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Going "Beyond Birth Control:" The Public Life of YAZ & Representations of Women's Reproductive Health in the U.S. Public Sphere

By

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Doctor of Philosophy

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By

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M.A., University of Cincinnati, 2006
B.A., Agnes Scott College, 2003

Advisor: Kimberly Wallace-Sanders, PhD

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A dissertation submitted to the Faculty of the
James T. Laney School of Graduate Studies of Emory University
in partial fulfillment of the requirements for the degree of
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Abstract

Going "Beyond Birth Control:" The Public Life of YAZ & Representations of Women's Reproductive Health in the U.S. Public Sphere

By Whitney Peoples

As a result of a 1997 change in the U.S. Food and Drug Administration's policy regarding advertising for prescription drug products, Americans have seen an increased number of broadcast DTC or direct-to-consumer advertisements. Women have emerged as an important target audience in this new advertising landscape through the marketing of products such as oral contraceptives. Through a case study of the oral contraceptive YAZ, this dissertation examines the discourses and identities surrounding women's reproductive health and sexuality that have emerged in the era of DTC marketing. A highly successful marketing campaign and several troubling encounters with the U.S. Food and Drug Administration, make YAZ ripe for an examination of public and private anxieties surrounding women's reproductive health and sexual practice. The case study includes an analysis of Bayer's marketing campaign for YAZ as well as the varied responses of governmental agencies and women's health advocates. Finally, the dissertation includes the results of a small interview study in which women were asked about their opinions on contemporary gendered health media. Engaging the idea of public and cultural pedagogies, the dissertation considers what is at stake when popular discourses come to constitute a large portion of both public visibility and public information about matters as important to women's health as contraceptives. By considering how legal, advocacy, social, commercial and personal discourses all work to contribute to dominant representations of women's reproductive health, the dissertation crafts an important new analytical framework for reading U.S. popular media and health culture called feminist health media literacy.

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Introduction

"In our Women's Healthcare business unit, we achieved sales of €627 million in the first quarter. The main growth drivers were the oral contraceptives of the Yasmin®/YAZ®/ Yasminelle® product line, sales of which rose by 41.1 percent (pro forma) when adjusted for currency changes. This positive performance was due particularly to the launch of Yasminelle® in Europe and of YAZ® in the United States and Latin America. In January, the U.S. Food and Drug Administration (FDA) expanded the registration for YAZ®, which can now be used in the United States to treat moderately severe acne in women" (Bayer Pharmaceuticals 2007, 8).

"As of October 18, 2013, the number of claimants in the pending lawsuits and claims in the United States totaled about 5,000 (excluding claims already settled). Claimants allege that they have suffered personal injuries, some of them fatal, from the use of - Bayer's drospirenone-containing oral contraceptive products such as Yasmin™ and/or YAZ™ or from the use of Ocella™ and/or Gianvi™, generic versions of Yasmin™ and YAZ™, respectively, marketed by Barr Laboratories, Inc. in the United States…As of October 18, 2013, Bayer had reached agreements, without admission of liability, to settle the claims of approximately 7,660 claimants in the U.S. for a total amount of about US$1.575 billion. Bayer has only been settling claims in the U.S. for venous clot injuries (deep vein thrombosis or pulmonary embolism) after a case-specific analysis of medical records on a rolling basis. Such injuries are alleged by about 2,300 of the pending unsettled claimants. Bayer will continue to consider the option of settling such individual lawsuits in the U.S. on a case-by-case basis" (Bayer Pharmaceuticals 2013, 65).

The two quotes above are both from Bayer Pharmaceuticals' quarterly stockholders' newsletters. The first quote comes from a 2007 first quarter newsletter, just about a year after the oral contraceptive YAZ had been approved by the U.S. Food and Drug Administration (FDA), and describes the overwhelmingly positive growth of Bayer's Women's Health division due to the success of the YAZ family of contraceptives. The second quote comes from a 2013 third quarter newsletter and describes Bayer's attempts to manage the legal, political and social fallout over the failures of the YAZ brand. These two quotes, just six years apart, signify YAZ's descent from a modern cure-all for the gendered maladies of menstruation to snake oil and set the stage for this dissertation.

YAZ is a member of a family of combination oral contraceptives developed and manufactured by pharmaceutical giant Bayer Healthcare. This group of contraceptives is distinguished by its use of the fourth-generation synthetic progestin drospirenone (DRSP). Approved by the U.S. FDA in 2006, YAZ came five years after Bayer's inaugural DRSP contraceptive, Yasmin, was approved. While initially only approved for the prevention of pregnancy, by 2007 the FDA also approved YAZ as a treatment for moderate acne and Premenstrual Dysphoric Disorder (PMDD), making it the first oral contraceptive approved to treat PMDD. PMDD is said to be a much more intense experience of the symptoms of Premenstrual Syndrome (PMS) and is further noted by a period of marked depression. The symptoms of PMDD are experienced specifically within one to two weeks before the start of the menstrual cycle. After this period, the symptoms are said to subside and not resurface again until the week to two weeks before the next menstrual cycle.

Bayer seized the opportunity to distinguish YAZ from its competitors by emphasizing its unique ability to do more than prevent pregnancy. As a result, Bayer launched an aggressive Direct-to-Consumer (DTC) marketing campaign for YAZ aptly title "Beyond Birth Control." As the quote from the 2007 stockholders' newsletter demonstrates, the "Beyond Birth Control" campaign would be wildly successful and would help make YAZ one of the best selling contraceptives on the U.S. market. As the main instrument of YAZ's success, it is particularly interesting that the "Beyond Birth Control" campaign would also be one of the primary means of the contraceptive's undoing. Roughly one year after YAZ was approved to treat acne and PMDD, the FDA would send a warning letter to Bayer's CEO regarding the accuracy of the information

presented in two of the broadcast commercials airing as part of the “Beyond Birth Control” campaign. This initial letter was followed by a number of other governmental interventions at both the state and federal level and eventually resulted in Bayer distributing a “corrective” campaign aimed at clarifying misinformation presented in earlier promotional materials for YAZ. As the 2013 stockholders’ newsletter reveals, these governmental interventions would prompt thousands of women to initiate lawsuits against Bayer, seeking damages for the adverse effects they experienced as a result of using YAZ.

This dissertation tracks the movement of YAZ from being one of the most successful contraceptive options on the U.S. market to one of the most embattled. YAZ is ripe for an examination of public engagements with women’s private health matters given the high level of visibility it achieved through its successful marketing campaign as well as its more recent encounters with the FDA and the U.S. legal system. YAZ’s public tenure operates at the intersection of a number of critical issues surrounding gender, consumption, the body, agency, politics, advocacy and economics. From this intersection, YAZ emerged as a technology of what Angela McRobbie calls the “new sexual contract,” which is marked by a call

> to young women, primarily in the West, to come forward and make good use of the opportunity to work, to gain qualifications, to control fertility and to earn enough money to participate in the consumer culture which in turn will become a defining feature of contemporary modes of feminine citizenship (McRobbie 2009, 54).

McRobbie contends that this call to public achievement and advancement for young women is conditioned upon the establishment of new modes of gender surveillance and management as well as a complete disavowal of feminist politics and critiques of patriarchy. As a technology of the “new sexual contract,” YAZ provides a strong

example of contemporary treatments of women's reproductive health in the U.S. public sphere and the relationship between those treatments and socio-political understandings of appropriate, or normative, feminine identity and practice. I use the specificity of YAZ's public tenure as a case study for understanding the treatment of women's reproductive health in the public sphere more broadly.

By tracing YAZ's trajectory, from public darling to public menace, the dissertation also examines how "proper" identities for women as seekers of reproductive health care in general and contraceptive technologies in particular are configured. This work asks critical questions about the representation not only of a particular product but the representation of women's reproductive health in public space and the representation of women as stakeholders in that health, both at the individual and community levels. Visibility and representation, or the when, where and how women's health issues and women themselves come to be seen, matter because they are connected to questions of social practice. Linking representation and shared cultural meaning, Stuart Hall argues that "cultural meanings are not only 'in the head.' They organize and regulate social practices and influence our conduct and consequently have real, practical effects" (Hall 1997, 3). Representations of women's health and women as healthcare stakeholders demonstrate public and popular knowledge of and beliefs about women's reproductive health needs and rights and, in turn, that knowledge informs real political, social and economic action.

My interest in this project grows out of my experiences working with feminist reproductive rights advocacy groups, my work as both an instructor and a student in Women's Studies and finally, my experiences as a patient with reproductive health care

needs. Through my work with the Georgia affiliate to the National Reproductive Rights League (GARAL) and my time teaching in Women's Studies I realized how inadequate the available public information on women's reproductive health care was. My teaching experience at two public universities in the early-to-mid 2000s revealed that my students' primary sources of information on contraception and sexual health were commercials for hormonal birth control. The pitfalls of these information sources became clear as we discussed women's health issues and students, particularly female students, became alarmed by their lack of information about their reproductive health and health care options. My work in these spaces pushed me to consider how public representations of women's reproductive health and sexuality come to function as a kind of de facto public education about these topics.

Certainly, advertising and the popular press have always been sources of information about women's reproductive health. Andrea Tone notes that, "until the 1960s [with the advent of the Pill], women got most of their contraceptive information and equipment from traditional nonmedical sources: neighbors, friends, advertisements, druggists and other commercial purveyors, and through the mails" (Tone 2001, 155). Post 1960, birth control became increasingly medicalized with the introduction of hormonal contraceptives and many of the public discussions of women's reproductive health moved from the public domain to the privacy of the doctor's office. This tide changed once again with direct-to-consumer advertising for prescription medication, which proliferated in the 1990's when the FDA issued formal guidelines for direct-to-consumer campaigns in broadcast media. The 1997 guidelines opened the door for the

contemporary landscape of broadcast campaigns for prescription drugs that take up much of today's television advertising space.

In the contemporary economy of images, reproductive health, and gender politics, I want to explore 1) what is being "taught" and how it is being represented in this ad hoc "curriculum" of public discourse and debate. I also aim to consider what is at stake if public debate and dialogue continues to be a main source of public information about women's reproductive health and rights. Linking public and popular representations with the production of knowledge about women's health, I study the implications for women's information gathering about their reproductive health and their sense of agency in terms of their own representations of these issues. At its core, this project engages fundamental questions about the relationship between discourse, power and agency. By examining how and where public discourses of women's reproductive health are shaped and produced I hope to better understand their potential implications as primary sites of knowledge production and dissemination. Furthermore, a more nuanced and complicated understanding of the production and location of these discourses can be used in developing other kinds of public discussion and information that might offer women more than what is currently provided in a news clip or a commercial.

Constructing An Analytical Framework

In identifying the identities and information that emerge from public discourse about women's health, specifically from public discourse throughout the YAZ affair, this dissertation draws on a number of important scholarly tools. Together, feminist media studies, cultural studies, feminist theories of race and difference, histories and theories of U.S. women's health advocacy, and feminist epistemologies form the analytical

framework of this dissertation. Using the work of feminist theorists on epistemology, this dissertation examines not only what we know about women and their reproductive health but also how we know it and which individuals we trust to teach it to us. Historians and theorists of women's and feminist health activism, including Nancy Tuana (2006), Kathy Davis (2007), and Wendy Kline (2010), have argued that feminist women's health activism and practice was always an epistemic project. Books such as *Our Bodies, Ourselves* and practices such as the well-known self-cervical exam served to redefine what counted as valid knowledge of the female body and who counted as a valid knower. In the chapters that follow, I ask questions regarding the kinds of knowledge produced about women's bodies and their health as well as questions about which individuals are understood to be the proper subjects of that knowledge.

As this project will examine representations of female sexuality and reproductive health as they are cross cut by issues of race, class, ability and historical constraints I draw heavily on the feminist theoretical concept of intersectionality. Coined by feminist legal theorist Kimberlee Crenshaw (1991), intersectionality emphasizes the interconnected nature of systems of governance/oppression and how, in turn, they produce subjects whose individual identities are lived at the intersection of any number of identity-related categories. An intersectional approach will allow me the necessary flexibility to examine how issues of race and class come to bear, simultaneously, on discourses of female sexuality and reproductive health. Moreover, intersectionality itself is a theory at the crossroads. Bridging the work of feminist and critical race theory, Crenshaw's work helps to support the interdisciplinary commitments of this project by bringing it into conversation with other influential fields of scholarship. As an

interdisciplinary study, this project actively engages feminist, critical race and cultural studies approaches as the foundation of my theoretical framework.

Feminist theory and other forms of feminist scholarship have long been concerned with the politics of women's reproduction (e.g. Sanger 1992; Bambara 2005; Davis 1983; Ross 1993). Dorothy Roberts' (1997) work on the relationship between women's reproductive freedom, policing, legislation and race was and is considered groundbreaking in studies of women's health. Though a legal scholar, Roberts' work is located at the intersection of critical race and feminist theories as she examines how poor and working class African American women are policed and punished for their fertility and reproduction. Complicating and contesting the feminist narrative of birth control as liberation, Roberts calls attention to the ways in which representations of women's sexuality and reproduction are both shaped by and help to shape legal and legislative discourses. Roberts' work helped to spawn new conversations concerning race, representation and reproduction (see Smith 2002; Nelson 2003; Silliman et al. 2004).

Like Roberts, scholars such as Rickie Solinger (2001) and Andrea Smith (2005) have also critiqued reproductive rights discourse that reduces reproductive autonomy to the issue of choice, of which contraception and abortion are central. Both Smith and Solinger argue for acknowledging the limits of choice, particularly when choice is exclusively linked to class and economic privilege. The conflation of reproductive choice with economic choice ends up being translated as having all the reproductive choice you can afford. Clearly, this offers middle and upper class women a kind of access that working class, working poor, and impoverished women are not provided. Reproductive choice as a product of economic privilege lends itself to easy use by

pharmaceutical companies, like Bayer, aiming to define potential users and better market products. As I argue throughout the following chapters, Bayer's "Beyond Birth Control" campaign revolved around choice and presented YAZ as a key facilitator of women's choices.

The reduction of women's reproductive choice to their economic ability raises important questions about the relationship of women's reproduction to capitalism more broadly. Feminist theorists (Hartmann 1997; Rubin 1997; Ehrenreich 2005) have attempted to explain the sexual and gender politics of labor and women's roles in capitalism. One result of these varied explanations is the longstanding contention that women's unpaid reproductive labor, both as bodies that physically reproduce in the biological sense and bodies that perform the daily labor of social reproduction (i.e. cooking, cleaning, etc.), is absolutely essential and invaluable to the successful operation of capitalism. Women's biological and social reproductive labor in the private sphere literally and figuratively prepares bodies to move out into the public sphere and participate in capitalism. Additionally, women are also integral to the work and success of capitalism as public sphere paid laborers and as consumers. Bayer's "Beyond Birth Control" campaign appeals to the site where all of women's identities under capitalism converge. The call to contracept is often made in economic terms, framing children as a costly expense in terms of time and money that detract from employment and leisure opportunities. Angela McRobbie argues "The concept of planned parenthood emerges in Western liberal democracies as an address to young women so that they may postpone early maternity to accrue the economic advantages of employment and occupational identity…"(McRobbie 2009, 85). Contraception is further invoked as an economic

discourse because it must often be purchased and, in the process, turn its users into consumers. For women, effective contraception is presented as the bridge between private sphere unpaid reproductive labor and public sphere paid labor and consumption.

