning clinics and women's refuges, which have impacted on women's lives across social classes. However women are affected differently by patriarchy and not all women benefit equally from positive gender related developments. Through the decades the influence and presence of feminism and the women's movement in Ireland has waxed and waned and historically it has been a movement of the middle classes and academics. It is too early to gauge if the most recent mobilisation has improved conditions for the development of a more widespread feminist consciousness. It certainly should ease the sense of isolation felt by women and practitioners such as P1A who have felt impeded by the absence of a feminist discourse. These developments can enhance capacity for activism and present an opportunity for progressing the feminist framework for practice and provide the missing link that can connect community development, women's health and wellbeing and gender based oppression.

The stories participants recounted in the early stages of the exploration of their understandings of gender incorporated descriptions of learning rules, codes and behaviours regarded as gender appropriate. They learned how to behave and function and behave in ways that supported the common good. The stories contain instances of resistance but ultimately, in the absence of an alternative narrative, participants had little choice but to accept that girls could not do science or become priests, that the intellect and qualities required made them, as females unsuited. *'We would have been aware of the fact that we were a bit discriminated against but it was kind of well that's the way it is. There was an acceptance about it'* (P2C) Participants described feelings of anger, anxiety, confusion and frustration and, although their responses were of accommodation and/or resignation they did not make a clear connection between these feelings and their sense of health and wellbeing. Liberation psychologists are in no doubt about the negative impact of oppression. Moane includes 'anxiety' and 'frustration' in an extensive list of negative emotions but identifies anger as 'particularly problematic' (Moane, 2011, p.86). Participants' responses also suggest an internalised oppression and an adaptation to the situation which inhibit the chances of challenging it (Williams, 2012; Freire, 1993), responses which are the engine that make the system of patriarchal oppression work and are necessary for the development and maintenance of the Irish culture and

collective identity regarded as essential in post-independence Ireland. In almost thirty plus hours of interview discussion the term patriarchy, a significant element of a feminist analysis, does not appear once. The avoidance in Ireland of the concept has been noted by O'Connor. In her extensive research of women in Irish society O'Connor (1998) draw attention to the 'good deal of cultural unease surrounding the concept of patriarchy, the suggestion being that although it may have existed in the past, this is no longer the case' (O'Connor, 1998, p.7).

A postcolonial analysis attributes this 'unease' to a pride in Irish identity and the accompanying sense of obligation to the unique community that constitutes the Irish nation. This obligation to the common good overrides other individual and group needs or desires. As discussed in Chapter 1, from a feminist perspective the application of a postcolonial analysis casts a shadow on the glow emanating from the success of the Eighth Amendment referendum. Instead this analysis guards against the danger of overstating the diminishing influence of the Catholic Church and the related influence of patriarchy in the Irish context as both are protected by their relationship with a nationalism which is 'much more powerful and socially embedded than that present in de Valéra's era (Malesevic, 2014, p.131).

Because gender can be considered so central to individual identity questioning gender beliefs can be challenging for people in many different situations. Adopting a feminist position which challenges the inequality of the dominant gendered discourse in Ireland, especially as a woman in Ireland, carries added risk because it questions how Irish society is organised. Within the gendered discourse of anti-colonial nationalism in Ireland, where it is given added weight by its relationship with Catholicism, how society is organised is essential to the unique national identity and the life of the nation (Mayer, 2002). The popularity of the phrase 'I'm not a feminist but ...' exemplifies the belief in the risk of identifying as feminist in a world in which gender inequality is a global fact of life. Against the backdrop of the celebrated uniqueness of Irish, adopting an obvious feminist identity can be seen as threatening community solidarity and can position you as the 'other'.

7.2.3 Critical reflection

The 'guardedness' identified by Moncrieff as a key characteristic of 'The Irish Paradox' (Moncrieff, 2015) made the planned for probing of the stories recounted by participants more challenging than anticipated. Unlike Moncrieff, whose exploration of the Irish psyche lacks a postcolonial analysis, I argue that the guardedness reflects a commitment to Irish culture and the collective 'we' of the Irish nation. This is not necessarily a conscious response. In my experience the cultural messages of anti-colonial nationalism in post-independence Ireland are persistent and pervasive. The plan was to use critical reflection to help break through the guardedness.

As outlined in chapter 4, critical reflection is a necessary tool in the task of problem definition and is 'a recognised professional activity' (Schon, 2009, p.4) that enables practitioners to live up to the values they espouse. As well as asking practitioners to think about their practice, critical reflection asks them to challenge the attitudes and assumption that practice by asking probing questions. In recognition of the fact that critical reflection, especially in isolation, is challenging, I encouraged an autobiographical approach and informed participants of the question in advance. The use of autobiography is a recognised way of helping people analyse and develop insight into their experiences. The process helps to the understanding of how experiences inform and are informed by attitudes and assumptions. Critical reflection is recognised in feminism as the basis of consciousness raising and is generally regarded as a characteristic of feminist research. It is identified by Robson and Spence (2011) as key in community development. The research process allowed for further probing questions to be asked in the interview and thereby incorporated the opportunity for critical reflection.

