

Introduction: 'Everyday health', embodiment, and selfhood since 1950

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What is 'everyday health'?

In 2017, Bodyform became the first UK brand to show menstrual pads stained with red liquid, rather than blue, in its adverts. The company's video campaign, accompanied by the #bloodnormal, also showed a woman in the shower with blood running down her thigh and a man buying menstrual products. Response to the campaign was largely positive, with many welcoming Bodyform's decision to challenge menstrual taboos. The campaign won the Grand Prix award in the 2018 Marketing Week's Masters Awards.¹ This positive response contrasts with previous storms over companies' attempts to push boundaries in menstrual advertising, including complaints in 1972 over the earliest foray into television advertising (a brief trial that was quickly pulled), in 1993 in response to the *Vespre Silhouette* ad featuring agony aunt Claire Rayner, and in 2003 when *Lil-lets* included a demonstration of the benefits of tampons in an ad filmed in the style of a 1970s children's television show.² If the Bodyform ad itself harnesses feminist celebration of menstruation to capitalist aims, the response to it demonstrates at least the partial success of menstrual activists in shifting public opinion.³

We could view this shift as an unambiguous advancement in attitudes towards menstruation – an everyday, normal health experience for millions of people, but one hidden and stigmatised for much of modern history. Yet, looking beyond public forms such as advertising, into private experiences of bodily and household management, challenges easy assumptions of unilinear progress towards

greater comfort with our bodies and their functions. When we interviewed Tricia (b. 1958), she told us that when she was a teenager, the fireplace in their spare bedroom was used solely for burning menstrual products.⁴ For Tricia, this allocation of household space was mundane; to listeners nowadays, it might seem bizarre, or cause an almost-instinctive recoil. The boundaries of the 'everyday' can shift in unexpected ways over time, and our understanding of what *was* 'everyday' in the past might well depend on where we fix our gaze: on public forms or private behaviours.

What do we mean when we talk about the 'everyday' and 'everyday health'? The 'everyday' has been the implicit and explicit focus of many scholarly traditions, from social histories that assumed the primacy of economic materialism, through the cultural studies of the 1980s onwards, to more recent historiographical debates on 'expertise' and 'ordinariness'.⁵ The extent of this scholarship reflects the changing nature and importance of the 'everyday' in politics, society, and culture since 1950, spurred by multiple developments including the reshaping of democratic politics and the institution of welfare states,⁶ the reconceptualisation of responsible citizenship in the aftermath of the Second World War,⁷ the expansion of consumerism and its insistence on happiness in every aspect of life,⁸ and the rise of identity-based political movements that broke down the boundaries between the public sphere and personal life.⁹ These developments had momentous consequences for understandings of health. Welfarism reframed notions of health in relation to citizenship.¹⁰ The flourishing of individualism, affluence, and consumerism meant the proliferation of privatised therapies for maladies of body and mind.¹¹ Liberationist activism tore open the ideological underpinnings and oppressive functions of traditional medical systems, throwing open the question of what good health really meant – accommodation to an unjust system or the flourishing of the entire self?¹² The concept of health that emerged out of these transformations was newly expansive, especially in its more recent association with terms like wellbeing, wellness, and self-care.¹³

The term 'everyday health' brings together multitudinous understandings of the 'everyday' and of 'health' and places them in historical and historicised contexts. We define 'everyday health' as the emotional, psychological, and bodily state-of-being in individuals' day-to-day lives, and the strategies they pursue (or do not) to maintain

equilibrium in this state-of-being.¹⁴ More than a descriptive term or a neatly bounded concept, 'everyday health' is a lens. Histories of 'everyday health' centre on the experiences of 'ordinary' people in their daily lives, as they work, socialise, and pursue relationships, and the resources they draw on to make sense of the thoughts, feelings, and sensations that make up their sense of 'health'. The perspective of 'everyday health' exists in contrast to histories that focus on states, medical professionals, and other experts, and extends the work of existing social histories of health that have partially supplanted top-down medical narratives.

Because it works outwards from experience, 'everyday health' is an inclusive concept that requires an intersectional perspective, considering how multiple aspects of identity (gender, sexuality, 'race', class, disability, and age) influence experiences of health and well-being.¹⁵ The concept therefore highlights embodiment and selfhood. This approach unites social history's attention to lived experience with the sweep of more recent cultural histories of emotion and subjectivity.¹⁶ It also fractures the assumed 'everyday' experience (white, male, working-class) of traditional social histories. The history of 'everyday health' is a political project.