While the economic dimensions of women's reproductive labor are critical, other scholars, however, have taken an explicitly cultural studies or media studies approach to the analyzing the representation and value of women's health and sexuality in the public sphere. Lisa Cartwright's (1995) work on the visual culture of medicine and medical practice examines how visibility is literally constructed in medicine via medical imaging technologies such as the X-ray and ultrasound. Cartwright argues that this technological visibility allowed medicine to develop an authority over the body and its cultural identities further allowing it to construct other, more social, kinds of visibility associated with particular bodies. Art historian and performance artist Terri Kapsalis (1997) also addresses the representation of women's sexuality through their reproductive health care. Whereas Cartwright emphasizes the ability of medicine to confer meaning on bodies, Kapsalis focuses on the performance aspect of both patient and doctor, effectively introducing the concept of agency. Moreover, Kapsalis more readily locates the practices she studies within both a medical and a popular culture context, making the link between discourses all the more clear.

In addition to Terri Kapsalis (1997), Jay Baglia (2005), Beth Jaworski (2009), and Tasha Dubriwny (2013) are examples of scholars that have also addressed the intersection of gendered health and popular discourse, including film, journalism, political commentary, television and music. As this dissertation focuses on the identities and knowledge produced about women's reproductive health in popular discourse, I

identify media, specifically advertising but also including print materials, television shows, feature films, websites and social media such as Twitter, as key sites of teaching and learning scientific, medical, and socio-cultural ideas about gendered health and wellness. In his work on newspaper coverage of the erectile dysfunction drug Viagra, Baglia argues "magazines and newspapers not only supply the public with particulars about health and medicine; this knowledge also shapes attitudes, actions, and decisions about the risks and benefits of health-related behaviors" (Baglia 2005, 29). Like Stuart Hall, Baglia alerts us to the relationship between the representations conjured in popular media and our thoughts, assumptions and material actions. Building on the work of these scholars, I argue that feminist health scholarship and activism are incomplete without an attendant engagement with popular media as a constitutive component of contemporary women's health discourse.

My analysis of media in this project is based on the analytical framework of feminist media studies. More specifically, I use feminist analyses of post-feminist media as I aim to make sense of the ways that feminism is both used and simultaneously silenced in public sphere discourse regarding women's reproductive health. Feminist media scholars Yvonne Tasker and Diane Negra refer to this as the "double address" of post-feminism, which acknowledges the benefit of feminism as a historical movement but identifies its continued presence as a nuisance for the contemporary woman (Tasker & Negra 2006, 171). From Bayer's marketing campaign to the responses of the FDA, public discourse regarding YAZ is a post-feminist endeavor as it is steeped in the feminist inspired language of choice and empowerment. Though feminism is weakly signaled through this language it is quickly disavowed, as women are encouraged to look

to pharmaceutical intervention and management or governmental protection as the proper site of their advocacy and empowerment.

Post-feminist media scholarship also makes possible an attention to the politics of representation as they construct proper and improper identities for women in the context of reproductive health discourse. Sarah Projansky argues that post-feminism is a set of discourses that "work hegemonically to transform feminism in the service of heterosexual masculinity and a dispersed, depoliticized, and universalized white, middle-class feminine/feminist identity" (Projansky 2001, 14). Projansky's "feminine/feminist identity" is a highly visible feature of YAZ's public career. Post-feminist media studies allows for an analysis of specific media products but also takes into account the wider realm of meanings and actions that imbue those products with their importance.

This project aims to correct the disciplinary isolation of work on issues of representation and visibility of female sexualities and reproductive health. By considering how governmental, advocacy, social and commercial discourses all work to contribute to over-arching dominant representations of female sexuality and reproduction, I bring together a wide variety of important scholarship to create a nuanced theory of representation and reproduction. Finally, this project continues the work of scholars such as Roberts, Kapsalis and Tone by bringing their work to bear on more contemporary phenomenon in the representation of women's reproductive health and sexuality.

Structuring The Study

I use an interdisciplinary and intersectional feminist methodology to structure and guide my research on YAZ. Feminist methodologies aim to correct the exclusion and devaluation of women's experiences and voices from academic scholarship and public

sphere discourse. They recognize women's "experiences" as a diverse category that refuses reduction to a single type of experience and refuses the easy resolution of conflicting narratives. Feminist methodologies also engage the political significance of research on women and gender by taking into account the larger political, cultural, social and economic climate that gives rise to the phenomenon being studied.

This dissertation uses a case study approach in order to center Bayer Pharmaceuticals' oral contraceptive YAZ. The case study approach is best suited to this research because it permits an in-depth analysis of YAZ. Shulamit Reinharz states that the case study approach in feminist research works to "illustrate an idea, to explain the process of development over time, to show the limits of generalizations, to explore uncharted issues by starting with a limited case and to pose provocative questions" (Reinharz 1992, 167). A case study of YAZ allows me to maps the competing, contradictory and complementary ways that women and their reproductive health are constructed and deployed as they circulate in different spheres of public and popular discourse and over time.

I use discourse and textual analysis, interviewing and digital research to both generate and analyze data. Norman's Fairclough defines discourse analysis as "oscillating between a focus on specific texts and a focus on what I call the 'order of discourse', the relatively durable social structuring of language which is itself one element of the relatively durable structuring and networking of social practices" (Fairclough 2003, 3). Fairclough's definition helps to position discourse analysis as both a method for data generation (e.g. a focus on specific texts) and a method of analysis (e.g. a focus on connecting the larger piece of "orders of discourse"). Moreover, Fairclough,

like Baglia and Hall, helps to make the important connections between representation in language and social practice. Following Fairclough, discourse analysis will function as my primary mode of analysis but will also inform data collection and generation.

Since my research relies heavily on analyses of verbal rhetoric and visual imagery, I engage methods of data generation that help me locate historical and contemporary examples of the phenomenon I am studying. I use what I term "bread crumbing" as a digital method that allows me to identify and access hard-to-find data sources. It is not, for example, standard practice for manufacturers to readily provide production information for their marketing materials, including names of actors, writers, directors, editors, and advertising agencies used in the creation of print and broadcast ads. That information can, but not always, be found more easily for popular commercials, e.g. infamous Super Bowl ads or others ads that win major awards or gain a certain level of notoriety. The invisibility of the production process of advertising is one of the factors that help it seem benign and inevitable, allowing it to operate seamlessly and almost imperceptibly in public and popular culture. Moreover, for commercials, like those in the "Beyond Birth Control" campaign, that have been removed from broadcast following governmental or legal intervention or other kinds of social outcry, it can be particularly difficult to find identifying information as manufacturers are eager to erase the stain of their mistake. In these cases, digital bread crumbing allows me to use disparate and incomplete sources to track back to and/or piece together and cross check the information I need. For example, in chapter four, while writing about an ad campaign produced by a now defunct local Planned Parenthood affiliate, I found the resume of one of the actor's

in the commercial online and was able to use it to confirm the official name of the commercial as well as identify the production company that helped create it.

This scavenger-like approach to generating data for context and analysis is critically important to research like mine that deals in the ephemera of public culture, of which advertising is a primary example. When searching for information on how to properly cite television commercials according to *The Chicago Manual of Style*, which is the citation style used by this dissertation, I found that there was no set criteria. According to the Q&A section of *The Chicago Manual of Style*'s official website,

> There is no provision for citing television advertisements in *The Chicago Manual of Style.* TV ads are in a sense part of the public experience and a matter of historical record. Say you are describing the advertisement for the Volkswagen Golf that features the Styx song "Mr. Roboto." It is a piece of popular media that you are describing and need not be cited—description suffices. It is not a matter of leading a reader to a specific source that can be obtained from a public archive (though you might be able to find a copy on YouTube). Should there be an occasion on which you did need to provide a reference citation, you could do something like this: Volkswagen. "Crazy Guy." Television advertisement. Arnold Communications, Inc., directed by Phil Morrison, 2000. But you would have to have that information (the ad won an ANDY, and information about it became readily available online, from a variety of reputable sources) (Chicago Manual of Style 2014).

The Manual recognizes the difficulty in obtaining the relevant production information needed for a formal citation of texts that are considered informal. Yet, even though the actual ads are ephemeral, their effects are much more lasting, which is why we need methods that allow us to make them visible and identify them as the highly orchestrated and productive tools that they are.

I conducted a small, semi-structured interview study as a means to generate data and to supplement my primary analytical practice of discourse analysis. Interviewing is particularly important to my study of women's responses to public representations of

reproduction and sexuality. Studies of representation using discourse analysis are important and often provocative but can ring hollow without attention to the corresponding issue of audience negotiation, reception and action in response to the intended meanings of media products. The use of interviewing also reflect my investments in a feminist methodology that seeks to center women's voices and experiences as critically relevant and necessary.

Finally, my own experiences negotiating my desires and demands for my reproductive healthcare, particularly around contraception, with and against those of my doctors, forms part of the methodology of this research. Using the work of Chikako Takeshita, I aim to use my experience as a reproductive health care patient as an "embodied knowledge" (Takeshita 2010). While "embodied knowledge" implies a more intimate relationship to one's field of study, it also reminds the knower of its limits as it only goes, literally, as far as one's own body. As Takeshita argues of her experience of embodied knowledge as both a user and researcher of the Intrauterine Device (IUD),

> I was naïve, though, to think that embodiment would somehow turn me into an authoritative knower…Instead it made it clearer that my situatedness—the historical, geographical, and social position that I occupy as an educated woman living in the United States 40 years after the contraceptive method was revived—shaped my own experience, which was not easily comparable to that of other women due to our grossly different positionalities" (Takeshita 2010, 40).

Takeshita calls on a kind ruthless reflexivity on her part to balance and integrate her experiences as an IUD user and her research on the development and historical use of the device. Moreover, putting her own experience within the larger context of the device's political economy and history prevents her experience from being the sole source of information about the device and its meanings. Through these methods, Takeshita is able to engage her experience as an IUD user, as opposed to disavowing it, without allowing it

to function as unquestioned expertise. This approach honors feminist commitments to the importance of the politics of locations in research and the refusal to claim a false sense of neutrality and objectivity in regards to one's area of study.

To make the case about YAZ and the representation of women and their reproductive health as I have explained it above, I follow the oral contraceptive across four main discursive moments in its public tenure. These four moments include the contraceptive's successful "Beyond Birth Control" marketing campaign; the U.S. Food and Drug Administration's regulation of the campaign and the product; the responses of feminist and women's health advocacy communities as characterized by the divergent responses of Our Bodies, Ourselves and Planned Parenthood to the marketing of YAZ; and the responses of women, aged 18-35, in Atlanta, Georgia, to the public visibility of women's reproductive health and YAZ. These four sites of public and popular discourse form the core of my study's data and are the subjects of the following chapters.

Chapter One, "Selling the Single Ladies: Birth Control, Advertising and the Female Body," focuses on Bayer's "Beyond Birth Control" marketing campaign for YAZ. This chapter maps the verbal and visual rhetoric of the campaign and introduces post-feminist media studies as the appropriate theoretical framework for engaging the representation and significance of women's reproductive health in the commercial discourse of advertising. Employing what I call the *Sex and the City* approach to feminism, borrowing from the widely popular HBO television series, the YAZ advertisements draw on the idea of a cosmopolitan and modern womanhood signified by a particular kind of class and race privilege. Like the expensive shoes and elaborate martinis for which Sex and the City's characters are known, YAZ's "Beyond Birth

Control" campaign aimed to present the oral contraceptive as yet another integral piece of the modern and sophisticated woman's repertoire. Yet, these representations are predicated on a nearly invisible female sexuality and the elision of potential health risks and side effects that hormonal birth control can pose for women.

Thus, these representations of female independence contribute to what I identify as a new kind of double bind characteristic of post-feminism that deems women unsophisticated and irresponsible if they decline hormonal birth control but offers them an equally limited role if they choose to accept it. Engaging the disciplinary responses of the FDA to Bayer's campaign will set the stage for a transition to Chapter Two of the dissertation, which will look more closely at public anxieties around women's reproductive health and sexuality and how those anxieties produce particular kinds of representations and rhetoric.

Chapter Two, "Regulating YAZ: Governmental Interventions, Consumer Protection and DTC Advertising," addresses the Food and Drug Administration's regulation of Bayer's "Beyond Birth Control" campaign. Using the framework of "cover stories" developed by Wahneema Lubiano (1992), this chapter examines how regulatory intervention directed at Bayer and the YAZ brand were presented as patient and consumer protection efforts but actually did very little to protect or empower women around their reproductive health. For Lubiano, *cover stories* are masking agents that use one story to distract and divert public attention away from another story that implicates more serious and sinister power machinations. With Lubiano's *cover stories*, the chapter asks what kinds of bodies and voices were mobilized to speak at the governmental hearing and in official regulatory documents. What kind of language and verbal rhetoric

was used to explain the issue and lobby for one side or the other? And, finally, in what ways did questions of women's health and/or sexual practice figure into these discussions.

Chapter Three, "Up for Sale(?): Women's Body Knowledge and Feminist Health Advocacy," unpacks the responses of Planned Parenthood and Our Bodies Ourselves to the rise and fall of YAZ. Each organization's respective response to YAZ offers context for its broader approach to popular media. In turn, I examine the contemporary role and treatment of media by women's and feminist health advocates. Through my comparison of these organizations, I propose an alternative framework for thinking through reproductive health in the contemporary media landscape that I term "feminist health media literacy." Feminist health media literacy is presented as the integration of a number of critical analytical frameworks, including feminist health studies, feminist body studies, media and cultural studies and feminist studies of difference. Bridging the theoretical and methodological work of these schools of thought serves to privilege the gendered body, as both a material and discursive entity. Here, the gendered body is always read in its relationship to multiple markers of difference, media and, contemporary ideas of health.

Chapter Four, "Crafting Epistemic Authority: Women's Approaches to Contemporary Reproductive Health Information and Decision-Making," explores the responses of a small group of women in the Atlanta, Georgia metro area to the public representation of women's reproductive health. Using feminist theories of epistemology, this chapter argues for the recognition of women's epistemological capacities and labor regarding their reproductive health. This chapter represents an important and necessary

intervention because, as I argue in the previous three chapters, representations of women's reproductive and sexual health in popular discourse rarely engage the voices of actual women.

These four chapters outlined above provide the groundwork for the dissertation's final chapter. The project's concluding chapter summarizes and synthesizes the research presented throughout the dissertation. This chapter further explains the social and political significance of this dissertation and explicitly names the ways in which women are identified throughout YAZ's public circulation. Finally, given the nuanced and multi-layered nature of the dissertation's subject, the final chapter offers next steps and new directions for research.