7.2.4 Doing and undoing gender

Interview Question three, the second interview question to focus on gender, was designed to encourage a more critical analysis of participants' experiences of and attitudes to gender. Responses to this question reveal a heightened sense of gender consciousness and an appreciation by participants that their gender lens had been refocused. The appreciation expressed by participants for the

opportunity for reflection and the learning that resulted from the activity underline the potential of such a relatively simple tool in the development of a critical gender consciousness. Reactions to the observation task drew attention to participants' inclination to a relatively gender-blind perspective in their everyday experiences and their personal level of accommodation with gender discrimination. In an effort to gauge participant potential to apply a feminist framework to practice I asked about the factors that influenced their decisions to address the issue of gender. Participants' responses relate to their personal everyday experiences in either their professional or private situations.

Participant responses to Question 3 about their thoughts on doing and undoing gender concur with the importance Ridgeway attaches to gender as 'a primary cultural frame' (Ridgeway, 2009, p.145). A prime example is P1C's observation of how a woman had to accommodate being subjected to relentless benevolent sexism by men in her role as leader in a group representing Ireland abroad. The protection of relationships was identified as the first factor participants considered when deciding about doing or undoing gender. Participants expressed concern that addressing gender would set up a negative and stressful reaction which would put the relationship at risk and possibly create an unworkable or unsafe situation. As a result of these concerns participants believed that the choice to challenge gender discrimination needed to be very selective, gentle and/or idiosyncratic rather than political and rights based. Even in seemingly promising situations there were a number of pre-requisite conditions including sufficient energy, the right words, thinking space that needed to be in place for participants to consider addressing the question of gender in a situation. Frequently a humorous response was regarded as the only suitable approach. In reality, gender, if considered at all, was regarded as a less of a concern than other forms of discrimination and undoing gender was regarded by many as antithetical to professional behaviour leading to a fear of disapproval, of being seen as obstructive and distracting from more important, serious and valuable work:

'It's not been easy to keep it on my radar because there are other inequalities that are to the forefront within the community development field' P1C.

Feelings of anxiety, hurt, fear, anger and uncertainty along with a significant level of accommodation and silence were identified in the responses of participants describing the impact of doing and undoing gender. One outcome of the antagonism towards the idea of gender as a social injustice and the subsequent invisibility of gender as an issue is the deskilling of practitioners:

You have to have that self-awareness prior to challenging and I think that has dropped down a level. Even in community development degrees how much is in there in terms of core modules? It has to start there in the training of community workers. P1B

All of this echoes Wilson's call in 1977 to 'inject some feminism into the community work scene' (Wilson, 1977, p.2) as only feminist practice based on a feminist analysis will make visible women, women's vulnerabilities and experiences in the disadvantaged communities served by community development. Developing the potential that is there presents a significant challenge and more critical reflection to help define the problem and commit to a feminist framework for practice:

I had to give it a lot of thought. It's not on the agenda at all. And I've only come to that realisation through the process of talking to you. It was work. I feel quite tired after it. P2C

7.3 Conclusions regarding gender

Ultimately the discussions on gender highlighted the fact that gender was effectively not really an active issue on the agenda in community development practice or discourse. While participants self-labelled as feminist some were still sorting their ideas during the discussions. In fact most of the participants observed that participating in the research discussion opened their eyes to the gender-blind nature of community development. As a result, there were often contradictions in the views they expressed. Sometimes the views expressed would suggest a feminist perspective in recognising women's gender based inequality, a perspective that could work successfully with the framework proposed in this study.

At other times a lack of empathy with women was obvious. Women, unlike men, were already involved in community development as volunteers or engaging in programmes and activities. The programmes and activities were not necessarily designed particularly with women in mind or to connect with any gender related agenda. There was a presumption that community development was obviously serving women's needs and as women were already obviously benefitting from what community development was offering so now the focus needed to be on men. The views expressed reflected a liberal perspective, one that advocates gender mainstreaming and gender equality. The belief, which supported the concern expressed in the 'National Strategy for Women and Girls 2017-2020' (Department for Justice and Equality, 2017) that women's equality has been achieved. As a result, the issue of men's equality now needed to be prioritised because men have suffered as their identity has taken a knock and they have lost their place in society. While men are unemployed women are gainfully engaged in their caring duties with family. Recognition that these gender prescribed caring duties put significant demands and pressure on women was relatively transitory as the belief that because women already get so much from community development the need now was to focus specifically on men and men's needs. The presence of men's sheds projects (<http://menssheds.ie/>), known to reinforce traditional conceptions of gender, in almost every community development area in Ireland is evidence that the general views of participants regarding gender related needs reflected the dominant or popular view. In comparison to the recognition of the need for a focus on men's needs a level of antipathy towards women is apparent in the expressed view that any specific gender related focus on women would need to be matched with an equal provision for men. In the absence of a feminist analysis this contradiction, which highlights a clear injustice, remains invisible.

A postcolonial analysis, while relatively contentious in academic circles in Ireland, accounts for the confusions and contradictions evident in participants' understandings of gender. It is reasonable to assume that these confusions and contradictions contribute to a lack of commitment to a feminist identity, despite a level of feminist awareness among the participants. This contradiction, in turn, accounts for the blindness in relation to the social injustice of women's

oppression and women's internalised subordination and occasionally evidence of antipathy towards women. A feminist postcolonial analysis also explains the paternalistic attitude that was evident in some of the discussions. A consciousness raising type process would make women unsafe. Disadvantaged women have enough problems without throwing feminism into the mix. Feminist ideas would make women vulnerable to a backlash-type response. I can empathise with that concern but I also trust women and their ability to reason and believe that they deserve the opportunity to have a voice and to engage in a reflective dialogue that challenges the attitudes that positions them as subordinate. Community development work with women frequently focuses on problematising local issues an approach that demands even more from women without recognising the constraints they face. Within the health promoting feminist framework proposed in this study, a framework that recognises gender as a determinant of women's health and wellbeing, the starting point is the sexism experienced in their everyday lives. For practitioners to have the confidence themselves to initiate the necessary dialogue they need to address their own internalised oppression and develop a more confident feminist identity.