Locating 'everyday health', embodiment, and selfhood since 1950

The aim of this volume is to establish 'everyday health' as a lens through which to re-examine the history of health and medicine in different times and places. The majority of chapters examine case studies from the United Kingdom (UK). However, we also include material on Europe and North America to illuminate the interrelation of major political, social, economic, and cultural transformations across the globe in the decades after the Second World War. In the UK, the story went something like this: The rise of the welfare state led to improved health across the lifespan, albeit differentiated by class and 'race', and subsequent greater attention to mind as well as body, as seen in the rise of notions of 'wellbeing'.¹⁷ These new psychological discourses, consequent upon improved bodily health, led to both a more expansive conception of 'health' and greater attention to interiority. This shift was evident in the mainstreaming

of therapeutic approaches once perceived as part of the counterculture, and in the infiltration of medicalised concepts such as 'stress' into everyday arenas such as working life.¹⁸ At the same time, the reshaping of citizenship, partially consequent on migration and changes to the ethnic composition of the UK, and eventually intersecting with the rise of the patient-consumer and liberatory activism, generated an altered discourse of rights and responsibilities.¹⁹ By the end of the twentieth century, patient groups and activist campaigns proliferated, demonstrating the consolidation of 'ordinary' people's belief that they had a right to speak up and to organise around matters of importance to their own lives and wellbeing.²⁰

At the same time, patterns of life were altering for young and old, partly in response to the wider changes ushered in by welfarism, and partly as an outcome of consumerism. Changes to the school leaving age, shifting parental expectations, and the further entrenchment of the 'teenager' as a distinctive life stage meant that, for many, adolescence became a time of youthful 'freedom'.²¹ The provision of old age pensions coupled with increased life expectancy democratised the experience of a similar period of 'freedom' in older age.²² These shifts coincided with revolutions in family life as changing patterns of marriage, divorce, and childbearing, as well as the assertion of LGBTQ+ rights, remodelled family forms and fractured the ideal of the nuclear family.²³ In turn, these transformations could not have happened without access to technologies that altered multiple aspects of life, from the influence of the Pill on bodily management and sexual autonomy,²⁴ to new household appliances that changed experiences of household labour and management,²⁵ through to the explosion of mass communication in magazines, television, and the internet that created new ways to understand health.²⁶ Because of these sweeping changes in technology and communication, it was difficult to remain entirely unaware of what was happening elsewhere in the world. As a result, new 'imagined communities' with shared expectations of the ideal body and mind formed across national boundaries – and new contests arose over which visions of healthy body, self, and society would achieve cultural domination.²⁷

This volume explores 'everyday health', embodiment, and selfhood against this historical backdrop. It is divided into four parts that foreground prominent aspects of representations, experiences, and modes of understanding 'everyday health': experiential expertise;

sites and spaces; mass media and networks of communication; and subjectivity and intersubjectivity. We open with Part I, 'Experiential expertise' as a statement of intent: instead of starting from the position of formal expertise and working down to how this affects people and practice on the ground, we centre experience and throw open the question of what constitutes 'expertise'. We then move on in Part II to consider the diverse 'Sites and spaces' where 'everyday health' was lived and made, leaving behind institutional sites and instead roaming across spaces including schools, community organisations, birth control clinics, cultural venues, and the home. Part III, 'Mass media and networks of communication', zooms in on crucial forums for the articulation, dissemination, and shaping of body, self, and 'everyday health' in the interconnected twentieth- and twenty-first-century world: print culture, mass-market magazines, television, and social media. Finally, in Part IV we turn inwards to 'Subjectivity and intersubjectivity', thinking about sources and approaches that place embodied selfhood at the heart of 'everyday health'. We discuss the context and content of each part more fully in our part introductions. Here, we highlight cross-cutting themes that further illuminate 'everyday health', embodiment, and selfhood since 1950: agency, power, and resistance; visibility, invisibility, and hypervisibility; and the local, national, and global.