Chapter One:
Selling the Single Ladies: Birth Control, Advertising and the Female Body

The U.S. feminist movements of the nineteenth and twentieth century made explicit calls for women's reproductive rights in the form of access to abortion and safe and legal contraceptive options. This chapter charts Bayer Pharmaceutical's appropriation of feminist reproductive rights rhetoric in their 2007-2011 Direct-to-Consumer (DTC) advertising campaign, "Beyond Birth Control." Through focusing on the YAZ campaign, the chapter illustrates how and in what ways women's reproductive health and sexuality are made in/visible in contemporary DTC advertising for hormonal contraceptives. The "Beyond Birth Control" campaign tapped into popular ideas about modern American womanhood, as seen in the HBO original series *Sex and the City* (*SATC*), in order to develop a marketable identity for the YAZ contraceptive. Just as the original series privileged white, middle-to-upper-class women as the ideal, so did the Bayer marketing campaign for YAZ. Moreover, the campaign shrewdly tapped into depoliticized notions of feminism, power and agency in order to position YAZ as a prime commodity rooted in narratives of women's empowerment. Engaging the work of feminist media scholars on post-feminist popular culture (McRobbie 2009; McRobbie 2008; Gerhard 2005; Tasker and Negra 2006), the chapter analyzes the visual and verbal discourse of the YAZ marketing campaign. Finally, by examining the U.S. Food and Drug Administration's (FDA) reprimand of Bayer over the accuracy of the campaign's claims, the chapter considers what is at stake when advertising constitutes a de facto public pedagogy about matters important to women's health issues, such as the choice of contraceptive.

Distinct from the concept of backlash, popularized by Susan Faludi (1991), post-feminism creates and maintains a different kind of relationship to feminist political

movements, particularly those associated with the latter half of the 20th century. Whereas backlash described the out-and-out repudiation of feminist politics and the undoing of feminist gains that began in the Reagan-era 1980's, post-feminism describes a more harmonious relationship, at least at first glance. Angela McRobbie argues that post-feminism "positively draws on and invokes feminism as that which can be taken into account, to suggest that equality is achieved, in order to install a whole repertoire of new meanings which emphasize that it is not longer needed, it is a spent force" (McRobbie 2009, 12). Feminist politics are given credit for empowering women and creating new opportunities in the work force that allow them to engage in public spaces and certain practices of consumption. More important, however, feminist politics are ultimately judged to be unnecessary and incompatible with women's newfound public sphere access and success. Under the logic of post-feminism, now that those gains have been achieved feminism is no longer necessary and only serves to hinder women with political, social, and sexual rules, or what McRobbie (2009) and Jane Gerhard (2005) refer to as the ghost of feminism past. Through the repudiation of feminism, post-feminist narratives offer a seductive version of women's success, which doesn't require collective politics or dissent. Post-feminism, in turns, lends itself to advertising discourses that seek to highlight women's increased economic access to consumption without engaging women's increased capacities for public sphere political and economic dissent.

The Historical Roots of Contemporary Contraceptive Advertising

Historically, the struggle over women's reproductive healthcare in the U.S. has always included questions of visibility and, more specifically, commercial visibility. As early as 1873, the U.S. grappled with the regulation of the commercial visibility and

exchange of sexually charged material, including information about and advertisements for contraceptives and abortifacients. Several scholars (Sarch 1997; Tone 2001; Linton 2007; Ferranti 2010) have explored the significance of historical forms of advertising for women's contraceptives to both the early twentieth century economy and to the public regulation of gender, sex and morality. Advertising under the euphemism "feminine hygiene" brought the twentieth century images and language dedicated to contraception. Early ads for contraceptives by companies such as Lysol and Zonite leveraged gender norms in order to exploit women's insecurities about pleasing male partners and preventing pregnancy. Ads often referenced women so overcome with worry about the management of their "feminine hygiene" that they sexually and emotionally alienated their husbands. As Andrea Tone describes,

> The headlines of ads were designed to inculcate and inflate apprehension in the readers' minds. They conveyed the message that ineffective contraception led not only to unwanted pregnancies but also to illness, despair and marital discord. Ads titled "Calendar Fear," "Can a Married Woman Ever Feel Safe?" "Young Wives Are Often Secretly Terrified," and "The Fear That Blights Romance and Ages Women Prematurely" relied on standard negative advertising techniques to heighten the stakes of pregnancy prevention (Tone 2001, 157–59).

According to the ads, the successful management of female fertility, which could be secured through the use their products, was the only cure for this peculiarly feminine anxiety. These early contraceptive ads, promoting one-size fits all diaphragms and douches, were simultaneously over and under scrutinized for their role in women's health and sexual practice. "Feminine hygiene" ads were largely ignored regarding the efficacy and safety of the products they promoted. Even though "feminine hygiene" was widely understood as a euphemism for contraception, manufacturers of ineffective diaphragms and douching solutions "absolved themselves of culpability by reminding critics that, by the letter of the law, their products were not being sold as contraceptives" (Tone 2001,

172). However, these advertisements were heavily scrutinized in terms of their legality, in terms of where they appeared and the language they employed, through the function of regulatory measures such as the Comstock Laws.

The Comstock laws of 1873 were an expansion of the U.S. obscenity laws that, for the first time since their creation, included contraceptives. Andrea Tone argues,

> The Comstock Act defined contraceptives as obscene and inaugurated a century of indignities associated with birth control's illicit status. Invoking its authority to regulate interstate commerce and the U.S. Postal system, Congress outlawed the dissemination through the mail or across state lines of any "article of an immoral nature, or any drug or medicine, or any article whatever for the prevention of conception" (Tone 2001, 4).

As Tone goes on to note the Comstock laws were not necessarily against birth control but were "a direct response to their newfound commercial visibility," i.e. advertising and sales through the U.S. mail (Tone 2001, 13). The Comstock laws and their focus on "commercial visibility" demonstrate that women's reproductive rights have never been just a question of legality. When, where and in what ways we can talk about contraceptives, particularly those aimed at women, has always been a cause for social and apparently governmental concern.

It would seem that we have come a long way from 1873 when contemporary contraceptive advertising is explicitly linked to pregnancy prevention instead of the vague "feminine hygiene." Not all public visibility of contraceptives signals progress, particularly when that visibility is only possible because of its connections to consumer culture and profitability. The current visibility of women's contraceptive options lies mainly in the hands of pharmaceutical companies and their marketing firms.

A 1997 change in the U.S. Food and Drug Administration's guidelines for Direct-to-Consumer advertising of prescription drugs, meant that drug manufacturers were no

longer forced to rely solely on the recommendation of doctors. Now, prescription drug companies seek to influence patients long before they reach a medical office via marketing campaigns that use print, broadcast and online media. Tuning into any U.S. television channel, viewers will undoubtedly encounter numerous commercials for prescription drugs ranging from blood pressure medication to prescription strength cosmetic treatments for facial lines and wrinkles. Oral and hormonal contraceptive manufacturers and marketers have capitalized on these new advertising avenues.

Employing a feminist or empowerment framework based heavily on the aesthetic principles of the widely popular HBO television series *Sex and the City*, Bayer crafted a particular version of modern womanhood, marked by whiteness, class privilege, youth and a meticulously managed (hetero)sexuality, in order to successfully market their products to young women. This mode of gender empowerment is summed up well in the series' pilot episode when Samantha, one of the four main characters, informs her sweet but naïve friend Charlotte, "Sweetheart, this is the first time in the history of Manhattan that women have had as much money and power as men. Plus, the equal luxury of treating men as sex objects" (Star 1998). Samantha's statement is indicative of the empowerment politics used and promoted by *Sex and the City*. This brand of politics equates women's progress with their wage-earning power, sees sex as a major expression of women's liberation and uses men as the standard by which to gauge this gender progress. Samantha's words also echo the findings of Karrin Anderson and Jesse Stewart (2005) in their analysis of the how *Sex and the City* narrative was used to create a homogenous identity for single women voters in the 2004 U.S. presidential election.

Anderson and Stewart argue that characterizations of the *Sex and the City* voter

were undergirded by definitions of contemporary feminism generated largely by post-feminist popular media. In these definitions feminism was marked by an "emphasis on self, on personal rather than political empowerment, and on dominance through sexual and/or economic channels…" (Anderson and Stewart 2005, 601). Bayer's references to *Sex and the City* signal both a departure and continuity with previous modes of advertising contraceptives to and for women. Advertisements for contraceptives have long played on women's anxieties about their reception and desirability of their bodies and have proposed pharmaceutical management as the proper intervention. Yet, birth control ads have also work to craft an image of the ideal modern woman and have positioned medico-technological and pharmaceutical intervention as an absolute requirement of that identity.

Sex and the City

From 1998 to 2004, the HBO series and film franchise, *Sex and the City,* followed four wealthy white women in New York City through their love, professional, family, friendship and sex lives. These four characters, Carrie, Samantha, Miranda and Charlotte, enjoyed a lifestyle rooted in both their class and race privilege. During the show's tenure, they came to signify single and liberated American womanhood. Expensive martinis enjoyed at chic Manhattan bars as well as dangerously high and even more dangerously priced Manolo Blahnik high heels became representative of a fashionable and attractive womanhood to which many women aspired. Anna König argues "In many ways the show itself has now become a lifestyle megabrand in its own right, representing sexiness, intelligence and wit through both script and costuming. By constantly referring to the show in their copy, fashion journalists are essentially

promoting a tried-and-tested lifestyle product that they already know to be a hit with readers" (König 2004, 141). König helps to illustrate how *SATC* was taken up in sites outside of the show as cultural shorthand for contemporary womanhood.

Part of *Sex and the City*'s appeal stems from a long popular culture tradition of keeping up with girls in the big city. As Kim Akass and Janet McCabe argue of the series, "*Sex and the City* references a classical Hollywood tradition of screwball as well as innovative TV sitcoms about single girls in the city, like *The Mary Tyler Moore Show*…and *Rhoda" (Akass & McCabe 2004, 12).* The show's relationship to earlier iterations of similar shows gave it a foundation in popular interest in the novelty of women living outside traditional heterosexual domesticity, i.e. marriage. *Sex and the City*'s story lines and writing sealed its fate as the most successful and iconic representation of twenty-first century American womanhood. As Darren Star, creator and Executive Producer of *Sex and the City* noted of the show's writing, "On *Sex and the City*, you've got a group of characters who live in a world that the audience participates in vicariously…People watch the show and think, *Yeah, that's me. That's my situation"* (Sohn 2004, 36). Star highlights both the familiarity and the fantasy that the show invoked for viewers. Viewers could, at once, relate to the stories but also vicariously participate in life, particularly a life in the city, to which they might not have otherwise had access. Yet, the show's investment in aesthetic storytelling was equally central to the successful execution of the story lines. By aesthetic storytelling, I am referring to the use of scenery, location and costuming as central to communicating the tone and meaning of the series overall and the individual episodes. The narrative function of *Sex and the City*'s use of fashion and Manhattan (as both an idea and a real material space) cannot be

overstated in the discussion of the show's appeal or its success. It is chiefly through the use of the aesthetic (e.g. space, place, bodies, costuming) of *Sex and the City* (but also what that aesthetic invokes, i.e. memories of the show, what the show represented in terms of femininity and womanhood, etc.) that birth control marketing summons a particular set of ideas surrounding ideal, cosmopolitan, desirable and, above all, modern femininity.

Noting the importance of wardrobe and costume in *Sex and the City*, Stella Bruzzi and Pamela Gibson argue that "fashion is the fifth character" in the show (Bruzzi and Gibson 2004, 115). For Bruzzi and Gibson, fashion emerges as a complementary and competing force in the development of *Sex and the City*, central to both its narrative development and its immense popularity. As a critical piece of the show's production, "the process of extravagant costume display has developed its own independent existence within the series and, bolstered by various extra-diegetic factors, has acquired a separate momentum" (Bruzzi and Gibson 2004, 123). The "extra-diegetic factors" Bruzzi and Gibson reference are Sarah Jessica Parker's, the actress who plays the series' main character Carrie, role as a fashion trendsetter during the show's tenure.

Parker even went on to work for high-end designer Halston as well as to design her own line for the now defunct discount fashion retailer Steve and Barry's, making something of a democratic argument that (high) fashion should be available to all regardless of income. Unfortunately, Parker's well-intentioned efforts rang hollow in the face of the show's guiding fashion ideology, in which even "discount" fashion is out of the reach of most average wage-earners as seen in the series episode "Sex and Another City" in which Samantha buys a fake Fendi bag in Los Angeles that costs $150.00.

Samantha's taste for expensive bags is further depicted in another episode in which she abuses her position as a celebrity publicist for actor Lucy Liu in order to get a coveted Birkin bag. In the show, the Birkin is quoted at costing four thousand dollars and that is the price to be paid only after one makes it through the five-year waiting list. Samantha's expensive purse fetish is characteristic of the manner in which the show introduces high fashion as essential to the lives the main characters lead. Anna König rightly contends that *Sex and the City*

> might be regarded as the explicit televisual embodiment of an alluring lifestyle. In addition to the stunning, and often stunningly expensive, clothes, the audience is tantalized by a complete way of life that incorporates Sunday brunches, skating in Central Park, expensive cocktails and yellow cabs. The pricey clothes should, therefore, be seen as an integral part of a complete New York lifestyle, one that undoubtedly has an exciting and romantic international appeal (König 2004, 140).

The incorporation of exorbitantly priced clothes and accessories is out of the question for the vast majority of women in the U.S. but the show used these things to establish the world of *SATC* as a desirable fantasy for its viewing audience. Furthermore, even though many, if not most, women are unable to afford a $4000 handbag, the show provided them with other opportunities to consume the *SATC* fantasy.

HBO's marketing of the show includes an online store where fans can purchase *Sex and the City* inspired items, including martini glasses, a nod to the show's role in popularizing the Cosmopolitan as the cocktail of choice for fashionable women everywhere, and other *Sex and the City* branded merchandise. HBO also established an on-line auction site where select items from the series were sold and the proceeds given to various charities. As Bruzzi and Gibson note of the importance of *Sex and the City's* relationship to fashion, "a large section of its audience watch it primarily to see the clothes…" and the show's well-known head costume designer Patricia Field, a fashion

institution in her own right, has, rightly, claimed "that the 'ripple effect' of the show makes it a 'virtual how-to-manual for New York style'" (Bruzzi and Gibson 2004, 123). However, *Sex and the City's* role as a "how-to-manual" extends beyond Manhattan and certainly beyond New York. While contemporary trends have changed and shoe designer Christian Louboutin now occupies the space of public interest that designer Manolo Blahnik once held, *Sex and the City* remains a key reference for contemporary ideas on stylish, modern and desirable (both sexually and socially) womanhood.

The prominence of fashion in the series is complemented by the importance of place or, more specifically, "the city" and all its attendant entanglements with notions of modernity. The city or the urban landscape has long been associated with a contemporary and cosmopolitan life. The city, and in this case New York City particularly, is representative of a physical location and a discursive site where particular identities are made and sustained. New York, and even more specifically, Manhattan are what make *Sex and the City*'s four main characters possible to begin with and are certainly apart of the show's allure for fans, especially those who live outside of New York. As evidence of the importance of place to *Sex and the City*, fans that visit Manhattan can take bus tours that stop at important locations from the show. Of their own experience on a *Sex and the City* tour, film and media studies scholars Kim Akass and Janet McCabe write

> The photo [of us sitting on Carrie's stoop] bears witness to the fact that we were there in New York. Not the real New York, you understand. But the New York fairy tale defined by nostalgia for old-time romance and the staging of possibility constituted in and from media texts. The 'on-location' tour enabled us to consume the fantasy as well as be consumed by it. But the photograph allows us to insert ourselves into our own Sex and the City narrative… (Akass and McCabe 2004, 236).

Akass and McCabe, both unabashed fans of the show and editors of an anthology of writing on *Sex and the City*, highlight the way the city functions as both a material space

but also as an idea central to how viewers encounter and consume the series.