7.4 Discussion: participants' understanding of health and wellbeing

7.4.1 The social model of health and community development

The feminist analysis that is the bedrock of this study affects the understanding of the principle concepts - health and wellbeing and gender and the relationship between them. '*Feminism is a movement to end sexism, sexist exploitation and oppression*' (hooks, 2000, p.viii) and every aspect of the study is influenced by a feminist analysis. Feminism influences beliefs about the professions involved and about professional practice. The feminist identity of the study is established in the recognition of the patriarchal gender regime as a social system that oppresses women and remains pervasive influence in Irish culture and politics.

Building on this foundation, using a social determinants model of health and recognizing gender as an overarching determinant, this study argues that women's gender based oppression is a negative determinant of women's health and wellbeing and an issue of social injustice. As a matter of social injustice it is

reasonable to expect that women's gender based oppression would be addressed by organizations or agencies claiming a concern with equality and social justice and a commitment to related values. This study focuses on two such organizations, community development and health promotion.

A review of the many definitions of community development identifies it as a practice committed to values of: '*social justice, collective action, equality and mutual respect, enabling and changing power relations*' (Gilchrist and Taylor, 2011, p.3). The Ottawa Charter, the agreement recognized as the official introduction of health promotion as a new health related discipline, laid the foundations for a partnership between health promotion and community development, with shared values and a vision of building healthier communities. The overlap of values and vision suggest either or both as potential protagonists in addressing the social injustice of women's oppression. However, the paucity of research literature or commentary in either health promotion or community development relating to gender and/or its impact on women underlines the neglect of gender and women's oppression by both.

Influenced by the women's health movement and feminist practitioners a significant body of literature on women's health has been produced. However discipline specialization means that health related literature, including that from a feminist perspective that acknowledges the relevance of social factors, remains disease and healthcare focused. The patriarchal culture and operation of male power within medicine and healthcare, the view of male physiology as the norm and the subsequent sex bias in treatment are serious problems that continue to require attention. In this study, however, the focus is on the wider picture and the promotion of women's health and wellbeing against a backdrop of women's gender based oppression, using a social model of health and wellbeing. The emphasis is on social and mental dimensions of health and wellbeing such as feelings of confidence, self-worth and competence, not just the absence of disease. This focus recognises the importance of social, cultural, economic and political factors on health and wellbeing and emphasizes psychological factors such as social status. With gender as an overarching determinant the concern is with the influence of gender on social relations and

the impact on women of gender based discrimination, gender related devaluation and women's social inferiority.

The power and influence of the medical model of health extends beyond the confines of medicine and healthcare to effect lay beliefs and understanding including those of other professions and disciplines. With its relatively easy access to communities, community development is a valuable conduit for health promotion initiatives and such programmes are regularly identifiable in community development plans. Generally, however, such programmes are behavior change and disease focused and take little cognizance of women's gender based constraints. As programmes are typically delivered by outside agencies such as health promotion, they reinforce the idea that health is someone else's business. The stated values of community development make it an apposite agency for the development of the feminist-Freirean type framework incorporating a social determinants model of health which is advocated in this study. The relationship between oppression and psychological wellbeing is widely acknowledged and the negative impact on feelings of confidence, competence, self-worth and power. Oppression undermines capacity for transformative action and a significant influence on capacity is the internalized subordination of the oppressed and their resignation to the situation. The study argues that such a framework built on a feminist foundation provides practitioners with an approach that can help overcome some of the current obstacles to addressing women's gender based oppression.

7.4.2 Understandings of health and wellbeing

As argued in Chapter 2, health, as a social construct, is influenced by attitudes, values and norms and the context of the situation so health or being healthy means different things to different people at different times (Ewles and Simnett, 1999; Keleher et al, 2007). Because of these different understandings 'the first major issue faced by any health promotion practice is how practitioners conceptualise health' (Labonte, 1998, p.9). So, because practitioners' understand of health will have a bearing on how they understand the relevance of health promotion in their work, I start the discussion of the findings by considering how participants' responses to this question contribute to the overall

enquiry. For example, do participants' responses suggest a bias towards the curative, disease based medical model or do they indicate an awareness of the social determinants model that recognises a link between the social and cultural context of women's lives and their health and wellbeing? A preference for the medical model identifies health as the responsibility of health professionals and healthcare services and outside of the remit of community development. Recognition of the relevance of everyday experiences and the social context to women's health and wellbeing would be a positive indication of potential for the implementation of a feminist programme for the promotion of women's health and wellbeing. The framework proposed in this study combines three essential pillars:

1. A holistic definition of health, incorporating a social determinants model of health
2. An emphasis on health promotion and
3. Health as a matter of social justice

The World Health Organisation definition of health presented in the 1986 Ottawa Charter for Health Promotion and referenced in Chapter two provides the necessary foundation for the three pillars. The definition presents health as a positive concept that recognises the importance of mental and emotional health and extends understanding to include wellbeing. The life-story style of the interview aimed to encourage reflection and assist participants meet the challenge of explaining their understanding of health and wellbeing.