Agency, power, and resistance

Hannah Gavron's *The Captive Wife: Conflicts of Housebound Mothers*, published in 1966, explained how and why motherhood stripped women of their independence. It compared the experiences of working-class and middle-class women and detailed the political, social, and cultural causes of young mothers' unhappiness. Gavron excoriated myths of romantic love extolled by 'the pop song, the advertisement, the magazine', arguing that the 'ordinary woman persists in the belief that in marriage one ounce of perfume is still worth a peck of legal rights and her dreams of power still feature the *femme fatale* rather than the administrative grade of the Civil Service'.²⁸ Gavron herself had graduated from the Royal Academy of Dramatic Arts shortly after her marriage. Her children were born in 1959 and 1961, while she studied sociology at Bedford College,

University of London (the book was based on her doctoral thesis). In retrospect, *The Captive Wife* established her as one of the pioneering female social scientists who 'helped to entrench new understandings of married women's employment as a fundamental feature of advanced industrial societies, and one that solved the dilemmas of "modern" woman across social classes'.²⁹ If this was the whole story, Gavron would be remembered as a liberated woman, the anatomist and antithesis of the captive wife; but, of course, it is not. She died by suicide in 1965.

Gavron did not accept many limitations in life. Beyond her extraordinary educational endeavours – embarking on a second undergraduate degree, motherhood, and doctorate at the same time – she seized on other opportunities, big and small, to change her life, change her self. Although she condemned women's magazines in print, a friend remembers the adolescent Hannah writing to *Woman's Own* for information about birth control, taking the matter of reproductive control into her own hands; her son writes about finding among her papers a 1964 clipping from a women's magazine showing the Mary Quant bob she adopted that autumn.³⁰ But within patriarchal culture, a woman's drive for research and her experimentation with appearance could leave her equally open to attack. Her family believed that she was let down by 'masculine sloth' when her supervisor kept her thesis in a drawer for six months, holding up award of her doctorate and the contract for *The Captive Wife*. Male malice was also suspected; the reference of another lecturer may have described her as a 'lightweight', presumably because he did not approve of her woman-centred research. Perhaps most devastating is the reported comment of Richard Titmuss, sociological behemoth, who chaired one of the London School of Economics interview boards that refused her a post: 'too much green eye make-up'.³¹

Hannah Gavron could stand outside the confines of women's roles and coolly analyse them, backed up by scholarly footnotes detailing qualitative and quantitative evidence. But these men could not see her as other than the archetypal young mother with children on the cover of *The Captive Wife*, trapped by the encircling golden ring, looking out but unable to escape (Figure 0.1). We always exercise our agentic capacities in relation to structures that we can work within, resist, or fight to change, but that we cannot control. Gavron's story reminds us of the potential for power and resistance,

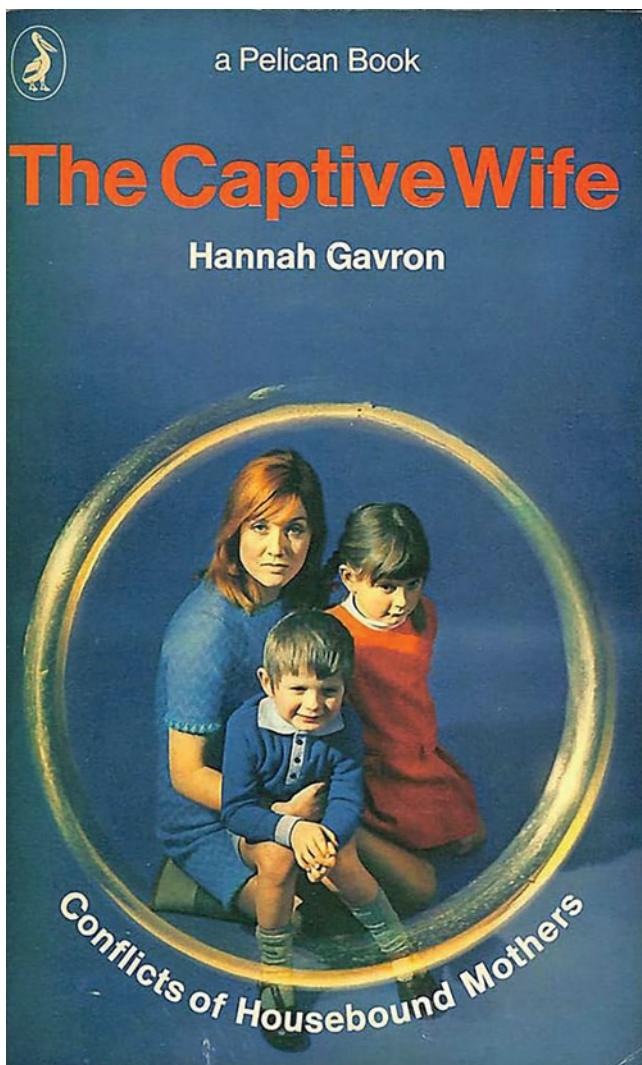


Figure 0.1 Cover illustration of 1970 Pelican edition of Hannah Gavron, *The Captive Wife: Conflicts of Housebound Mothers* (first published by Routledge & Kegan Paul, 1966). Original cover design and photograph by Graham Bishop. This photograph by Tracey Loughran. All rights reserved and permission to use the figure must be obtained from the copyright holder.