Sex and the City created and circulated a powerful trope of American womanhood that became and remains an important reference for popular discourse on modernity, gender, sexuality and wealth. As Anderson and Stewart note the series' notoriety,

> one needed little if any specific knowledge of the series and its characters to understand what was being suggested by the "Sex and the City Voter" label. Much of the journalistic discussion of the "Sex and the City Voter" was accompanied by a still photo of the series' main characters: four attractive, upscale, Anglo, single women living in New York whose fashion-forward attire and provocative expressions marked them as women primed to consume (Anderson and Stewart 2005, 603).

Images of young and well-dressed women in bars with stylish cocktails invokes an almost Pavlovian association with *Sex and the City* and its subsequent associations.

As advertising often relies on cultural shorthand to communicate complex ideas in short amounts of space and time, the familiarity of the *Sex and the City* model of womanhood presented an attractive tool for advertisers and companies. Bayer's "Beyond Birth Control" campaign consistently presented images of young, white and seemingly affluent women in trendy urban environments that mimic the characters and familiar scenes of HBO's *Sex and the City*. Jane Arthurs (2003) calls this approach re-mediation, which describes "the forms in which new media arise, as each medium 'responds to, re-deploys, competes with and reforms other media'" (Arthurs 2003, 83). Remediation allows a new media form or product to engage with older media forms and products. For Arthurs, *Sex and the City* "re-mediates the address developed in the established women's media, namely glossy women's magazines," like Cosmopolitan (Arthurs 2003, 84). Arthurs argues that the women of *SATC* are "updated versions of the 'Cosmo' woman…" as seen through the show's treatment of sex, sexuality and independence (Arthurs 2003, 89). The show's pilot episode, for example, resembles the vibrant covers of women's

magazines as it jumps from character to character doing point of view interviews, with each one introducing a new question or issue characterizing contemporary concerns regarding love, sex, and heterosexual relationships. The explicit dialogue about sex, pleasure, beauty, and finance is, as Arthurs contends, "a re-mediation of the content and address of women's magazines for television" (Arthurs 2003, 89). Re-mediation allows *Sex and the City* to invoke familiar sites, such as women's magazines, but in new a form and format in order to better connect with and engage the viewing audience. Re-mediation of women's magazines or earlier television and film products give the show a framework to begin with but also allows it the space to reconfigure that framework as the need arises. Moreover, re-mediation offers the audience something familiar as an entry point, while they are introduced to something new. Bayer Pharmaceuticals' marketing campaign for YAZ uses re-mediation as tool to reach a particular demographic with messages about its product. Tapping into *Sex and the City* characterization of contemporary womanhood, identified by being single, young, white, thin and seemingly affluent, and using the aesthetic principles of the show, Bayer developed a shrewd marketing campaign for YAZ.

(Medicated) Sex in the City: Reading Bayer's "Beyond Birth Control" Campaign

Developed and distributed by Bayer Pharmaceuticals, YAZ was approved by the U.S. Food and Drug Administration in 2006. Once approved, Bayer began an aggressive marketing campaign titled "Beyond Birth Control," signaling the drug's ability to not only serve as a contraceptive but to also treat PMDD or premenstrual dysphoric disorder. Whether PMDD is a genuine disorder has been widely debated by women's health professional, advocates and patients. It is often defined in relation to premenstrual

syndrome (PMS) as a more intense manifestation of symptoms such as bloating, irritability and fatigue. Bayer loosely defined PMDD as the "emotional and physical premenstrual symptoms that are severe enough to impact your life" and quickly carved out a unique market position for YAZ by claiming that it was the only oral contraceptive approved to address these symptoms (as quoted in U.S. Food and Drug Administration 2008, 4). The vague definition of PMDD allowed Bayer to covertly market to women who were experiencing the less severe PMS in addition to women genuinely suffering from PMDD. Developed by the marketing agency Young and Rubicam, the "Beyond Birth Control" campaign helped to fuel Bayer's success with YAZ. Advertisements for YAZ appear to define impacting one's life as interfering with one's ability to interact in social and commercial spheres.

One of the earliest commercials in the "Beyond Birth Control" campaign evoked the *Sex and the City* aesthetic by featuring two young, attractive, thin women in trendy clothing sipping drinks in rooftop bar against a big city skyline. As the women chat, an additional woman approaches the pair, who are obviously surprised to see her as they say "Wow, look who's here." The new addition to the group explains, "this time last month I'd never have made it but my doctor gave me a birth control pill called YAZ." Another member of the groups pipes in to sing the praises of YAZ but also to provide the obligatory health warnings for all birth control. As this last member finishes her contribution to their conversation her friends offer praise by telling her, "Wow, you really know your stuff," to which she replies "I didn't go to medical school for nothing."

The second commercial released in the "Beyond Birth Control" campaign featured a series of vignettes that showed women literally "fighting" off the symptoms of

PMS and PMDD to the soundtrack of the Twisted Sister classic "We're Not Gonna Take It." However, in order to invoke female empowerment and control the version of the song used in the commercial is a cover performed by the sister duo The Veronicas. In each of these scenes, the women are shown actively fighting off and eliminating these worrisome reminders of the body's processes. One actor kicks irritability into pieces and out of view while another woman shatters moodiness with a powerful punch. All the actors in this commercial achieve these mighty victories against the body while doing everyday mundane activities like working, shopping or exercising in nicely appointed metropolitan spaces.

Like the first two ads, the third commercial in the campaign predictably portrayed young, mainly white women, in metropolitan landscapes. In this commercial, the symptoms of PMDD haunt women as brightly colored balloons that float through the air just above their heads. The balloons remain suspended above the women through the work of YAZ. Some women are seen holding balloons in the ad but they quickly release them, letting the string slide through their fingers, signifying not only their release of a particular symptom but also their release of that which may be negatively impacting their life. As its tagline suggests and the commercials supposedly demonstrate, YAZ indeed offers something "beyond birth control," it offers women protection against pregnancy and, more importantly, the tools of bodily management, that allow them to live modern and urbane lives.

All three of these commercials show women, always young, thin and usually white. The setting for the commercials is always a trendy urban environment, as indicated by spaces heavily populated with young, attractive individuals participating in

leisure activities including dining out or shopping. The women in the commercials are depicted as poster children for what Joan Morgan once called “the daughters of feminist privilege” as they are always portrayed as professionals through their presence in professional office spaces or by their self-identification, for example, as doctors (Morgan 1999, 55). The feminist privilege of the commercials’ subjects is further noted by their economic privilege, signaled through their participation as consumers. The commercials’ use of young, active women interacting with one another invokes ideas of women’s independence, agency and empowerment. In the commercial, women are represented as being powerfully in charge of their lives and their bodies. Independence, agency, empowerment and bodily control were and are hallmarks feminist politics and activism. Invoking these themes allows Bayer to leverage the cultural capital of feminist successes without having to commit to the politics that makes those successes possible. This version of feminist progress and empowerment is demonstrated in the first commercial as the voice of medical authority for the risks of birth control is one of the women in the group as she tells her friends “I didn’t go to medical school for nothing.” Improper grammar notwithstanding, this moment is significant because it notes a kind of class and cultural capital. The woman’s final declaration regarding her medical school education also speaks to calls from the women’s health movement for women’s control over their bodies and health. Here, the voice of medical authority is no longer a white man in an even whiter lab coat but a young vibrant woman eschewing traditional medical garb for a tank top and skinny jeans all while still being able to wield the power of medical language and knowledge without missing a beat. In this scene there are a number of representative and discursive challenges at work. Not only is the proper subject of

medical authority being called into question but also the very sites in which medical authority can be properly deployed.

The first commercial moves the preferred site of medical knowledge, particularly medical knowledge of women's reproductive health, from the pseudo-privacy of the doctor's office to the open and public space of a bar. Interrogating the tension between public and private in regards to women's reproductive health, Terri Kapsalis argues, "the public performance of female privates is a particularly troublesome act" (Kapsalis 1997, 5). For Kapsalis, cultural and social notions of female propriety and shame render something as routine as the female pelvic exam an "inherent problem" because "It is a practice that necessitates the public exposure of the shameful female privates" (Kapsalis 1997, 5). Moreover, Kapsalis goes on to argue that acts such as draping a sheet over the lower body of the patient, effectively hides her privates, even from herself, acting as an additional cover, literally and figuratively, to help manage the troublesome public display of the private parts (Kapsalis 1997). Kapsalis fully brings our attention to how meticulously managed the public/private divide is when it comes to women's reproductive health.

Given the management of the public/private divide as a key site of policing of female respectability, the open discussion of women's contraceptive options and premenstrual symptoms in a bar seems to disrupt long held social taboos. The public discussion of women's reproductive health in a social setting seems to echo earlier feminist practices of communal information sharing, such as the classic example of community taught cervical self-exams. However, the distortion of those earlier activist scenes become clear when we see that in the YAZ commercial the participants have

traded hand mirrors and speculums for martinis and prescriptions, more deeply entrenching women's health in the medical establishment as opposed to creating alternatives to it. Tasha Dubriwny (2013) notes a similar process of appropriation and re-direction of feminist health activism in her analysis of the American Heart Association's "Go Red" campaign, which addressed women and heart disease. Dubriwny argues,

> On the surface the purpose and main themes of the "Go Red" campaign replicate some of the main tenets of the women's health movement. Underlying much of the discourse of the "Go Red" campaign, for example, is the theme of women's empowerment and agency, as women are encouraged to take action and form a sisterhood…Nevertheless, despite these similarities, some striking differences also emerge regarding the themes of women's relationship to the medical industry, the role of the medical expert in the health care encounter, and the context of women's health. Most prominently, unlike the critical stance toward the medical industry encouraged by the women's health movement, the "Go Red" campaign prompts a near-unquestioning embracing of medical knowledge and technology (Dubriwny 2013, 2).

In addition to further embedding women in the mainstream U.S. medical establishment, the growing visibility of women's health in the public sphere has also created new opportunities for developing women as medical consumers. Bayer aimed to expand gendered stereotypes of women's supposed penchant for shopping for shoes and clothes to include shopping for birth control as an accessory. In the YAZ promotional material, the economic privilege of the women is shown not only through their professional employment but also through their ability to consume the leisure products and activities that provide the context for both commercials. As women's health has gained more public visibility, it has become key site for further developing women as consumers.

To further develop women as medical consumers, Bayer drew on *Sex and the City*'s investment in gendered consumption. The series did not just tell the story of its four main characters but, as I argue earlier in the chapter, offered viewers the chance to purchase and consume their very own *Sex and the City*. Akass and McCabe's argument

about the ownership afforded them through the *Sex and the City* tour and photo elides the importance of consumption as the real mechanism through which the work of narrative appropriation and ownership occurred. The two authors/fans were able to access their personal *SATC* narrative through their role as consumers who paid to participate in a tour. Their paid entrance to the tour is what allowed Akass and McCabe to obtain the photograph, which became the pathway to their "ownership" of a piece of the *Sex and the City* narrative. Consumerism as both practice and social ethic were driving forces behind *Sex and the City*'s success just as they are foundational to the larger U.S. social identity in the contemporary moment.

As described earlier in this chapter, *SATC*'s seamless integration with the fashion industry was an important mode through which the show represented the main characters as not only chic but also as consumers, specifically high-end consumers. Bayer also aimed to integrate trendy fashion with the YAZ brand in order to help identify the contraceptive as a kind of fashionable accessory to be purchased and consumed. In 2009, for example, Bayer produced a waiting room brochure for YAZ that, in addition to providing basic information about the medication, invited readers to sign up for *YAZXpress™*. The brochure described *YAZXpress* as a "program that keeps you in the know about YAZ® (drospirenone & ethinyl estradiol), as well as fashion, music, style and more" (Bayer HealthCare Pharmaceuticals 2009, 12). The brochure promised subscribers daily reminders via email and text, information on birth control including YAZ and "the latest buzz on fashion, music and style" (Bayer HealthCare Pharmaceuticals 2009, 12). This brochure positions YAZ in the same way that it positions fashion, style and music, i.e. as a cutting edge and on-trend accessory.

Bayer aimed to further solidify YAZ's bifurcated identity as both a medical commodity and a lifestyle commodity with its 2008 "Step Up and Go Beyond" contest. The contest invited aspiring fashion designers to design a new pill pack for YAZ and to submit their design to the competition where they could win $10,000. Ogilvy Public Relations, the agency that developed the "Step Up and Go Beyond" campaign for Bayer, explicitly referred to the contest as a "fashion campaign" that "challenged aspiring designers to step out of their comfort zones and go beyond by re-designing a new YAZ pill case and transforming it into a fashion accessory" (Ogilvy Public Relations Worldwide 2009). The contest clearly aims to transform YAZ from a medical technology and commodity into a fashion accessory that one wears and uses as an expression of identity (stylish, fashionable) rather than simply a pill taken to manage the body. Recasting oral contraception as an accessory instead of a pharmaceutical technology works to position women as consumers not patients or medical stakeholders. Moreover, it helps to mask the ways in which YAZ, as a pharmaceutical technology, impacts the body in a way that a scarf, jacket, pair of shoes or purse does not.

In order to promote the contest, Bayer partnered with the non-profit organization Step Up Women's Network, which focuses on women's empowerment and describes it self as "a national non-profit membership organization dedicated to strengthening community resources for young women," (Bayer HealthCare Pharmaceuticals 2008). The contest also boasted celebrity judge Nina Garcia, a fashion critic who became widely known for her role as a judge on the fashion-based reality TV show *Project Runway.* Interestingly, Garcia briefly worked with *SATC* head costume designer Patricia Fields, who served as a guest judge during season one of *Project Runway*. Garcia's involvement

with the contest worked to further establish it as a fashion and style endeavor. Whereas Ogilvy described the birth control pill pack as something that must be transformed into a fashionable accessory, Garcia described the pill pack as already having been an accessory and an iconic one at that: "The design challenge we're posing is a fashion transformation unlike any other," said Garcia. "We're taking an iconic accessory — the birth control case — and asking aspiring designers to take a shot at redesigning it into a chic, more sophisticated carrying case that they could slip into their purses" (Bayer HealthCare Pharmaceuticals 2008). For Garcia, the transformation lies in the ability to make the "iconic accessory" into something sleek, smart and sophisticated; in other words, something that we might expect *SATC*'s Samantha to pull out of her $4,000 Birkin bag.