Using the autobiographical approach there were encouraging signs in the early stages of interviews of a holistic understanding of health and wellbeing that emphasized psychological and emotional health and referenced elements of Ryff's scale of wellbeing referred to in Chapter five (Ryff, 2008) and which are also identified by Labonte in his 'Fields of Wellbeing' (Labonte, 1998), particularly feelings relating to autonomy in control of life. There was recognition of a connection between health and wellbeing and having control over everyday life events. One example was the recognition of the need for equilibrium, the rebalancing of this equilibrium when it is upset by pressures of life and the value of having the resources or capacity that is required for the

rebalancing such as space, choice and supportive relationships. Having the capacity to challenge threats to damage to these elements of health and wellbeing and lessen personal vulnerability was also identified as important. When these positive experiences were counterbalanced by stories highlighting women's vulnerability and lack of power in the face of oppressive sexist attitudes and behaviours there were hints of accommodation and resignation to the situation. These responses were accompanied by an evident understanding of the negative impact of such experiences on mental and emotional health and feelings of wellbeing, and pointed to a break in the link between response and understanding. This broken link, which highlights the absence of the critical feminist analysis, diminishes the potential for implementation of the necessary feminist support initiatives.

The hint of conflict between understanding and action identifiable in the personal examples of health and wellbeing were even more evident when participants' focus moved to the health and wellbeing of women in the community and how, if at all, it featured in community development practice. As before there was clear evidence of participants' awareness of the pressures of women's everyday responsibilities, the guilt brought on by concerns about competence and commitment, women's lack of free time and the unremitting nature of women's gender related roles and responsibilities. Lacking in relation to the health and wellbeing of women in the community, however, were clear examples of how to support women reset the equilibrium in their own lives or, indeed of the need to do so. Descriptions of programmes which did exist highlighted the broken link between understanding and action. Lacking the feminist analysis, identified as necessary in feminist commentators such as Robson and Spence, 2011 and Ruzek et al, 1997, referenced in Chapters 5 and 2 respectively, programmes were generally gender-blind or based on a deficit model of women and in danger of reinforcing the gendered roles and responsibilities that participants recognized as constraints on women's lives.

There is evidence in the data that some beliefs and attitudes expressed by the community development practitioners in this study mirror similar beliefs and attitudes that have been criticised by commentators of health promotion practice. Cribb and Duncan (2002), for example, criticise a lack of clarity

regarding about what precisely is the objective of health promotion and the notion that health promotion is unquestionably a good thing and therefore, whatever is done in the name of health promotion, it is beneficial. A typical example in the data is that providing women only spaces for women to meet and talk, whatever the topic, is good enough. Doubt about the potential for such groups to provide the missing link of a critical feminist analysis is supported by the research of Ward and O'Donovan (1996) which identified a lack of a feminist perspective in women's groups in Ireland.

Community development as an approach and as an agency for health promotion is a central belief of health promotion and is identified in models of health promotion (Naidoo and Wills, 2000). However, professional specialization which protects health promotion as a specialist provision, and is 'interested primarily in developing and underpinning the infrastructure of health' (Cribb and Duncan, 2002, p.19) which results in a disease based, behavior change model of practice discourages a stronger commitment to health promotion in community development and impedes the potential of community development to deliver a feminist, social justice based model of health promotion for women. P2D's refusal to deliver a diet change food programme to Traveller women is evidence of how the behaviour change emphasis of health promotion can be a wedge that contributes to the separation between community development for those with a more critical social justice perspective. There was however contrasting evidence that highlighted the attraction of behavior change programmes such as the smoking programme for women planned by P2B that are presented as contributing to curing cancer. The confusion of what constitutes health promotion in community development and the potential of community development to address women's gender based oppression requires the missing link of critical feminist analysis that connects women's everyday experiences with their health and wellbeing.

Evidence of the potential of participants to provide the required missing link sometimes came from general comments in the discussion as the interview was winding up. The comments showed that, as a result of engaging in the interview, the consciousness of participants was alerted to the possibility of a different or more critical perspective. The comment from P1B was typical:

You know there's something of a nugget in there to me around gender and the impact of being carers. Women are expected to be carers by everyone whether caring for children or husbands or their community and there's something we need to discuss around carers and in terms of gender and the impact on their health. P1B

P1A expressed a desire to know more and an opportunity or 'a bit of a framework' to tease out her ideas because:

You know it's just ... it's (gender) there from birth and we're seeped in it as we are with other mindsets and other discriminations. But to try to free yourself from that you need a framework, the tools. P1A

7.4.3 Health and wellbeing and gender and the relationship between them

Following the globally recognised Ottawa Charter definition of health I stuck conscientiously to the extended term health and wellbeing throughout the research. I used it in the information literature that accompanied the invitation to participate and in the interview discussions. In other words I always referred to health and wellbeing, never just health. Participants generally struggled with the extended concept and often flitted between the two different models, medical and social. The influence of the dominance of the medical model which understands health as an individualised medical issue rather than a structural social issue in their understanding was clear. Nowadays health promotion messages that focus on disease prevention such as advice on diet, exercise, alcohol intake and the dangers of smoking are relatively global, especially among educated, professional people such as the participants. There were a number of brief references by participants about the incompatibility in their own lives between knowing what they should be doing and actually doing it. Although such health promotion messages are often included in the calendar of community development programmes they are, as one particular example showed, generally delivered by health promotion specialists. Health promotion, in other words is someone else's business and not that of community development.