its limitations under certain circumstances, and the importance of the long-term perspective to understanding what change has been enacted. There is still a tendency, especially in popular narratives, to romanticise the onward march of progress in the postwar decades: to tell tales of longer lifespans, liberalising legislation, and liberation, while glossing over the injustices that called laws and activist movements into being and the inequalities that remain. Across this volume, authors explore how diverse groups – adolescents, patients, housewives, mothers, LGBTQ+ people, feminists, disability activists – negotiated the restrictions on their lives and reshaped understandings of their bodies and selves. These chapters do not ignore the pervasive power of state bureaucracies, social hierarchies, and stigmatising beliefs but they always pick out the agentic capacities of individuals and groups.

The concept of 'everyday health' helps us to consider agency, power, and resistance in more open-ended ways. Placing day-to-day experience at the centre of our understanding forces us to move towards fluidity and emphasis on the multiple networks people operate within during their everyday lives, and away from top-down models that petrify their more passive status at particular moments, but without denying the existence or importance of those moments. In this volume, Hannah Froom tells how a young girl without tampons feared going swimming at school but wore multiple pairs of underwear under her costume and went anyway; her choices were limited, but she took what action she could. Grace Redhead details the ignorance and racist assumptions that Black women faced in negotiating sickle cell anaemia, but also how they worked to support others in patient groups and became doctors. Beckie Rutherford describes how a disabled woman excluded from an inaccessible feminist disco wrote a play about the experience and joined a radical group that set up its own socials. Other chapters offer similar examples of agentic action within externally imposed boundaries – this tells us something about how people make 'everyday health' and helps us to consider anew what constitutes power and resistance, both in and beyond activism. Crucially, emphasising embodied experiences also maintains the focus on subjectivities rather than structures, and agency rather than powerlessness. As Kathleen Canning argues, understanding the body as a complex site of inscription, subjectivity, and resistance offers an intricate way of retheorising agency.³²

Structures do matter, but they are not everything. Where activism around 'everyday health' is inspired by the desire to resist and rework the top-down operation of power, it can shed new light on the relationship between state and citizens. We might think here of anti-vaccination and anti-fluoride movements that resist state intervention because of fears about the unknown and potentially negative effects of measures to improve health, and in doing so lay bare the extent and limitations of state power, and the capacities of private citizens to withstand its reach.³³ Because activism around bodies and health often arises out of the 'everyday', from experience rather than on abstract grounds, it can also challenge more traditional ideas of what activism *is*. In Fleur MacInnes' chapter in this volume, we see how friendship and mutual aid were powerful forces enabling trans people to connect and form communities. In some circumstances, becoming visible to yourself and others is not only an important precursor to activism, but an essential part of what it means.

This 'everyday' basis for action is found across multiple activist movements, each containing contests for power within the movement, as well as fighting more established structures outside. The Women's Liberation Movement (WLM) slogan 'the personal is political' formed the basis for Women's Health Movement (WHM) activism that sought not only to validate women's bodily experiences but to demonstrate the inseparability of subjective experience from its social and political context. At the same time, campaigns against misuse of the injectable contraceptive Depo-Provera by Black feminists complicated the notions of 'choice' promoted by white feminist health campaigners.³⁴ Meanwhile, in activism around specific health crises, including AIDS Coalition To Unleash Power (ACT UP), Fat Liberation, and sickle cell campaign groups, 'experientially-inspired' activists have been forced to seek coalitions with medical experts – representatives of the wider system they fought against.³⁵ Activism can incorporate negotiation as fightback. Looking through the lens of 'everyday health' shows how people used their embodied health experiences to resist, inform, and reformulate dominant modes of understanding, and how they have forged new discourses, spaces, and communities on the basis of these shared experiences.