Through the "transformation" of the "Step Up and Go Beyond" contest, the pill pack would no longer have to be hidden at home in a top drawer or medicine cabinet out of public view. The re-designed pill pack, which was less a re-design of the actual pill pack and more the creation of a trendy carrying case, could be brought into public consideration as a fashionable accessory not a tool of body and fertility management. The pill pack makeover returns us to the first commercial in the "Beyond Birth Control" campaign when it appeared that Bayer was flouting tradition by producing a commercial that seemed to normalize women's open and public discussion of contraception. In the pill pack makeover contest, we see that actual contraceptive technologies for women require a makeover or dressing up before they are suitable for public debut. The limits of the contest are also seen in the competition's four official judging criteria. The competition advised that each entry would be judged on the following criteria: "Most embodies the theme of female empowerment (25%); Most creative and original (25%);

Most discreet (25%); Most fashion forward and stylish (25%)" (Bayer HealthCare Pharmaceuticals 2008). The call to female empowerment, creativity, originality, fashion sense and style echoes Bayer's use of the *SATC* model of contemporary American womanhood. However, the third criterion, which privileges the most discreet design, undoubtedly displays a connection to cultural taboos about the public visibility of women's contraception and menstrual management. Kaye Houppert argues that such taboos regarding women's menstruation created a "culture of concealment" wherein manufacturers are forever producing new ways to make sanitary napkins and tampons look less like tool of menstruation management and more like mirror compacts, tubes of lipstick and hair curlers (Houppert 1999, 13). This "culture of concealment" also links us to the early twentieth century practice of referring to contraception as feminine hygiene in order to avoid public engagement with women's bodily needs. Privileging a discreet design, i.e. one that hides or completely camouflages the pill pack, further proves Kapsalis' earlier assertion that "the public performance of female privates is a particularly troublesome act" (Kapsalis 1997, 5). The judging criteria reveal not only the cunning way in which Bayer brought together the main tenets of its representation of modern femininity but also the way in which those tenets are still tied to traditional notions of proper femininity, which favor discretion, silence and invisibility.

Finally, efforts to reclaim and re-design the birth control pill pack are particularly interesting given the pack's history. Andrea Tone notes,

> Presumably the 'problem' of patient compliance was remedied by the Dialpak, an oral contraceptive package introduced in 1963 to remind women to take their Ortho-Novum. Instead of getting a vial of undifferentiated pills, women could get the Dialpak, permitting them to check at a glance if they had taken their daily tablet (Tone 2001, 258).

According to Tone, David P. Wagner originally designed the Dialpak to help remind his

wife to regularly and correctly take her own birth control pills. Tone points out that the creation of the Dialpak was rooted in gendered stereotypes of women's supposedly inferior mental faculties. Unfortunately, giving the modern day contraceptive pill pack a makeover does little to challenge this sexist and offensive history.

While women's increased economic and professional independence, signaled by their consumption, emerges as a focal point in the "Beyond Birth Control" campaign, explicit references to their (hetero)sexuality are conspicuously absent. In the three YAZ commercials discussed above, men function primarily as background props that provide the context for the women's activity. Women are seen performing these activities (shopping, eating, and exercising) with each other allowing the commercials to showcase a kind of benign version of feminist sisterhood. However, this sisterhood is centered on the practice of capitalist consumption and not feminist political resistance. Nevertheless, the second commercial does explicitly evoke feelings of protest and resistance given the song choice of "We're Not Gonna Take It." Ironically enough, however, what is being resisted are women's own bodily processes as opposed to political, social, or economic injustices. In this approach to feminism and female empowerment, women are literally their own worst enemy, battling their very own bodily betrayals brought on by menstruation.

The absence of men or allusions to women's (hetero)sexual relationships is suspicious given that YAZ is, in fact, a prescription birth control agent. The primary purpose of this medication is presumably the prevention of pregnancy, which can occur as a result of heterosexual sex. YAZ, however, was heavily marketed as a tool to manage physical and emotional changes associated with menstruation rather than a tool to prevent

pregnancy. The second and third commercials actually begin by explaining that all birth controls pills are ninety-nine percent effective when taken as directed. The opening statements seem to situate the ability to prevent pregnancy as old news, a happy side effect perhaps, to the more important work of mitigating monthly bloating and irritability. In other words, in each commercial the focus is not on YAZ's ability to prevent pregnancy as much as its ability to combat the physical and emotional symptoms of menstruation that "are severe enough to interfere with your life" (U.S. Food and Drug Administration 2008, 4). Taking YAZ, so the story goes, will allow women to continue with an uninterrupted life of consumption, typified by meeting one's friends at a bar or successfully buying clothes during "that time of the month" since they won't be fighting "the bloat."

The notable absence of men in the YAZ campaign could be proof of Jane Gerhard's (2005) argument that the nature of the relationships between *Sex and the City*'s main characters constitutes a "powerful if not political" kind of sisterhood (Gerhard 2005, 39). Gerhard contends that though this sisterhood may not be powerful in the feminist political sense it nonetheless disrupts normative female heterosexuality by privileging women's relationships with each other. For Gerhard, the centrality of the women's relationship to one another gives the show queer potential:

> *SATC* is a series that has taken advantage of the narrative possibilities afforded by queerness. By "queerness" I mean narratives, images and plot structures that can be read as queer, whether or not the characters, actors or writers involved identified themselves as queer. As queer involves attempts to weaken the naturalized and normalizing binaries of sexuality (straight vs. gay) and of gender (masculine vs. feminine), it offers important insights into the show's approach to the women's desires (Gerhard 2005, 37).

Yet the queering of female heterosexuality that Gerhard identifies in *Sex and the City* is only possible because the women in the series are first, undoubtedly, constructed as

heterosexual beings. They use hypersexual dialogue with one another to describe and discuss their sexual encounters with men. Where Gerhard sees queer potential in *SATC* through its insistence on women's relationship to one another, the "Beyond Birth Control" campaign forecloses the possibility of queer modes of female heterosexuality despite its representation of women's relationships to one another. Even though the YAZ marketing campaign privileged interactions between women, the corresponding piece that identifies their heterosexuality, the thing to be potentially disrupted, is noticeably missing. The commercials' brief mention of the contraceptive properties of YAZ, through the acknowledgement that birth control is 99% effective when taken as directed by a healthcare provider, could be taken as an indication of the heterosexuality of the intended audience or potential users of the medication. However, that the contraceptive properties of YAZ are relegated to a brief two second introduction at the beginning of some of the commercials signals that the potential heterosexual activity of the audience is of little consequence to the manufacturer or to the value of the product being advertised. This is in stark contrast to *SATC*, where the heterosexual activity of the main actors forms a major portion of the show's core.

Muting the presence of men in any kind of sustained or remotely sexual way in these commercials helps to circumvent issues of women's sexuality or references to sex all together. The images of women in these commercials depict a safe or apolitical "liberated" woman. We are never forced to consider the consumers of YAZ as sexual agents as we might if they were pictured with (hetero)sexual love interests. The actual birth control properties of the medication are consistently downplayed precisely because to highlight them might force the viewer to acknowledge the nature of the activities for

which women really need birth control. For example, YAZ promises "shorter, lighter periods" which, among other things, has consequences for women's ability to circumvent social and cultural taboos that deem sex during menstruation unclean, undesirable and inappropriate. This kind of acknowledgement might also force viewers not only to consider women's sexuality but also what that sexuality looks like outside of traditional heterosexual marriage since the depictions of women in these commercials often allude to a single lifestyle.

Jane Arthurs' discussion of re-mediation, as defined earlier, is helpful in understanding how birth control advertisements adopt but reconfigure the *Sex and the City* model of modern femininity for the marketing of their products. Given that *Sex and the City* is often cited for its no holds barred approach to women's sexuality it is interesting that the YAZ campaign renders women's sexuality silent. As Jane Gerhard argues of *Sex and the City* "many critics and viewers initially believed that the sex talk was the aspect of the show that was most innovative and had the most potential to disrupt confining gender constructions" (Gerhard 2005, 45). Admittedly, birth control commercials cannot be quite as brash as the actual television show in terms of the representation of female sexuality. While *Sex and the City* originally aired during late primetime on HBO, a paid premium cable subscription, YAZ ads aired throughout the day on both network and non-premium cable TV. YAZ advertisements had to address issues of audience (i.e. children) and U.S. Federal Communications Commission (FCC) guidelines for network television in a way that *Sex and the City* did not. When *Sex and the City* finally entered syndication on cable channel TBS it too was subject to editing. A *New York Times* article described the syndicated version of the show as having been

"…razored down for size and taste, sometimes using alternate filmed scenes, most often with simple editing tricks," indicating that much of the show's straight-forward sex talk was considered too much outside of HBO (Nussbaum 2004). Yet, the YAZ advertisements would not be required to exactly mimic *Sex and the City*'s approach to female sexuality in order to represent it in a more nuanced and dynamic manner, especially since the representation of female sexuality in *Sex and the City* is not perfect by any standards. Nevertheless, the question remains, how could these commercials offer more dynamic representations of women's sexuality and relationships with each other? However, given the constraints of the advertising genre, it is doubtful that the commercials are capable of producing more nuanced imaginings of women's reproductive health and sexual practices.

Even as re-mediation allows the YAZ commercials borrowing from the *Sex and the City* model to revise the model to fit their immediate needs it does not allow them to completely recreate the model. Moreover, through the feminist analytical framework of post-feminism, *Sex and the City* itself emerges as a poor example to follow for cutting edge representations of feminist or empowered womanhood. Despite its bold disruption of normative female sexuality, the show consistently dangles the carrot of marriage and traditional heteronormative family as the women's ultimate goal. In the show's pilot episode when Miranda exasperatedly asks her friend if they plan to give up on love, Carrie responds with "Oh no, no, no, no. Believe me, if the right guy comes along, you two right here [gesturing toward Miranda and Samantha], this whole thing, right out the window" (Star 1998). Though Carrie's friends laugh at her declaration, there is more than a kernel of truth to it as the series finds all four women consistently struggling with,

almost exclusively, heterosexual relationship norms. More importantly, it is generally not the goal of advertisements to do the work of offering complex and challenging representations of anything. Advertising exists to sell, its ability or willingness to educate or advocate goes only as far the utility of those enterprises to capital and consumption. The images of the women in these commercials coupled with the idea that they are living out a modern and liberated American womanhood is but a distortion and an elision of feminist politics.

These marketing approaches, as I have read them, are but appropriations of an appropriation. *Sex and the City* itself should not necessarily be read as a feminist enterprise or, at the very least, an enterprise capable of producing nuanced representations of women's sexualities. Nevertheless, it does adopts the gains made by feminism in terms of its content but also in terms of its very ability to exist as a television show and film franchise. When asked about the show's relationship to "the women's movement," lead actor Sarah Jessica Parker responded

> These characters and the actresses playing them, reap enormous benefits from the women's movement. The characters have sexual freedom, opportunity and the ability to be successful. The have the ability to be leaders and to be strong, assertive and confident. If you grow up with the right to choose, vote, dress how you want, sleep with who [sic] you want, and have the kinds of friendships you want, those things are the fabric of who you are. But I don't think of it as a feminist show, because true feminists may take issue with certain things about the women and would want things to be different for them. Cleverly or not, we have steered clear of labeling ourselves, but that's also reflective of who we are as women (Sohn 2004, 24).

Parker's response demonstrates the show's rather ambivalent relationship to feminist politics and feminist gains. Parker identifies both the characters and female actors as beneficiaries of feminist politics but not as feminists. The refusal to identify as feminists is, for Parker, both a product of clever strategy and gendered essentialism. Jane Gerhard

speaks to *Sex and the City*'s uneasy relationship to feminism by labeling it as a post-feminist venture that "shadowboxes with history, or specifically, with second wave feminism. The ghost of 70s feminism haunts [*Sex and the City*] through a repressed, nightmarish vision of autonomous womanhood…" (Gerhard 2005, 37). Gerhard's "ghost of 70s feminism" appears in Parker's response as the mythical "true feminist" who, apparently, stands in negative judgment of the show. The very model of womanhood that the YAZ campaign looks to imitate maintains a tenuous relationship to feminist political ideals. It is the very tenuousness of the marketing campaign's relationship to feminism, vis-à-vis *Sex and the City*, which makes it so very critical.

Where Gerhard identifies the ghost of feminism as haunting *Sex and the City*, feminist media scholar Angela McRobbie argues that the show takes a much more active role in its relationship to feminism. For McRobbie, "*Sex [and] the City* works as a provocation to second-wave feminism and how it enacts a kind of gender re-stabilization by summoning the ghost of the old disapproving feminist…only to dismiss her in a flash by over-doing, quite hysterically and fearfully, the comforting rituals of femininity" (McRobbie 2008, 541). The summons and dismissal McRobbie describes are characteristic of post-feminist popular culture more generally.

Bayer's "Beyond Birth Control" campaign is an example, par excellence, of a post-feminist paradigm at work. The campaign draws on feminist themes of women's empowerment, autonomy and women's community while simultaneously directing women to find solutions through consumption, mainstream medicine and body management. Aptly, McRobbie argues, "that this popular feminist appropriation permits more subtle modalities of gender re-inscription and re-subordination to be pursued"

(McRobbie 2008, 533). In the current market, McRobbie's "subtle modalities of gender re-inscription and re-subordination" are achieved through a recasting of women's agency as patients and activists to agency as consumers of health care. Women's empowerment around reproductive health has been reduced to choosing between brands of birth control instead of advocating for more research on contraceptive options, like hormonal contraceptives for men, or investigating alternatives to oral contraceptives all together. McRobbie identifies the deployment of the rhetoric of choice and freedom as central to post-feminist popular culture; "drawing on a vocabulary that includes words like 'empowerment' and 'choice', these elements are then converted into a much more individualistic discourse, and they are deployed in this new guise…" (McRobbie 2009, 1). Susan J. Douglas, like McRobbie, returns to the tension between the individual and the collective and the role, meaning and context of choice and freedom.

Writing about the beauty industry in the 1980s, Douglas argues

> The appropriation of feminist desires and feminist rhetoric by Revlon, Lancôme, and other major corporations was nothing short of spectacular. Women's liberation metamorphosed into female narcissism unchained as political concepts and goals like liberation and equality were collapsed into distinctly personal, private desires. Women's liberation became equated with women's ability to do whatever they wanted for themselves, whenever they wanted, no matter what the expense (Douglas 1995, 246)..

Feminist struggles over reproductive justice are not just about birth control but are linked to larger critiques about the division of social and familial labor that leave women with the lion's share of the work when it comes to biological and social reproduction. Related feminist critiques around child care, parental work leave, and women's "second shift" are lost in advertisements that seek to represent feminism or women's liberation as their ability to participate as consumers. Whether one can circumvent menstrual cramps in order to meet friends for lunch or manage acne through the use of YAZ are intensely

personal issues and solutions that elide more public and systemic matters of reproduction. Yet Bayer's marketing cleverly tapped into the power behind the rhetoric of choice by depicting YAZ as a facilitator of women's choice. The company's most recent campaign for their newest product in the YAZ family, BeYAZ, best demonstrates the appeal to choice as the foundation of female freedom.

Approved by the FDA in September 2010, BeYAZ differs from its predecessor only in the addition of folate, an essential B vitamin needed by women of childbearing age to help combat neural tube defects, like spina bifida, during pregnancy. Whereas YAZ's relationship to choice was seen in its ability manage the body in terms of the physical signs of menstruation, BeYAZ is presented as a facilitator of choice explicitly through its ability to prevent pregnancy. In the first and, to date, only commercial for the new product Bayer moves away from the explicit language and imagery of body management seen in the commercials discussed earlier in this chapter and more fully and explicitly into the language of choice.

The commercial opens with the female narrator hailing her female audience by invoking the familiar "you" as in "You know what you want today but you never know what you might want to tomorrow. It's good to have choices. It's good to have BeYAZ from Bayer." The voice-over is complemented by scenes of young racially diverse women shopping in a department store like setting. Here the customers shop not for traditional consumers goods like clothes or furniture but for major life choices and experiences. Some choose travel or the purchase of a home while others choose graduate school and a new car. The unifying theme of all of these "purchases" is that they are made possible by that which is made impossible through the auspices of BeYAZ: having

a baby. Using only the clues presented in the commercial, viewers are left to assume that, once again, it is women's own bodies that will betray and hinder their choices. In the earlier YAZ commercials that betrayal came in the form of bloating and irritability. In the BeYAZ commercial it comes in the form of pregnancy.