There was a limited awareness of the social model of health although, after some discussion, there was some evidence of an increased consciousness of a potential negative relationship between the pressure of women's prescribed gender responsibilities and their health wellbeing. The realisation of this connection was, however, quite tentative and was understood predominantly in a personal sense rather than collective sense in the lives of women who are economically and socially disadvantaged.

A number of interrelated issues made the task of linking the three constituent elements of the triangle during the research just too difficult: a) participants' limited experience and understanding of the workings of the social model of health b) participants understanding of health primarily as an individualised medical issue rather than a structural social issue and c) the distortion of diseased based health promotion messages. The gap meant that the relationship between gender as an oppressive influence on women's health wellbeing and social justice remained invisible and, therefore, not something that should be of concern to community development. The missing link was the absence of a critical feminist analysis.

In my analysis I explored how participants' avoidance of gender and their oscillation between a social model and a medical model of health related to their experience in practice. The analysis showed that, in the absence of a critical feminist perspective participants did not identify women's gender based oppression as a social justice issue and therefore something that should be tackled by community development. Instead, partly influenced by a top down, economically influenced agenda setting, based on a traditional gendered view of the man as breadwinner and a sense of empathy for men, men and men's needs were prioritised. 'This approach lacks an underlying gender analysis and consequently marginalises significant sectors of women, and disadvantaged women in particular, from its concern' (Barry, 2008, p.9). Within this gender-blind, economically influenced agenda, despite the disproportionate impact of austerity measures on women, there was little evidence of a sense of empathy with women and women's needs generally remained invisible. In fact there was a presumption that, because of the level of engagement of women with community development, women's needs are being met. Also, women are

fine because they are busy attending to their prescribed gender based caring responsibilities. They are expected to carry on doing what they are supposed to do which is to hold communities together. Women's identity is subsumed in their family responsibilities and, in the absence of a critical feminist analysis, familism, despite the impact it has on women's sense of autonomy or self-determination, was generally regarded as a good thing. Instead, because men have lost their identity as breadwinners and find themselves isolated and disconnected from family, men's needs needed to be prioritised. The invisibility of women and the absence of an understanding of the oppressive nature of gender in women's lives reflect the gender blind nature of anti-poverty and social inclusion policies in Ireland. These policies are based on an approach that 'lacks and underlying gender analysis and consequently marginalises significant sectors of women, and disadvantaged women in particular, from its concern' (Barry, 2008, p.9).

Participants' understandings of these concepts were tied to the influence of particular policies and priorities that reflected the contemporary political narrative and agenda, the belief that other factors such as poverty are more important than gender and the belief that, despite the core community development principle of building healthy communities, the responsibility for health lies elsewhere and responsibility for the promotion of health is outside of their remit.

7.5 Reflections on the road ahead

7.5.1 Influence of neoliberal policies and practices

The most vulnerable and marginalised in Irish society and the services that support them, including community development, were disproportionately affected by the recent economic crisis in Ireland. At the time of the research interviews community development had suffered significantly from cutbacks and reorganisations, something I also experienced in health promotion. The changes had been going on for a decade. Funding was cut to the bone and any autonomy they had had basically been erased. Morale was low, a factor that I believe contributed to the difficulties in getting participants for my research. Health promotion refused to participate on the basis that gender was not an issue of

any importance at that time. In the absence of a critical feminist analysis in community development gender and women's oppression, if it ever was an issue, paled into insignificance relative to other more visible injustices. Gender as a social injustice and the impact it has on women's lives is invisible because no one is looking for it.

The severe measures implemented by Government to address the crisis inevitably influenced attitudes and options at practice level and, having experienced the cuts and reorganisations as a public service worker at the time, I empathise with those working at the coalface. I was, however, shocked that throughout my discussions with participants there was no real acknowledgement of or sense of empathy with women in recognition of the particular and unequal impact the austerity measures had on them. With devastating cuts to welfare benefits such as lone parent allowance, child benefit, back to school payments, rent supplement, disability and carers allowance and cuts in health and social services women, who have the responsibility for holding it all together in these communities, are particularly affected. A critical feminist analysis, incorporating a principle of critical consciousness, which can shed light on how women's experiences impact on their lives is needed to develop insight into how community development can support the promotion of women's health and wellbeing and address the continuing injustice of women's gender based oppression.

7.5.2 Health as the purview of health promotion rather than community development

The proposal in this study to address the social injustice of women's gender based oppression through a partnership of community development and health promotion is supported by research and makes sense in theory. In reality the proposal faces a number of difficulties. The principal problem is the possible variations in understandings of the key concepts that are combined to make up the framework, community development, health promotion, health and wellbeing, gender and gender as a determinant of women's health and wellbeing. The variations in understanding generally result in a sometimes significant gap between rhetoric and practice.