Thinking about and through the 'everyday' enables the location of different sites and/or nodes of agency, power, and resistance and

different historical actors. Not all acts of agency, power, and resistance can be described as 'activism'. A more multifaceted approach incorporates acts as simple as buying or boycotting consumer products or making complaints.³⁶ It brings in those who, like the readers of *Chatelaine* discussed by Whitney Wood, wrote to magazines for guidance.³⁷ It makes visible people who found out about 'everyday health' from television chat shows like those Fabiola Creed analyses. It includes those who, like the disabled women and their families who contested assessments of their capacity for work inside the home cited in Gareth Millward's chapter, advocated for themselves and family members in day-to-day interactions with medical and other authorities. It embraces acts of individual rather than collective resistance such as the development of self-care strategies that circumvent medical authority; a strategy Carol Tulloch deployed when, stuck at home in lockdown, she fell back on her knowledge as an academic and the resources of her wardrobe to create new styles and to renew herself.³⁸ This approach contributes to a bottom-up history in which individuals and groups draw on the resources available to them to understand and to act, in circumstances of and not of their own choosing – in this way enacting agency, power, and/or resistance.

Visibility, invisibility, and hypervisibility

'Study the historian before you begin to study the facts', urged E.H. Carr in *What is History?* (1961), a text that is still a standard feature of undergraduate historiography modules.³⁹ Carr argued that every decision about what aspect of the past to research involves judgements about what is or is not important. History is perspectival. These research decisions are made by humans who exist in particular positions in time and space. To understand the history in front of you, study the historian before you begin to study the facts. And so Carr set in motion a torrent of critical reviews and historiographical essays in which undergraduate students, struggling to grasp a complex philosophical position that undermines pretty much everything in their historical training to date, tried to study the historian: 'Sheila Rowbotham writes women's history. She is biased because she is a woman.' This is progress of a kind. It shows that women's history

is on the curriculum now. E.H. Carr only ever referred to the historian as 'he'.

There are different kinds of invisibility. We are used to thinking about marginalised groups 'hidden from history' and research that is framed as a recovery mission – making the invisible visible to redress historical imbalances of power. We are perhaps less used to thinking about the invisibility of power, or at least not in those terms. But invisibility is the privileged status of the male historian never described as 'biased' because he is a man who writes about men – after all, who else should be a historian or the proper subject of history?⁴⁰ It is the advantage of the male bodies assumed as the norm in most scientific and medical research – after all, why would the effects of the menstrual cycle on athletic performance matter to sports science?⁴¹ It is the claim to life of the white female reproductive bodies that exist as the norm for obstetrics and gynaecology – after all, what is there to gain from investigating why Black women are four times more likely to die in pregnancy or childbirth than white women?⁴² It is the extra money in the bank account of the able-bodied student not charged extra for 'accessible' accommodation – after all, is it really a basic right to be able to move around easily in your own home?⁴³ As anyone catcalled, harassed, abused, or manhandled on the street because of misogyny, homophobia, racism, or ableism could tell you, in some places, some bodies are invisible, and that invisibility is a mark of power, not its absence.

The reverse of invisibility is not always visibility, but hypervisibility. In the recovery model of history, to come to notice is to be made visible – to be seen, heard, and validated; to claim power. In the example of street harassment, to come to notice is to be made hypervisible – to be objectified, silenced, and delegitimised; to be forcibly reminded of your lack of power. The hypervisibility of some people could not exist without the invisibility of others. In her history of infertility, Naomi Pfeffer cites the case of a childless woman who, over a two-year period in the late 1940s, underwent two dilation and curettage operations, a tubal insufflation, a salpingogram, an endometrial biopsy, and a host of injections, courses of tablets, and douches, before her husband's semen was tested and found to contain no spermatozoa.⁴⁴ Within the patriarchal medical culture that positioned women as reproductive vessels, this man's body was invisible while his wife's body became hypervisible, the object of

incisions, scrapings, piercings, distension, and ingestion. Those who hold power can also hold the dual status of invisible/visible; the rule that determines the exception, the person who can speak and know they will be heard. Those who do not hold power more often occupy the contradictory position of invisible/hypervisible; ignored until their existence is questioned, treated as though claiming unjustified privilege for daring to come to notice. For the powerless, the pendulum does not swing from invisibility to visibility without a barrage of outraged questions about why there isn't an International Men's Day or White History Month or Straight Pride.⁴⁵