At one point in the commercial a stork carrying a small purple bundle in its beak literally steps out of nature, depicted in the commercial by a store display of a forest, and approaches one of the shoppers as if to hawk its wares. The woman bends down to the eye level of the stork to signal that she is thoughtfully, if only briefly, considering this choice but ultimately decides to pass with a slight shake of the head and wave of the hand. Literally and figuratively leaving the stork behind, she continues to shop and ultimately chooses a trip to Paris. In this approach to life, there are no considerations of the class politics of any of these choices or of the realities of racism, sexism, heterosexism or able-ism that may truly be severe enough to interfere with women's lives. Here the presence of choice alone is represented as the key to women's liberation.

Bayer's invocation of the power of choice and its relationship to female agency and autonomy in the "Beyond Birth Control" campaign rests on a rather narrow vision of freedom. YAZ's vision of freedom closely, though perhaps not completely, follows a more traditional liberal feminist approach where equality to men is the defining characteristic of women's liberation. This approach, however, leaves unquestioned the underpinnings of men's status and simply asks that women have equal access to it. In other words, the more fundamental questions surrounding the difficulty of dating, going to graduate school, buying a home or traveling abroad while one has children are left unasked and unanswered. The solution seems not to lie in envisioning a world in which

parenting, particularly mothering, does not preclude one from these opportunities, rather the objective is to problematize the responsibility of parenting and, as a result, develop better ways to manage women's fertility.

Many feminists, however, have long critiqued the liberal feminist notion that choice is the single most important factor in women's reproductive freedom and equality overall. Rickie Solinger describes the limits of choice when she argues,

> …Choice became a capacious, empowering emblem of liberation from the tyranny of biology. "Choice" also became a symbol of middle-class women's arrival as independent consumers. Middle-class women could afford to choose. They had earned the right to choose motherhood, if they liked. According to many Americans, however, when choice was associated with poor women, it became a symbol of illegitimacy. Poor women had not earned the right to choose. As dependents they could not afford the right to choose. As dependents they were categorically excluded from good choice making (Solinger 2001, 199–200).

Solinger firmly locates choice as a middle-class privilege and reveals the ways in which it is policed in the context of poor and working-class women. Liberal feminist approaches to choice as the linchpin of women's equality, silently conflate choice with economic privilege while simultaneously claiming that choice should be available for all women. Yet, for some women having or not having children has no bearing on their ability to attend college or take international trips. Family income, quality of secondary education along with crime and criminal justice surveillance often constrain the types of choices presented in the BeYAZ commercial long before the issue of pregnancy arises. Feminists of color organizing around women's reproductive health care coined the term reproductive justice as a way to account for the larger web of forces that structure women's abilities to choose (Silliman et al. 2004).

The disavowal of feminist politics in the YAZ promotional campaign allows representations of birth control and of feminism to ignore real concerns from feminist

activists about the continued marginalization of women on a number of fronts. Moreover, the concerns outlined in this chapter regarding the kinds of women afforded representation in the YAZ campaign as well as the veracity of the information presented in the campaign, are particularly important in the consideration of issues of public education or how and in what contexts we come to learn information about female sexualities and reproductive health. Stated otherwise, what is at stake when the commercial discourse of advertising comes to constitute a major piece of our collective public education about contraceptive options and other women's reproductive health matters?

Pulling Back the Covers: The Underside of Medicated Sex

The Comstock laws arguably went too far in their attempt to regulate away all forms of commercial visibility for contraception. However, advertisements for contraceptives are not the best and certainly should not be the only source our social and individual education about reproductive health care options, female sexuality or women's liberation. As of October of 2008, the FDA cited the pharmaceutical giant Bayer for false advertising in its commercials for YAZ. In a letter faxed to Reinhard Franzen, CEO of Bayer Pharmaceuticals, the FDA argues,

> The TV ads *entirely omit* the material limitation from the PI of the drug's PMDD indication—i.e., that "YAZ has not been evaluated for the treatment of premenstrual syndrome (PMS)"—and fail to convey that the drug is only indicated for women who experience the symptoms presented to such a degree that they have PMDD, rather than PMS. As a result of the failure to convey these material facts, and the failure to explain what PMDD is, in contrast to PMS, the TV ads misleadingly suggest that YAZ is approved to treat women with any severity of the symptoms presented, regardless of whether their symptoms are actually severe enough to constitute PMDD (e*mphasis added*) (U.S. Food and Drug Administration 2008, 4).

The FDA's letter also argues that the YAZ ads divert attention away from information

about potential side effects of the drug,

> The audio communication of serious risk disclosures during the "major statement" is minimized by distracting visuals, numerous scene changes, and other competing modalities such as the background music which combine to interfere with the presentation of the risk information….*The overall effect of the distracting visuals, graphics, concurrent supers and background music is to undermine the communication of important risk information, minimizing these risks and misleadingly suggesting that YAZ is safer than has been demonstrated by substantial evidence or substantial clinical experience* (emphasis added) (U.S. Food and Drug Administration 2008, 6).

The FDA letter aptly demonstrates the inadequacies of birth control advertising as a (primary) form of social and reproductive health education. There is so much information that is not provided in advertising because its negative implications could interfere with positive representations of the product and, ultimately, its sales. The letter further indicates that the misleading components of the commercials were not oversights but direct and explicit strategies used by the advertisers to misinform potential consumers in order to drive sales.

Moreover, this is not the first time pharmaceutical companies, like Bayer, have been cited for false advertising in general and specifically in the case of oral contraceptives. According to *The New York Times*, in 1999 the FDA issued a similar letter to Pharmacia and UpJohn regarding its injectable contraceptive Depo-Provera, “likewise, the Government said, information about the risks of Depo-Provera, an injectable contraceptive, was jumbled in the audio and visual parts of a television commercial. The multiple messages ‘virtually insure that consumers will have trouble fully comprehending any of the information’” (Pear 1999). Understanding the side effects of a drug like Depo-Provera are quite important because it, unlike the pill or the once-monthly vaginal ring contraceptive, Nuvaring, cannot simply be discontinued once

adverse side effects set in. As an injectable contraceptive, users must wait for the contraceptive to run its three-month course through their bodies and, subsequently, endure any and all side effects produced as a result of the drug.

In addition to the deceptive character of these commercials, it's also important to think about who is represented in the commercials as well as who is not. As much as the advertisements offer information about YAZ as a reproductive health option, they also teach viewers about the ideal users of these products through the representations they employ. The YAZ campaign used young, unmarried, thin, middle-class, and overwhelmingly white women as the standard for representing contemporary women's lives and health needs. When limited representations like those of the "Beyond Birth Control" campaign, are the terms of the public debate, it becomes impossible to talk about the competing histories of contraceptive triumphs and abuses in U.S. that had varying impacts for different groups of women.

It is not surprising that women of color are often missing from the YAZ commercials or appear in limited numbers given the history of oral contraceptives. A history that, rooted in eugenicist and population control ideologies, often deemed poor women and women of color unfit for proper use of the Pill. Scholars such as Dorothy Roberts (1997) have written about the dangerous side effects of Depo-Provera and the use of poor and working class Black and Latina women as its target demographic.

Roberts argues

> Depo-Provera has an alarming track record for abuse both in the United States and in developing countries. American doctors, who had access to the drug as a cancer therapy even before its approval for contraceptive use, regularly administered it to Southern Black and Native American women for birth control (Roberts 1997, 145).

For Roberts the misuse of Depo-Provera is linked to racist population control narratives

that sought to curb the fertility of people of color in the U.S. and in the Global South. Roberts' argument regarding Depo-Provera helps to demonstrate the ways in which particular bodies are imagined as better suited to certain contraceptive technologies over others. Andrea Tone concurs with Roberts in her work on U.S. contraceptive politics and the intrauterine device (IUD) in the 1960s and 70s,

> Within a political environment replete with racists and elitist stereotypes regarding women's procreative identity, policy makers, legislators and population control proponents evaluated the Pill. Fears of the consequences to *taxpayers* of noncompliance among women of color and poor women exaggerated suspicion that only middle-class women, presumed to be white, educated, and responsible, could be 'trusted' to swallow a pill for twenty consecutive days (Tone 2001, 259).

The YAZ campaign is a prime example of the way that ideal users continue to be imagined and communicated in contemporary contraceptive politics. The centrality of white, middle-to-upper class able-bodied women in YAZ's promotional materials renders other women invisible and inconsequential in the trendy landscape of birth control as designer commodity. From earliest days of the development and production of contraceptives, there have been ideas about which bodies and which lives fit as ideal users for different contraceptive technologies. Bayer Pharmaceuticals' YAZ is deeply implicated that history and its contemporary manifestations.

In response to the FDA warning, Bayer agreed to run a $20 million corrective ad campaign. The main commercial used in the campaign returns to the original Beyond Birth Control ad discussed at the beginning of this chapter. In this commercial the audience is no longer posed a voyeur, watching a scene among friends unfold. Rather, the friends are not present and the viewer is invited into a one-on-one conversation with the same "doctor" featured in the first commercial. The actor holds her gaze with the camera and thus with the viewer, creating a conversation between the two about YAZ.

The commercial's dialogue consistently uses the pronoun "you" as a way to further establish the connection between commercial and viewer. The sixty-second spot opens with the actor looking directly into the frame, saying, "You may have seen some YAZ commercials recently that were not clear. The FDA wants us to correct a few points in those ads." There is no pretense about why we, the audience, have been called into this conversation. For the duration of the commercial, the actor's face dominates the frame, at times completely filling it and eclipsing all other bodies and activities occurring in the background. The close-up shots are used specifically to punctuate important information about YAZ that Bayer must get right or else face additional sanctions from the FDA. The dialogue is delivered slowly and deliberately and is supported by on-screen text further explaining or summarizes the information.

The corrective campaign returns to my earlier question regarding whether it is at all possible to look to contraceptive advertising for more sound representations of women's sexual health and practice. The corrective ads do nothing to present alternate forms of representation, either for the product or the target audience. Though the address deployed in the commercial is markedly different from its predecessor, not much else has changed. The audience still encounters the young doctor in stylish dress at the same rooftop bar. The "distracting visuals" have been minimized in accordance with the requirements of the FDA but the narrative devices that craft a particular image around youthful, stylish, responsible, and modern woman are still firmly in place.

If, as all of these commercials suggest, being a smart, young, successful and modern woman requires using hormonal birth control, what do we make of the women who refuse it or question its suitability for their bodies and lives? One of the most

obvious dangers of the YAZ lifestyle narrative is that it implicitly works to set up a dichotomy between the "kind" of women who use oral contraceptives and those who don't. The public recognition of birth control, and by extension women's reproductive health, as important and attention worthy creates the opportunity for new modes of surveillance of women's reproductive health and sexual practice. In this "new" reproductive ethic, birth control becomes a marker of modernity as it is presented as a protector and enabler of choice, which emerges as key currency. This move marks women who choose to use birth control, and more specifically YAZ, as responsible, progressive and modern while women who refuse birth control are marked as irresponsible and unmotivated.

Chikako Takeshita describes a similar scenario with efforts to recuperate the intrauterine device (IUD) after the fallout from the scandal of its poor design and subsequent consumer health scare in the 1970s and early 1980s. According to Takeshita, desperate to restore its image as a safe and reliable technology, supporters of the IUD attempted to direct attention away from the device and onto its users.

> The second step in securing the future of the IUD entailed placing the blame on the users' sexual activities…By redefining the appropriate user, developers were able to argue that the technology was actually inherently safe and that it had been inserted in the wrong women in the past (Takeshita 2010, 45–46).

Takeshita's "wrong women" correspond with the "sexually irresponsible" or, at the very least, unsophisticated women silently invoked in contemporary birth control advertising. Both of these categories of women violate proper heteronormative female sexuality and, as a result, find themselves on the margins of meaning and thus of medical representation and advocacy. Yet, these concerns around representation, advocacy and identity are unable to emerge in a discourse that presents itself as simply being about choice and

opportunity.

Given the misleading information in Bayer's Beyond Birth Control campaign and its reliance on hollow invocations of female empowerment, it is critical that women and feminist health advocates consider other ways to educate and inform ourselves about reproductive health while recognizing that alternate manners of address are not possible without explicit connections to feminist history and politics. Alternative sites of information on women's hormonal birth control are important not only for the perspectives they allow for but also because they help put control back in women's hands.

Chapters Three and Four will return more fully to the issue of alternative sites of information on women's health. The next chapter, however, will move into a more in-depth discussion of the Food and Drug Administration's scrutiny of Bayer's "Beyond Birth Control" campaign. The FDA, along with twenty-eight states, levied disciplinary actions against Bayer for its YAZ marketing strategy. This next chapter places Bayer's battle with the FDA over marketing YAZ in a larger historical context of similar battles over marketing treatments for PMDD, one of YAZ's major indications. This chapter will address the character of public and governmental anxieties around women's reproductive health and safety and how those anxieties produce particular kinds of representations and rhetoric.

Chapter Two:
Regulating YAZ: Governmental Interventions, Consumer Protection and DTC Advertising.

> *Bayer, Dr. Dinger, I hold you accountable. Why was she not told? She had a right to know clear and accurate, true information. I am here to say today that I do not want other daughters, other women, to die because the information is unclear…Europe, where you live, Dr. Dinger, warns of a higher risk. Australia warns. Canada warns. England warns. England tells their daughters that the totality of available evidence now clearly shows that the risk of venous thromboembolism for Yasmin is higher; higher, not the same, not questionable, not unclear. Higher.* (Cindy Rippe[1] as quoted in U.S. Food and Drug Administration 2011b, 235).

Cindy Rippe spoke the above words as she testified on behalf of her daughter, Elizabeth, at a December 2011 joint meeting of the FDA's Advisory Committee for Reproductive Health Drugs and Drug Safety and Risk Management Advisory Committee. The meeting was called to discuss the safety and efficacy of YAZ and other oral contraceptives that contained the progestin drospirenone (DRSP). Cindy Rippe testified on her daughter's behalf because Elizabeth died three years earlier on Christmas Eve 2008 due to complications associated with taking YAZ. Rippe's story of loss and anger over the oral contraceptive was one of several told at the meeting. For Rippe, and many others, the pain, suffering and death of women using YAZ and other DRSP oral contraceptives was completely preventable if those women had been properly informed about the risks associated with the drugs. The anger of former DRSP contraceptives users and their families is further justified when we consider that the FDA's joint meeting was a culmination of more than three years of high profile scrutiny of Bayer's DRSP family of contraceptives by governmental entities like the FDA. I take up Rippe's simple yet

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[1] The FDA meeting transcript lists the spelling of the last name as Rippy. Subsequent research, including a review of follow-up media and an obituary for Elizabeth Rippe, has revealed that the last name is correctly spelled Rippe.

[2] Final Judgment at 6, People of the State of California v. Bayer Corp., No. GIC 878812

poignant question of "why was she not told," by examining governmental and regulatory responses to Bayer regarding their family of DRSP oral contraceptives.