Community development and health promotion are frequently recognised as suitable bedfellows as they have, in theory, much in common. Community development talks about building healthy communities and in health promotion a community development approach is de rigueur. Both espouse principles of empowerment, autonomy, social justice and community participation. In practice, despite espousing such principles the absence of a feminist analysis, an essential link in the framework, means that both disciplines are in practice in generally gender-blind. The gender-blindness seriously limits understanding of a social model of health, understanding that is further hampered by contradictions in the discourse of health promotion. These contradictions do little to enhance understanding in other disciplines such as community development, of health and wellbeing within the context of a social model of health or the relationship between social determinants and health and wellbeing. However, because of discipline specialisation health promotion and health promotion specialists are regarded as the experts in relation to the development and delivery of health promoting programmes.

These programmes are, in theory, based on a social model of health and are concerned with addressing social conditions. In practice the contradictions are clear. There is little obvious correlation between the disease based, behaviour change, lifestyle based programmes that are generally offered by health promotion and the social injustice of gender or any other form of oppression experienced by people in marginalised communities. The biomedically informed health promotion agenda is to change people's behaviour rather than address the unjust social conditions that a social model of health recognises as determinants of health and wellbeing. The contradictions are not always obvious to community development practitioners who, understandably, put their trust in the experts. Health promotion messages about the dangers of smoking, drinking and lack of exercise are generally understood and accepted by educated, middle class people. So, a rationale that favours targeting disadvantaged communities, where levels of smoking, alcohol consumption and exercise compare unfavourably with recommended guidelines, can seem to make good sense. As a seriously underfunded, under resourced community development manager the offer of health promotion programmes that are advertised as for the good of the

community, are good value for money and add to the prospectus of community development provision is a difficult proposition to resist. After all the health promotion personnel are the experts.

7.5.3 The wider social context: Ireland as a postcolonial nation?

In my analysis of the nature of the Irish context of this study, an analysis informed by significant personal experience, I am comforted by the acknowledged struggles of other commentators, both academic and non-academic, to provide clear evidence of the nature of the Irish psyche. By some it has been identified as something one can sense rather than see. I struggled for some years for a satisfactory explanation of what I was sensing. It has required the extensive probing of the literature necessary for this study to provide an answer which I believe validates my experience, an investigation made more challenging by the gender-blind theorisations that dominate. A full understanding required a feminist analysis. The elusive nature of the desired evidence is also influenced by the fact that a defining characteristic the Irish psyche is, as I experienced in my research, what is not said, what is excluded rather than what is included.

I concur with O'Connor's observation regarding the cultural unease in Ireland, for example, with the concept of patriarchy, an unease which O'Connor links with a concern that criticising patriarchy is an attack on men. Such antagonism challenges the sense of collective identity that is a key element of postcolonial nationalism. The number one aim of postcolonial nationalism is to overcome the history of oppression by making a clear break with the ousted oppressive power by moulding a new and unique identity. The legitimating and exclusionary narratives designed to ensure the development and perpetuation of this unique identity, to keep this collective national consciousness alive and limit scepticism and criticism are assertively enforced. In the moulding of the post-independence state gender is a fundamental tenet with unambiguous roles allocated to men and women in a patriarchal regime that oppresses women. Men replace the colonial masters, assert their authority and take control of the creation of the new identity. Women, as well as being reified as symbols of the nation are the reproducers of the nation biologically, culturally and symbolically. The sense of

nationhood has grown over the decades and is thought to be stronger than ever in recent years.

Clear evidence of the influence of an embedded post-independence nationalist narrative was difficult to decipher in the research interviews. However, in nearly thirty plus hours of discussion mostly centred on experiences of gender as women in Ireland, there was little direct reference to patriarchy. There were, however, occasional signs of antipathy towards women counterbalanced by clear evidence of empathy for men. There was evidence of a level of internalised subordination in participants' acceptance or ignoring of sexism and gender based discrimination despite expressed feelings of anger and hurt, their general reluctance to undo gender and a generally feminist free analysis in their practice.

When there was acknowledgement of a patriarchal-type influence in Irish society the Catholic Church was identified as the perpetrator. After all the church related disasters that have been uncovered in Ireland in recent years and the response of the Church to them, people are generally less perturbed about criticising the Church than previously. The general opinion was that the traditional patriarchal attitudes that prevailed at one time in Ireland, attitudes highlighted in participants' own stories, were due to the influence of the Catholic Church. Now, however, the influence of the Church has waned and those traditional attitudes no longer prevail. Perhaps connected with the cultural unease about patriarchy and the idea that there is any intentional gender injustice in the way of women's oppression in modern Ireland certain facts remained ignored. For instance the Catholic Church retains significant control of first and second level education in Ireland. In other words the vast majority of people in Ireland have been and continue to be educated in Catholic schools. So, a level of criticism of Ireland and Irish ways has become possible by using the Catholic Church as a scapegoat. Any further criticism of the persistent and pervasive patriarchal nature of Ireland and Irish culture can be regarded as anti-Irish as it has potential to threaten the stability of the collective self-image as a uniquely moral country that has social justice at its core. The future of Ireland depends on the proud collective and unique 'we' and a strong sense of exceptionalism.