The concept of 'everyday health' simultaneously sidesteps and confronts this bind. When we place day-to-day experience at the centre of our histories, our immediate question is what everyday life looks like *for that person*. At the conceptual level, this approach is de facto inclusive and intersectional. It also makes us better able to avoid assumptions about what constitutes the 'everyday'. At the same time, thinking through the 'everyday' pitches us into questions about allied categories – the mundane, ordinary, normal, and natural – and reveals their status as constructions rather than descriptions. This is one reason why 'everyday health' holds radical potential. In this volume, reading Ben Mechen's analysis of *The Joy of Sex* next to Karissa Patton's examination of the work of feminist volunteers at the Calgary Birth Control Association (CBCA) underlines the contingency of classifications of the 'everyday' and their relation to power. The sexologist Alex Comfort saw liberation as stripping sex back to the 'natural', while CBCA workers understood the legal and political structures that shaped sex, and the degree of foreplanning and aftercare necessary for women to have sex safely. Comfort's (hetero)sexual man exists on the same spectrum as Carr's male historian – the norm, unless you exist outside the boundaries of his discourse.

This interrogation of the 'everyday' that the concept of 'everyday health' invites therefore also exposes who or what is visible, invisible, or hypervisible. We might pause here on 'youth' and 'older age', categories invoked across many chapters in this volume. From the 1950s onwards, social scientists and then cultural studies scholars demonstrated keen attention to youth and, to a lesser extent, older age.⁴⁶ In contrast, historians mostly neglected 'youth' and 'older age'

until quite recently.⁴⁷ Likewise, although age is an integral aspect of lived experience, and should be central to genuinely intersectional analysis, such approaches rarely foreground it.⁴⁸ Asking why 'youth' and 'older age' are not visible in historical scholarship reveals aspects of their cultural invisibility/hypervisibility that are tied to power relations. There is a sharp disparity between the worship of youth and the invisibility of older people in mass culture, but neither status carries power.⁴⁹ Rather, as Caroline Rusterholz and Rosie Gahnstrom, Lucy Robinson, and Rachel Thomson show in their contributions to this volume, the media positioning of young people (and especially young girls and women) as at-risk goes hand in hand with the assumption that young people are spoken *for* and *about* – in other words, they should be seen and not heard. In this case, putting the perspectives of young people at the centre of our histories as demanded by the lens of 'everyday health' complicates tendencies to look at experiences of youth through adult eyes.⁵⁰ Meanwhile, in a nice counterbalancing gesture, Kate Mahoney shows that bringing intergenerational dynamics into play reveals aspects of the perspectives of younger/older people that might be missed through exclusive focus on either life stage.

The reparative work of 'everyday health' is to try to bring those who are invisible/hypervisible to ordinary visibility – to write our/their histories in ways that represent but do not objectify, sensationalise, or deny the conditions of oppression. This is no easy task, as Daisy Payling discusses in her chapter, on creating and adapting a public engagement activity for young/adult and queer/non-queer audiences. These acts might become easier as structures open up/are broken down, as the 'we' who speaks in academic texts more often shares ground with the 'them' who are written about, and as the business of writing from and about experience, embodiment, and the self attains more prestige. We are some way off this state of affairs. We have been able to include histories of Black, disabled, and trans 'everyday health' in this volume, but this is good fortune. In the UK the Black health and medical humanities is still an emergent area.⁵¹ The histories of disabled and trans people have been viewed through pathologising medical lenses for so long that the shift to 'everyday health' is especially fraught.⁵² Black, disabled, trans, and non-binary scholars are underrepresented in the historical profession,

and the formal structures of the Research Exercise Framework make contributing to edited collections a risky business for those in insecure positions.⁵³

The distinction between invisibility/visibility and invisibility/hypervisibility comes into play too. The volume includes two male authors but not a single chapter deliberately centred on male experience. It is difficult to avoid the conclusion that male historians are not researching 'everyday health' partly because Man as abstract category still holds the status of unquestioned norm and rational non-bodied subject – with all the implications that holds for the abstract category of Woman and the lived experience of women. There is a lot of work to do.