In October 2008, just months before Elizabeth Rippe's death, Reinhard Franzen, then President and Chief Executive Officer of Bayer Healthcare Pharmaceuticals, received a warning letter from the FDA's Division of Drug Marketing, Advertising and Communications (DDMAC). The letter concerned two broadcast commercials, "Not Gonna Take it" and "Balloons," that were part of Bayer's popular and successful "Beyond Birth Control" promotional campaign for the oral contraceptive YAZ. As discussed in Chapter One, the letter claimed that the two ads were misleading on three fronts: (1) the representation of the drugs intended purpose or indication, (2) representation of the drug's efficacy, and (3) the commercials' explanation of the risks associated with taking YAZ. Moreover, the FDA claims that misinformation presented in the commercials violates several provisions of the Federal Food, Drug and Cosmetic Act and, as a result, should be corrected immediately. The warning letter was an early sign of the troubles to come for the popular oral contraceptive.

As a pill that went beyond the basic work of contraception, YAZ was approved to treat the symptoms of PMDD (Premenstrual Dysphoric Disorder) and "mild-to-moderate" facial acne (put a footnote here to explain mild to moderate). These indications were particularly important to the ways in which YAZ was able to distinguish itself from other contraceptive competitors and market itself to potential users. For the FDA, the YAZ marketing "misleadingly suggest[s] that YAZ is effective in a broader range of patients and conditions than has been demonstrated by substantial evidence or substantial clinical experience" (U.S. Food and Drug Administration 2008). Wahneema

Lubiano's critical framework of "cover stories," (Lubiano 1992) provides a compelling framework through which to examine the discourse of public and governmental anxieties around women's reproductive health and safety through an analysis of the FDA's regulation of YAZ marketing.

Writing about the spectacle of the 1991 Clarence Thomas confirmation hearings, Lubiano argues that the Hill/Thomas debate was a well-orchestrated cover story. Lubiano maintains that the media coverage of the Thomas hearings constructed a *cover story* that kept public interest focused on the relationship between Hill and Thomas and on an simplified approach to race, specifically blackness. *Cover stories*

> Cover or mask what they make invisible with an alternative presence; a presence that redirects our attention, that covers or makes absent what has to remain unseen in the *seen* is to function as the *scene* for a different drama. One story provides a cover that allows another story (or stories) to slink out of sight. Like the 'covers' of secret agents, cover stories are faces for other texts, different texts. They are pretexts that obscure contexts, fade out subtexts, and, in the case of the Clarence Thomas hearings, protect the texts of the powerful [emphasis in original] (Lubiano 1992, 324).

For Lubiano, the *cover story* obscured more complicated engagements with the ways in which state power, as well as the power of racial and class privilege, functioned in relationship to Thomas and in opposition to Hill.

Lubiano's term "cover stories" is used here as a way to understand the multiple ways that YAZ was presented to the public. What do the narratives of the FDA warning letters, proceedings and other relevant documents reveal about the concerns and issues regarding YAZ and about governmental advocacy for women's reproductive health? In what ways do these narratives come to function as *cover stories*, obscuring other kinds of meaning and meaning-making processes? The chapter begins with an examination of the early warning letters sent regarding the marketing of YAZ sent to Bayer Pharmaceuticals

by the FDA's DDMAC. The chapter moves on to other examples of the FDA's scrutiny of both Bayer and other prescription women's health drugs. I close the chapter by examining the recent FDA hearings regarding YAZ's labeling practices and its suitability for sale given new information about its relationship to increased risk of blood clots.

Advertising Health: Understanding the History and Role of DTC Advertising

The history of Direct-to-Consumer (DTC) advertising is a long and winding one, dating back as early as 1906 with the Wiley Act, which regulated product labeling with regard to truthfulness of claims of effectiveness and therapeutic benefits (Palumbo & Mullins, 2002). Regulation and control over the labeling and marketing of Over-the-Counter (OTC) and prescription only medication shifted back and forth between the U.S. Food and Drug Administration and the U.S. Federal Trade Commission until 1971 when the FDA was given "explicit and primary authority over prescription drug advertising (Palumbo & Mullins, 2002, 428). The first print DTC advertisement was issued in 1981 and the first broadcast ad followed two years later in 1983. By 1985 the FDA released guidelines for DTC advertising (Palumbo & Mullins, 2002). Early advertisements were mainly print ads, when more broadcast ads began to enter the market the FDA found that the existing regulations were insufficient. The FDA issued draft guidelines regarding broadcast DTC advertising in 1997, and they were formalized in 1999. These new regulations relaxed certain requirements regarding the "brief summary," which is required of all DTC ads and should "provide the drug's side effect, contraindications, warning and precautions as well as the indications for use" (Palumbo & Mullins 2002, 428). In order to satisfy the "brief summary" requirements within the confines of a thirty second broadcast commercial, the FDA developed the "adequate provision" requirement.

“Adequate provision” offered alternatives to the brief summary requirement by relieving broadcast ads of the responsibility of listing complete risk information. Instead the ad only had to make provisions for viewers to access complete product labeling, which included risk information. The adequate provision requirement could be met, for example, if a broadcast commercial directed viewers to a website where more information on the product could be found or to a 1.800 number where further information could be requested. As companies no longer had to figure out how to fit large amounts of technical risk information into a short commercial, the adoption of the “adequate provision” policy made it easier for pharmaceutical companies to enter into broadcast DTC marketing and sparked a surge of new DTC advertisements.

The 1997 change in the FDA regulations not only opened the door for broadcast commercials; it also resulted in the heightened level of visibility for DTC pharmaceutical marketing. Even though print DTC advertisements had been around since the mid eighties, broadcast commercials significantly raised the profile of pharmaceutical marketing. While one might have to find the right publication or the right magazine issue to encounter DTC print advertising, the ubiquity of television made broadcast advertisements more broadly accessible and, thus, visible. Moreover, given the limited availability of publicly accessible health information, DTC marketing of pharmaceuticals becomes an important site of potential information. As pharmaceutical companies and the FDA aimed to take advantage of the possibilities of broadcast DTC advertising, they struggled to blend the commercial requirements of advertising, to sell a product, with the unique public health responsibilities that come along with advertising prescription drugs.

The FDA acknowledges the public health role of DTC advertising in their initial 2008 warning letter to YAZ, writing "these violations are concerning from a public health perspective because they encourage use of YAZ in circumstances other than those in which the drug has been approved, over-promise the benefits and minimize the risks associated with YAZ." (U.S. Food and Drug Administration 2008). The aforementioned warning letter to YAZ is a good example of the regulatory and compliance issues brought about by broadcast DTC advertising. The following section explores the letter and its connection other, similar pharmaceutical marketing issues seen in women's health marketing.

Warning, Warning: Danger Ahead!

While the FDA and other regulatory bodies argue that DTC advertising serves an important function by informing and therefore empowering consumers, they continue to struggle with the most appropriate ways to ensure that that function is being achieved in an honest and intelligible fashion. The FDA's 2008 warning letter to YAZ contended that the ads are guilty of "broadening the indication" of YAZ in regards to its treatment of women's premenstrual symptoms and acne. The letter argues that the broadcast advertisements do not adequately distinguish the mood disorder PMDD from the more common PMS, leaving viewers of the commercial to confuse the two and think that YAZ is also appropriate for the treatment of PMS. The letter also states that although YAZ is approved to treat moderate acne, the commercials suggest that "YAZ is indicated for acne of all severities," again leading viewers to think YAZ will perhaps be useful in situations for which it has not been tested or approved.

The FDA also takes issue with Bayer's representation of YAZ's efficacy, again, in terms of treatment of both PMDD and acne. The 2008 letter claims that through the use of music and visuals, the ad "Balloons," described in Chapter One, implies that "women are saying 'goodbye' to their symptoms and are now symptom-free, when such elimination of symptoms has not been demonstrated by substantial evidence or substantial clinical experience" (U.S. Food and Drug Administration 2008). The letter additionally states that "the overwhelming impression conveyed by the TV ads is that treatment with YAZ results in clear, acne-free skin for those women suffering from acne;" the letter goes on to note, though YAZ saw some strong improvement in subjects' acne in clinical trials, these results "do not demonstrate that YAZ results in clear, acne-free skin for a typical woman; rather, these results demonstrate that it reduces the amount of acne lesions more than placebo but does not result in completely clear skin for these women" (U.S. Food and Drug Administration 2008). Finally, in what would eventually become the linchpin of YAZ's governmental and regulatory troubles, the letter indicates that these commercials failed to adequately convey the risks associated with use of YAZ. Moreover, when the risks are represented, the letter contends the commercials work to minimize them through distracting visuals and audio.

Just six months after the October 2008 letter, the FDA sent yet another written warning to Bayer Pharmaceuticals in March of 2009 regarding its online marketing of YAZ and two other drugs, Mirena and Levitra. As with the broadcast portion of its marketing scheme, this letter argues that the company's sponsored links on search engine results overstate the effectiveness of the drugs in question, fail to communicate pertinent risk information for each drug and do not clearly represent each drug's indication.

Regarding the omission of risk information, the 2009 letter notes, "this omission of risk information is particularly concerning as one these products, YAZ, has a Boxed Warning" (U.S. Food and Drug Administration 2009, 3). By citing the boxed warning, which is the FDA's strongest warning for pharmaceutical risk information on a product's label, the letter acknowledges that YAZ carries increased and, perhaps, unique risks of which potential users must be warned.

Though both of the FDA's warning letters note several major issues in Bayer's representation of YAZ, they do so almost exclusively through narratives of regulatory compliance. Yet, as noted earlier, the FDA claims to understand DTC advertising as a tool of consumer empowerment and public information, both of which include but go beyond matters of basic regulatory compliance. The letter speaks little of the women who may or are already using YAZ as a contraceptive and/or a more general tool of bodily regulation. The letter is a measurement of the extent to which Bayer acknowledges and satisfies the FDA's requirements for broadcast advertising of prescription drugs. The warning letter centers abstract and impersonal regulations and minimizes the costs and harm to actual women. Yet, the FDA's letter is one of only a handful of regulatory interventions concerning YAZ and its impact on actual and potential users. The letter, then, is particularly important to considerations of how critique and intervention can be made regarding women's health in U.S. political and public debate. What does this letter tell us about the tenor of this and other regulatory/governmental responses to YAZ? In particular, how do the 2008 letter and other regulatory actions that followed it obscure or reveal the major actors involved in YAZ's public tenure? Finally, how are the various actors positioned and recognized in

relation to one another and to the product? Addressing these questions will reveal the main themes and *cover stories* embedded in the regulatory discourse surrounding YAZ.

Déjà Vu: Revisiting Sarafem and Earlier Marketing Strategies for PMDD

In 1999, faced with the loss of its exclusive patent on the popular depression treatment Prozac, Eli Lilly pushed for the inclusion of Premenstrual Dysphoric Disorder as one of the conditions Prozac was able to treat. Lilly was successful and a year later, in July 2000, the FDA approved Prozac, rebranded as Sarafem, as a treatment for PMDD. Eli Lilly immediately began marketing the drug's new indication with a physical makeover for the actual pills, changing the color from green and yellow (Prozac) to pink and lavender for those that would be sold under the Sarafem brand.

The gendered underpinnings of the Prozac-to-Sarafem color change are so obvious that it seems unnecessary to examine them further. Yet, their transparency is precisely why they must be examined. It reminds us that even in the contemporary moment of women's advancement and claims of post-feminism, some conservative notions of gender, no matter how patronizing, are so accepted as innocuous that they do not require *cover stories*. Product marketing, which includes matters like pill color, serves as cultural shorthand, invoking deep-seated discourses of identity, meaning and value. In the case of Prozac's conversion to Sarafem, a change in color denotes a change in gender focus since lavender and, most certainly, pink are tied almost exclusively to femininity. Eli Lilly drew on normative gender discourses to communicate the new target audience for their rebranded drug. The company also began a DTC ad campaign aimed at introducing PMDD to a consumer audience and presenting Sarafem as an appropriate intervention and treatment for PMDD.

The broadcast component of the marketing campaign included a commercial, entitled "Shopping Cart," which a depicted a frustrated middle-aged white woman trying to make it through a rather aggravating trip to the grocery store**.** The commercial begins by focusing on the woman's inability to a retrieve a metal shopping cart from the stack of carts standard at any grocery store. A female voice-over instructs both the viewer and the woman in the commercial to "Think about the week before your period." The disembodied voice then asks, "Do you feel irritability, tension, tiredness?" As each of these three words appears, one-by-one, on the screen, the frame freezes on a close-up of the woman's annoyed face. The commercial cuts to a green screen and the words "Think it's PMS? Think Again" appear on screen in time with the voice-over. The commercial cuts back to a view of the woman still wrestling with the shopping carts, this time we see her from inside the store as she stands outside one of the large commercial windows becoming increasingly agitated and physically violent with the carts. The voice-over instructs us, "It could be PMDD. Premenstrual Dysphoric Disorder." As she says these last three words, the commercials cuts back to an outside shot and the words appear on screen. The voice-over continues, "You know, those intense mood and physical symptoms the week before your period." In order to fully demonstrate that these cart troubles are about the individual woman's unrecognized/undiagnosed premenstrual issues and not about the inevitable and routine blunders of navigating metal shopping cart usage, a black woman appears on screen next to the frustrated white woman. This woman is able to retrieve a cart with complete ease and quickly walks away leaving her white counterpart completely befuddled at her own inability to complete such a seemingly simple shopping task. The woman is able to finally "free" the cart just as the

voice-over says "Sound familiar? Call to get free information about PMDD and a treatment your doctor has to relieve its symptoms. Why put up with this another month?" The commercial ends with the woman walking away still frustrated, demonstrated by her accidently running the newly liberated shopping cart into several other carts.

This commercial, released seven years before the first YAZ ads mirrors those later commercials in several ways. In this commercial, as in the YAZ ads, the woman is unable to engage in appropriately feminine behaviors, like shopping, rendering her femininity peculiar and in need of intervention and management. Menstruation and the bodily changes it brings each month are imagined as something akin to an auto-immune disorder in relation to women's appropriate feminine roles, attacking their ability to fully participate in those roles and achieve proper identification and satisfaction as women. The commercial further foreshadows the representational work of the "Beyond Birth Control" campaign in its treatment of PMDD. In this commercial, PMDD is defined in relation to PMS. PMDD is marked by being more intense, more difficult and thus more prohibitive than PMS. Just as a loose classification of PMDD would make YAZ and Bayer Pharmaceuticals the target of the 2008 and 2009 FDA warning letters, Eli Lilly's Director of U.S. Regulatory Affairs, Gregory Brophy, received an untitled warning letter from the FDA in November 2000.

In the Eli Lilly letter, the FDA "…concluded that [the commercial was] misleading, lacking in fair balance, and therefore in violation of the Federal Food, Drug and Cosmetic Act and its applicable regulations" (U.S. Food and Drug Administration 2000, 1). The letter argues

> The imagery and audio presentation of the advertisement never completely define or accurately illustrate premenstrual dysphoric disorder (PMDD) and there is no

> clear distinction between premenstrual syndrome (PMS) and PMDD communicated. Consequently the overall message broadens the indication and trivializes the seriousness of PMDD" (U.S. Food and Drug Administration 2000, 1).