7.6 Concluding observations

The purpose of my professional work as a women's health officer within health promotion was to improve women's health. Definitions of health vary but my approach combined a social determinants model of health with a feminist analysis. In applying this combination I identified gender as an overarching determinant and, reflecting the ideas outlined in the Ottawa Charter, I extended the definition of health to include wellbeing. I completed my framework for practice by adopting a person centered, participative, reflective group approach with women. The approach was a transformative one for women who participated in the various projects. My efforts to develop collaborative partnerships with other health professionals and community development practitioners to work within and develop this framework, were, however, less successful. In this study I have tried to understand the reasons for this limited success in engaging other appropriate practitioners and to assess the potential for future development. I did this by investigating community development practitioners' understandings of the key concepts, gender and health, and their opinions about the scope for addressing gender as a determinant of women's health and wellbeing through planned interventions.

Health promotion practice is controlled by health services and delivers a disease based agenda. Despite its rhetoric, it does not address social conditions or the social determinants of health, nor extend the definition to include wellbeing elements such as autonomy and environmental mastery. In this study I explore the potential of community development to deliver the feminist, social justice based framework I believe is necessary to promote the health and wellbeing of women and address the social injustice of women's gender based oppression.

Potential is there for the development of the critical feminist analysis that is necessary to recognize the impact of gender based oppression in women's lives and understand it as a social justice issue that community has a responsibility to address. The one aspect of the research that gives me most hope is participants' overall response to the observation task that I set as an encouragement to critical reflection. However, a collective effort is required to meet the many challenges presented by this responsibility particularly in endeavoring 'to retain an ambition for women's equality in the context of competing demands for

action on other equality issues’ (Department of Justice and Equality, 2017, p.17). Although the proposed framework is identified as health promotion the social justice emphasis makes community development a suitable conduit for the delivery and development of the framework. The outcome is also a positive for my preferred methodology in research, understanding research as a transformative process and a characteristic of feminist research.

If practitioners could see the connection between their work and the social determinants of health and wellbeing, with an emphasis on the elements of wellbeing such as self-worth and confidence and the effect of internalised subordination, it would be a good strategic move. Viewed from a critical feminist perspective the connection between the different sides of the triangle, community development, gender based oppression and women’s health and wellbeing, is more visible and more easily understood. The drive and desire characteristic of a feminist identity helps to think more strategically and to meet the challenges of such an agenda. A critical feminist perspective recognises the concerns about men’s needs and understands that ‘action to promote women’s equality will benefit society more broadly’ and create a ‘fairer society which allows women and men alike to flourish’ (Department of Justice and Equality, 2017, p.7). A feminist analysis provides a more positive approach than one that simply reinforces a traditional gendered mentality which is actually damaging for men. Although it does benefit society at large, a feminist perspective means challenging the status quo, the thinking, for example, behind ‘men’s sheds’ and the hostile sexism of the men on the job activation scheme that P2C identified.

Power’s (2014) study on ‘Resistance’ in community development identified pockets of resistance. Ledwith (2011), like other community development analysts contend that community development needs to expand its frame of reference. I see my framework as a way to do that by applying a feminist analysis which is a social justice analysis. If community development is about social justice it needs to get up and fight. My concern is that, in the Irish context in particular, the argument becomes rather circular if gender is not understood as a social injustice that is oppressive for women. I know from the work I did with women that using the type of feminist-Freirean model of practice that

encourages critical reflection and is favoured by Ledwith (2011) that women's consciousness is raised and women can make small but, for them, significant changes, that at least eases the pressure. I did not get the chance to grow that and build a collective identity because the necessary support from other agencies was not there.

Progressing the proposed framework requires training as was noted in the analysis. Training would need to address the issue of practitioners' confidence in relation to challenging gender. It would need to be a critical reflection process that would genuinely challenge practitioners' thinking. Such an approach was characteristic of my PLA projects with women and has informed the framework proposed in this study. The cultural resistance to critical reflection is a challenge to such an approach and, to realise its potential the process needs to be designed and delivered by a committed and experienced facilitator. As one of the participants, who admitted being exhausted at the end of interviews, acknowledged, it is a process that takes effort on the part of participants because it requires serious thinking.

So basically, the future plan would be to take a critical feminist perspective and develop a strategy to focus gender issues and strengthen the perception of it as a key social justice issue. The strategy would also need to involve challenging the neoliberal tendencies of community development and work 'to reclaim its radical agenda' (Ledwith, 2011, p.3), an agenda that 'builds confidence as people begin to question their reality, and act together for change' (ibid). The strategy would strengthen the idea that gender is an aspect of social justice and is a key issue. Training would have an emphasis on critical reflection and analysis which would support the development of a feminist perspective and influence practice.

In this discussion/conclusions chapter I have identified some of the most pertinent findings of the research. Although previous research identified an absence of feminism in community development the level of gender-blind analysis uncovered in this research is a concern that underlines the need for the study. This gender-blindness of practitioners points to a gap between rhetoric and practice which results in a neglect of the damaging effects of gender as a social injustice in already marginalised and disadvantaged women's lives. As well

as shedding a much need light on this gap this research provides a possible way forward in a conceptual framework which links community development, the promotion of women's health and wellbeing and gender. The struggles participants experienced in connecting the different elements of the framework underline both the value and the originality of the proposal as well as the gap in knowledge that it addresses. The findings also highlight the precarious nature of feminism in community development, a situation exacerbated by the acceptance by practitioners of the everyday sexism they experienced in their own lives. Although this discussion of the findings paints a relatively pessimistic picture of the situation it also presents some reasons for optimism regarding the potential of community development to implement the proposed framework. Firstly, there is the willingness of community development practitioners to participate in the research despite the very considerable pressures being experienced in the sector. Secondly, the increased consciousness that resulted from the relatively simple reflective task in Question 3 of the process indicates a willingness to challenge their own thinking, a necessary constituent of transformative learning.