The local, national, and global

An own-brand packet of paracetamol tablets from the UK chemist Boots currently costs less than one quarter of some brand rivals. It is one of the most mundane and affordable items in the home medicine kit. The tablets are manufactured in Barnsley, South Yorkshire and distributed by The Boots Company PLC, based in Nottingham.⁵⁴ The tablets, constituted from pregelatinised maize starch, sodium metabisulfite (E223), and magnesium stearate, are much the same as those marketed elsewhere in the world under the brand names Tylenol (USA), Calonal (Japan), Captin (Germany), or Napa (Bangladesh).⁵⁵ The synthesis of paracetamol was first achieved by the North American chemist Harmon Northrup Morse, first tried on humans by the German clinical pharmacologist Joseph von Mering, and 'rediscovered' as the result of a paper by the Jewish-English emigré Bernard Brodie and his colleague Julius Axelrod, the New York-born son of Jewish immigrants from Poland.⁵⁶ Paracetamol is an international phenomenon. So too, it turns out, is Boots; 'the nation's chemist' appointed its first agent to India in 1919, expanded its international networks in subsequent decades, and by the 1960s was 'an international player of worldwide significance'.⁵⁷ It is currently owned by the North American pharmaceutical giant Walgreens and trades across six countries and two continents.⁵⁸

The simple act of reaching for a tablet when we have a headache enmeshes us in a global network.⁵⁹ We live in localities and hold

national passports but our lives, and therefore our experiences of 'everyday health', are global as well as local and national. This is not just because we live in the age of the internet and instant connectivity. This introduction earlier outlined major political, economic, social, and cultural shifts since 1950; these developments occurred across many parts of the globe in the same period, if to different extents and on different timelines. The rise of welfare states, reshaping of citizenship, transformation in life patterns, revolution in sexual and family life, proliferation of psychological discourses, and access to life-changing technologies – these transformations are apparent in whole or substantial part across the western world. Their effects on experiences of 'everyday health' simultaneously transcended national boundaries and were refracted through local healthcare systems, organisations, structures, and traditions.⁶⁰ This means that while the majority of case studies in this volume focus on the UK, they will also be of use to future scholars of 'everyday health' as they seek to find suitable sources, develop research methods, establish patterns, and separate out local from global effects.

We include chapters that do not centre on the UK – Karissa Patton on the Calgary Birth Control Association, Evangelia Chordaki on the Greek women's movement, and Whitney Wood on Canadian responses to 'natural birth' – in part because these case studies provide opportunities to trace transnational exchange of ideas and practices related to 'everyday health' and in this way also reframe the British history chapters within an international context. Chordaki and Patton explore local and national manifestations of the global feminist self-help health movement. The other authors who examine activist movements, MacInnes and Rutherford, explore local case studies that branched out to the edges of the nation and beyond. The analytical frames of all four chapters draw on scholarship from across the globe, reflecting the soft internationalism of radical politics in these decades. Likewise, Wood shows the role of mass-market magazines as vehicles for the dissemination within and across borders of ideas about 'everyday health'. Chapters by Froom, Rusterholz, Payling, and Gahnstrom, Robinson, and Thomson also draw on mass-market magazines and show the same processes at work in the UK, underlining a central feature of mass media wherever it is found. Moreover, the conscious effort to avoid lazy assumptions about what is global and what is local makes us think differently

about other mediums of communication: social media platforms like Instagram, as Louise Morgan discusses in relation to clean eating, operate across the globe, but most accounts do not achieve worldwide followings, and the influencers she considers are not household names outside the UK.

This 'internationalised' approach relates to our vision of the history of 'everyday health' as a political project. In recent years, British history was first subjected to Michael Gove's attempts to narrow it back to an 'island story' and then co-opted into the culture wars concocted by right-wing agitators and enthusiastically endorsed by Conservative politicians.⁶¹ Those of us whose identities are global not local, who see ourselves as connected to diasporic peoples, LGBTQ+ siblings, or workers of the world, over and above our national identities, want to understand how those histories link up to the times and places in which we stand now; those of us who see history as perspectival want more perspectives, not fewer; those of us who care about History and its future are saddened and angry at this continuous attack on what it is and can be. There are more histories of 'everyday health' in the UK than elsewhere in the world partly because for decades the Wellcome Trust has funded the health and medical humanities here. The predominance of these histories in this volume reflects that research strength. But we also want this volume to acknowledge the place of the UK in the wider world and to acknowledge the powerful impulses towards transnationalism within the wider historical discipline over the twenty-first century's opening two decades.⁶²

The pursuit of this vision is justified by the extensive and unforced connections across borders that can be traced in every chapter in this volume. As well as those already mentioned, we find a British physician writing a work on sex that drew on sexological research from North America and elsewhere and achieved bestseller status in many parts of the globe (Mechen); UK television personalities adapting the American talk show model for their national audience (Creed); European Economic Community rulings causing problems for the Conservative government's position on disability benefits in the late 1970s and 1980s (Millward); Black British women drawing on family diasporic histories to make sense of and explain their lives (Redhead and Tulloch); and oral historians writing from the self,

but drawing on scholarship from a subfield unusually international in scope because it speaks to method more than content (Mahoney and Loughran). Understanding 'everyday health' means working out its meanings at the local level, but to grasp the concept in its fullest dimensions, we also need to look to the network of relationships between the local, national, and global.

Conclusion

In Deborah Levy's *Hot Milk* (2016) the narrator, an anthropologist by training, takes her mother to a Spanish clinic to seek treatment for her psychosomatic paralysis. She describes watching the nurse take her mother's case history:

My mother is giving a history of her present illness. Where does that history start? It moves around in time and merges into past history, childhood illness and all the rest of it. This is not chronological time. Julieta will have to later transcribe Rose's words and author her case history. I have been trained to do something similar, except I am not a physiotherapist, I am an ethnographer. Julieta will at some stage have to describe the complaint that brought the patient to her clinic. Symptoms and their presentation. It is not one complaint. It is not even six. I overheard twenty complaints but there were more. The past the present and the future are simultaneously present in all these complaints.⁶³

The entanglements of 'everyday health' similarly move between body and mind, self and other, past and present. There is a lot of history to chart.

This volume spans decades and continents, but it is only a starting point in explorations of 'everyday health'. It draws together exciting new research on this underexplored area but is also intended as a spur to future studies. Many histories of 'everyday health' remain to be written. This volume reflects the current state of scholarship, which in turn reflects historic imbalances of power and the complex positioning of different groups. Future histories of 'everyday health' will have to explicitly address the effects of globalisation, and work out how to combine historical specificity with awareness of the extent of transnational exchange. The history of 'everyday health'

is barely out of the starting blocks, and there is much to look forward to from here.

Where future scholars might most directly benefit from this volume is in the conceptual and methodological approaches it puts forward for researching and writing about 'everyday health'. The history of 'everyday health' starts by centring experience. There are many ways we might try to understand that experience. We can examine the external influences on it or we can try to capture subjectivity through direct testimonies. Because 'everyday health' is an expansive concept, it generates methodological eclecticism. In this volume, scholars draw on state records, social surveys, newspapers and magazines, television shows, personal, activist, and voluntary sector archives, oral histories, and the resources of the self. They employ diverse theoretical and conceptual frameworks, including queer theory, feminism, autoethnography, phenomenology, and science and technology studies. These different approaches hang together, like glass beads of different colours and shapes on a necklace string, through authors' commitment to locating and representing ground-up histories of health, subjectivity, and embodiment. As an endeavour, the history of 'everyday health' is therefore creative and experimental.

The creativity is apparent above all in these scholars' ways of recapturing voices that would otherwise be lost. It is not easy to locate direct testimony about intimate aspects of selfhood, and even when this can be found (or created) it is not a straightforward guide to what people thought or felt at the time.⁶⁴ We are all unreliable narrators. We write for audiences, we speak to our interlocutors as much as for ourselves, we forget because we will or we must, we rearrange our thoughts and feelings so that we can live with them. But how much more difficult when there is no direct testimony! The contributors to this volume seek out the voices of past people in tribunal records, newspaper reports, and letters to newsletters and magazines. These voices are heavily mediated, but an echo is better than a silence. Thinking about 'everyday health' raises questions about who is represented, who has the power to speak, and who is listened to – but also how we, as historians, can access and hear these voices.

This volume has started this work, and its chapters demonstrate what can happen when we place 'everyday health' at the centre of

our histories. Benefits include complicating understandings of power and resistance; deepening and extending notions of identity and intersectionality; and encouraging and celebrating methodological diversity. As we centre 'everyday health', however, we must be alive to the need to continually incorporate more and diverse experiences, and to the shifting nature of the 'everyday' itself. What we think is 'everyday' in the present will inevitably shape the questions about 'everyday health' that we ask of the past. We need to find the right starting points, the ones that will not blind us to the messiness of the histories that we might encounter, their many possible ways of ripening, and the multitudes that coexist within even one subjectivity, one past, one potential future.

Notes

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