*Today I stand
In a field and shout.
I shout for some cannot hear
I shout for some will not listen
I stand up and shout
Because each voice is important
Each must be heard,
Each given a chance
To stand up and shout
In their own language
Their own voice
Their own field
Fence and hedge will not keep out
Forever
Those who do not want you
To stand up and shout
Only want you to sing their song*

*So will come in, take your shout
Take your field
I will not yield to them
But add each lost voice to mine
Today, in my small field
I stand up and shout.
(Carruth, 2017, p.57)*

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Appendices



College of Social
Sciences

Plain Language Statement

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Study title and Researcher Details

The title of the study is 'Mirror, mirror: an exploration of female community development practitioners' understanding and experience of gender and how it connects with their practice in the promotion of women's health and wellbeing'. The focus of the study is informed by my experience as a Women's Health Officer and health promotion practitioner in the Irish health services. The research is in support of my Doctorate in Education (EdD) from the University of Glasgow.

What is involved on the study?

The invitation is open to community development practitioners in *geographical area deleted* area of the HSE (Health Service Executive) Ireland. The research will involve a group of five female community development practitioners in a number of structured group discussions which will take place over five sessions of similar length. Including comfort breaks and lunch each session will last for approximately five hours. The focus of the sessions will be:

1. Each participant's sense of identity and status as a woman
2. Changes in their sense of identity or status over each participant's lifetime

3. Relationship between each participant's identity as a woman and her sense of wellbeing
4. Relationship between personal and professional identity
5. Ideas for improvements in the promotion of women's health and wellbeing

The research is designed to build personal and professional knowledge and confidence through critical reflection on the questions being addressed. The opportunity for personal reflection is enhanced by participants having prior knowledge of the question to be addressed in each session and the need to carry out a small task in preparation for each session. For most sessions the task will be to choose an image which supports participants' response to the question being addressed. The action focused nature of the research aims to provide participants with the opportunity to identify ideas for improved practice in the promotion of women's health and wellbeing. These ideas along with the research report should provide knowledge to inform community development policy and practice, particularly in relation to women.

CONSENT FORM

I understand that Rosalie Doherty is collecting data in the form of taped interviews for use in an academic research project at the University of Glasgow.

I confirm that I have read and understood the Plain Language Statement for the study and I have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

I give my consent to the use of data for this purpose on the understanding that:

- All names and other material likely to identify individuals will be anonymised.
- The material will be treated as confidential and kept in secure storage at all times.

Signed by the contributor: _____ Date: _____

Researcher: _____ Date: _____

Researcher's name and email contact: Rosalie Doherty

rmadoherty@eircom.net

Supervisor's name and email contact: Barbara Read

Barbara.Read@glasgow.ac.uk

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Appendix 3: DOING AND UNDOING GENDER - an observation and reflection task.

Human beings interact extensively in their private as well as the public domain, personally and professionally. In all of these interactions, consciously or unconsciously, we contribute to the shaping of gender. We are all, in other words, involved in 'doing' or 'undoing' gender in our everyday interactions. For this task I want you to observe examples of doing or undoing gender in your interactions, personal and professional. I want you to observe for example how the interactions ignore or accept, confirm, resist or challenge traditional gender norms. Gender is observable in every aspect of the interaction, in for example behaviour, dress, opinions stated or how people present. You can be actively involved in the interaction or a witness. In your recording of the interaction take note of the who, what, when, where and why. In the FEELINGS section include, if possible, the feelings before, during and after the interaction.

INTERACTIONS		
You DOING personal		
You UNDOING personal		
You DOING professional		
You UNDOING professional		
FEELINGS		
Before		
During		
After		

Record thumbnail sketches of your chosen interactions. There is space for two personal examples of doing and undoing and two professional examples of the same. You may not identify examples in all the slots. That is not a problem.

Appendix 4: INTERVIEW SCHEDULE

Interview question 1: *What are your memories of growing up as a girl and young woman in Ireland?*

What messages do you recall?

Where did the messages come from?

How did you feel about the messages?

How did you respond to the messages?

Interview Question 2: *What is your understanding of health and wellbeing?*

What do you understand by good/positive health and wellbeing?

How do you think being a woman impacts positively/negatively on your health and wellbeing?

What do you think are the positive/negative influences on women's health and wellbeing?

Interview question 3: *What did you observe about gender, how it manifested in your everyday life, how you responded to experiences and describe associated feelings?*

See Appendix 3

Interview Question 4: *How, if at all, do you think women's gender as a determinant of women's health and wellbeing might be addressed in community development policy and practice?*

As a community development practitioner, how do you understand the relationship between community development and gender as a factor in the promotion of women's health and wellbeing?

What factors do you think have a potentially positive impact on community development being proactive in addressing gender as a determinant of women's health and wellbeing?

What factors do you think have a potentially negative impact on community development capacity to address gender as a determinant of women's health and wellbeing.

How do you think these factors might be overcome?