At the request of the FDA, Eli Lilly pulled the "Shopping Cart" ad that same month. What is most intriguing about Sarafem's representational problems is that they are repeated almost exactly by YAZ only seven years later. That Bayer is able to replicate the very same violations with regard to defining PMDD and presenting risk and efficacy information raises serious questions about the effectiveness of the FDA's advocacy and intervention in the name of consumer protection. More specifically, this demonstrates the limits of imagining consumer protection as regulatory compliance and of limiting public health advocacy, with respect to advertising, to consumer protection models. How might YAZ's representations of women's menstrual health have differed if the initial Sarafem intervention had included critique about the overall representation of women and their health needs and instead of only focusing on the presentation of risk information?

Uncovered: The Baycol Backstory

While Sarafem offered an early look at what would become the primary representational concerns for YAZ, it was another Bayer Pharmaceutical medication that would serve as the foundation for YAZ's undoing. Approved by the FDA in 1997, Baycol was apart of a group of drugs known as synthetic statins, which worked to lower cholesterol and prevent heart disease. Like all drugs, statins came with some potentially serious side effects including the development of rhabdomyolysis, or the serious deterioration of muscle tissue. Unlike other drugs in the statin class, Baycol carried an increased risk for rhabdomyolysis and, for some using Baycol, that risk was fatal. As the FDA noted in a "Talk Paper,"

> Cases of fatal rhabdomyolysis in association with the use of Baycol have been reported significantly more frequently than for other approved statins. Fatal rhabdomyolysis reports with Baycol have been reported most frequently when used at higher doses, when used in elderly patients, and particularly, when used in combination with gemfibrozil (LOPID and generics), another lipid lowering drug (U.S. Food and Drug Administration 2001).

Indeed by 2001, 31 rhabdomyolysis deaths in the U.S. had been linked to Bayer's Baycol and another 21 deaths internationally (Furberg & Pitt 2001, 205). As a result, Bayer decided to voluntarily withdraw the drug from the market worldwide.

Following their decision to recall Baycol, Bayer issued a "Dear Doctor" letter, aimed at physicians, to explain their decision. In the letter, Bayer seems to strongly suggest that their chief reason for removing the drug from the market were the poor prescription habits of prescribing physicians:

> Bayer Corporation has already placed a contraindication in the Baycol product prescribing information sheet against co-prescription with gemfibrozil and issued letters to healthcare professionals warning against co-prescription of these two drugs. Despite these and other actions, Bayer has continued to receive reports of rhabdomyolysis when gemfibrozil is prescribed as a co-medication. Since the co-prescription of Baycol and gemfibrozil has continued despite communications by Bayer against this practice, the company has decided to take the following voluntary action to prevent further cases of rhabdomyolysis: **Effective immediately, Bayer has discontinued the marketing and distribution of all dosage strengths of Baycol. Patients who are currently taking Baycol should have their Baycol discontinued and be switched to an alternative therapy** (emphasis in original) (Bayer Pharmaceuticals 2001).

Though the co-prescription of Baycol with the drug gemfibrozil increased the likelihood of serious side effects, higher dosages of Baycol alone were also known to cause serious complications. The company introduced higher dosages of Baycol in both 1999 (0.4mg) and 2000 (0.8mg) amid reports of lower efficacy rates of its original dosage of 0.2mg. The company itself notes in the same "Dear Doctor" letter, "Our ongoing scrutiny of post marketing reports of rhabdomyolysis, including fatalities, has revealed an increased reporting rate of rhabdomyolysis with Baycol relative to other statins, especially when

gemfibrozil is co-prescribed. *These data also suggest an increased reporting rate of rhabdomyolysis at the 0.8mg dose of Baycol alone* (my emphasis)" (MacCarthy 2001). Despite voluntarily removing the product from the market, it is clear that Bayer finds fault not with the products but with the prescribing physicians.

Bayer's unwillingness to take responsibility for the safety and efficacy failures of its products are especially questionable since it was later revealed that at least some officials in the company were aware of complications associated with taking Baycol in higher dosages. Just one day after the drug was approved by the FDA in 1997, a company executive sent an email stating his concerns about Baycol's potentially dangerous interactions with other drugs, noting Baycol could cause "drug interactions that could be magnified at higher doses" (Petersen and Berenson 2003). Moreover, company officials also exchanged emails that demonstrated their anticipation of physician compliance complications with regard to proper prescribing. As the *New York Times* reported,

> Some Bayer executives, however, were aware that doctors might ignore the label change. In August 2000, Laurie Simpson, a manager in Bayer's strategic analysis division, wrote to Tig Conger, vice president for cardiovascular and metabolic marketing, saying, "If the physician's experience is that he/she has safely used combinations in the past, tendency would be to discount the contraindication" (Petersen and Berenson 2003).

Bayer's seemingly benevolent decision to take Baycol off the market did not protect them from consumer and regulatory inquiries into their accountability for the drug's dangerous failure. As documents surfaced as a part of consumer legal action against Bayer regarding Baycol, it became clear that the company knew or at least suspected greater safety risks than were communicated to the larger public. It is estimated that worldwide, some six million individuals used Baycol by the time it was removed from the market

four years after it was approved and introduced in the U.S.. Given its widespread use, notifying the general public about serious health implications associated with the drug should have been paramount. As a result of its failure to notify prescribing physicians and consumers, Bayer was met with an enforcement action pursued by the Attorneys General of thirty U.S. states, in which "the Attorneys General allege that while Bayer informed the U.S. Food and Drug Administration about these adverse effects, Bayer failed to adequately warn prescribers and consumers about them" (Delaware Department of Justice 2007). As a part of the action, Bayer reached a settlement in which they agreed to pay a total of eight million dollars to the states involved and agreed to obey all appropriate regulations regarding the marketing of its products. Despite these interventions, Bayer still refused to admit wrongdoing on its part with regard to the development, promotion, and sale of Baycol.

The Baycol story is important for understanding Bayer's troubles with YAZ because it laid both the regulatory and ethical groundwork for the company's representation failures in the YAZ campaign. The 2007 judgment regarding Baycol would serve as the framework through which those same thirty states would reconvene barely a year later and bring new action against Bayer, this time over the "Beyond Birth Control" campaign. The participating Attorneys General argued that the YAZ campaign violated the Final Judgment in the 2007 Baycol matter, which required that Bayer must "comply with all applicable laws and regulations relating to the marketing, sale and promotion of its products. Bayer shall not make any false, misleading or deceptive representation regarding any of its Products in violation of any applicable laws and

regulations…"[2] The 2008 letter to Bayer from the FDA concerning the broadcast commercials constituted a violation of the 2007 Baycol settlement agreement and set into motion the last seven years of Bayer's struggles over YAZ. The result of Bayer's 2008 violation was a modification to the original 2007 Baycol settlement judgment. The modification required Bayer to "disseminate corrective advertising that addresses the issues identified in the warning letter…[and] to spend a least $20 million on this corrective advertising campaign."[3]

More than the legal connection, Baycol and YAZ are connected in that they both point to a central and recurring issue for Bayer Pharmaceuticals specifically and DTC advertising more generally: representation. In both the case of YAZ and Baycol, the main issue is whether Bayer adequately informed both physicians and the general public of the benefits as well as the risks associated with using their products. The FDA refers to this as the "fair balance" requirement of DTC advertising. In 1999, barely two years after the drug was approved, Bayer received a warning letter from the FDA's DDMAC regarding its promotion of Baycol. The letter accuses Bayer's promotional materials of overstating the efficacy of the drug in relation to other statins on the market and of lacking equitable presentation of both efficacy and risk information. In other words, as with the YAZ campaign, Bayer overstated the value of Baycol while downplaying its risks.

Bayer, like all drug makers, is routinely confronted with a difficult task in terms of the representation of their products. The purpose of product promotion is to drive

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[2] Final Judgment at 6, People of the State of California v. Bayer Corp., No. GIC 878812 (Super. Ct. Cal. Jan 23, 2007).

[3] Stipulation for Modification of Final Judgment and [Proposed] Order at 3-4, People of the State of California v. Bayer Corp., No. GIC 878812 (Super. Ct. Cal. Feb. 6, 2009).

sales, which is usually achieved through highlighting the benefits of a particular product. In the case of pharmaceutical product promotion, there is a public health imperative that calls on companies to educate potential consumers and prescribing physicians about the risks associated with the use of the product as well. These two imperatives of pharmaceutical product promotion, public health and sales promotion, are in many ways profoundly at odds with one another. Stated otherwise, the goals and requirements of DTC advertising are fundamentally irreconcilable. Moreover, there is no real force to push for the reconciliation of these twin motives as profit-based approaches often win out over models that privilege citizen agency and empowerment through information gathering and informed decision making.

While the FDA may mete out certain penalties or State Attorneys General may come together in joint action against a particularly egregious organization, they are not able to devise sanctions and penalties stiff enough to fundamentally roust these billion dollar companies and their commitment to ethical business practices. Bruce Lambert, a professor in pharmacy administration at the University of Illinois “lauded the F.D.A. for insisting this time that Bayer run a corrective advertising campaign. But he referred to the corrective $20 million ad campaign for YAZ as ‘chump change’ and ‘just the cost of doing business. I don’t think it is likely to stop,’ he said, ‘unless there are more significant consequences’ (Singer 2009). Lambert’s less-than-optimistic response is further vindicated by the actual language of the both 2007 and 2009 Judgments in which Bayer concedes absolutely no wrong doing. The Stipulation for Modification of the Final Judgment reads, in part

> Defendant Bayer enters into this Modification solely for the purpose of resolving the investigation by the Modification Signatory Attorneys General…and to avoid

> unnecessary expense, inconvenience, and uncertainty, but without admitting any violation of the Final Judgment or state consumer protection statutes, and without admitting any wrongdoing and for settlement purposes only.[4]

Both the Stipulation for Modification of the Final Judgment and the original Final Judgment deny any wrongdoing or liability and, in doing so, mirror the language Bayer employed in the Baycol "Dear Doctor" letter discussed earlier. That Bayer can simultaneously agree to run "corrective" advertising but deny "any violation of the Final Judgment or state consumer protection statutes" is a glaring example of a legal double-speak that completely erases the consumers who are invoked in the use of "consumer protection statutes". Simple grammar helps illuminate the stickiness of this language when we understand that corrective advertising must correct something, in this case it is the previous advertising used by Bayer to promote YAZ; advertising that was found to be in violation of FDA regulations for DTC promotion and potentially violated consumer protection statutes of thirty states. Yet, despite these basic and obvious facts, the corporation is still able to claim innocence.

In the face of compelling evidence from major regulatory entities such as the FDA, a special taskforce of state Attorneys General and courts of law, Bayer continued to deny responsibility for its dangerous products and marketing practices. How, then, are citizens and Bayer's consumers supposed to hold the pharmaceutical giant accountable? Bayer's willingness to withdraw products from the market, pay million dollar settlements to multiple states or run expensive corrective advertising campaigns are *cover stories* for willful corporate blindness to the needs and rights of consumers and of the citizens who make up the communities in which these corporations operate. The *cover stories* depict a corporation invested in public health needs and the protection of not just consumers but

[4] *Id*. at 2

patients. Yet, the language of users, consumers, patients, and citizens are completely missing from both the 2007 Judgment and the 2009 Modification Judgment. Legal redress is clearly limited, in this case the limitations favored regulations and statues, not people.

The ways in which users of these pharmacological technologies fail to figure in regulatory interventions supposedly made on their behalf highlights the limits of governmental advocacy for the protection and promotion of citizen health needs. Chikako Takeshita's (2011) notion of biopolitical subjecthood provides a framework for understanding how users of Bayer's products, and women users more specifically, figure, or not, into the regulatory and legal advocacy discourse. According to Takeshita, women are figured as "biopolitical subjects," in reproductive health discourse concerning contraceptive technologies as their political subjectivity, i.e. their citizenship, public sphere recognition, and right to representation, is understood through/with their biological capacities to reproduce. Biopolitical subjects are constructed through biopolitical scripts, which are "three-ways co-configurations of technologies, users, and modes of governance over the body" (Takeshita 2011, 28). To be a biopolitical subject, particularly for women in regards to contraceptive technologies, is to be stripped of one's status as an individual, through which Takeshita locates women's agency and autonomy. As she notes of the development of the intrauterine device, "Researchers' exclusive interest in the uterus had already displaced women's agency in favor of their biology. Homogenizing their bodies further muted their individuality and agencies" (Takeshita p.57). Though Takeshita's work implicates the discourses of population control that sought to manage the reproductive capacities of women, particularly in the global south,

through contraceptive technologies, her work helps illuminate the processes by which women are implicated and imagined in the development and regulation of reproductive technologies beyond the IUD as well. As stakeholders in reproductive health development, women are absent from the very discourses that purport to protect and represent them. The erasure of women's agency and their reduction to biological processes as a means by which to include them in regulatory interventions is nowhere more evident than in the recent FDA safety hearings concerning YAZ.

A War Of Words: FDA Safety Hearings And Women's Testimonies.

In December 2011, the FDA held a joint meeting of the Reproductive Health Drugs Advisory Committee and the Drug Safety and Risk Management Advisory Committee to review the safety data on DRSP contraceptives, of which YAZ is one. The meeting was called as an attempt to make sense of the growing confusion over the safety of contraceptives containing drospirenone (DRSP). Eight separate studies on the safety and efficacy of Yasmin, the first generation DRSP contraceptive developed and distributed by Bayer, had been conducted with varying and conflicting findings. The findings in question centered on whether using oral contraceptives that contained the progestin DRSP put one at greater risk for developing certain types of blood clots. DRSP, known as a fourth generation progestin, was combined with the synthetic estrogen Ethinyl estradiol (EE) to form the combined oral contraceptives (COCs) Yasmin (3mg DRSP/ .03mg EE) and YAZ (3mg DRSP/.02mg EE). From its initial approval, there were concerns about the effects of the DRSP progestin used in YAZ and Yasmin, as it carried the risk of raising potassium levels in the body. Moreover, since Bayer's YAZ family of contraceptives, including Yasmin, BeYAZ, Ocella and Safyral, were the only oral

contraceptives to use the DRSP, they were a unique addition to the oral contraceptive market and needed to be studied further. Three of the studies, all of which were (not so) coincidently funded by Bayer Pharmaceuticals, found that there were not elevated risks associated with the use of DRSP containing COCs like YAZ, while the other five independent studies found varying degrees of risk elevation in the use of COCs containing DRSP.

In preparation for the December 2011 meetings, the FDA's Division of Reproductive and Urologic Products, Office of New Drugs Division of Epidemiology II, Office of Surveillance and Epidemiology, and the Center for Drug Evaluation and Research prepared a report summarizing the findings of the relevant studies, offering limited analysis as to their respective strengths and weaknesses. Bayer also submitted a Briefing Document to the committees participating in the joint meeting (Bayer HealthCare Pharmaceuticals 2011). Since the committee was tasked with formulating recommendations for the regulation of YAZ, the FDA report began by suggesting pertinent questions and issues for consideration. These suggestions included questions such as

> How do you view the impact of differences between studies, particularly those that provide differing results? How do different study designs, study populations, comparator groups, and handling of potential confounding factors affect the outcomes of the various studies? Are there other important confounding variables that need to be addressed? Based on your interpretation of the available epidemiologic studies, do you believe that users of DRSP-containing COCs are at an increased risk of VTE compared to users of COCs that contain other progestins? Do you believe that the benefits of the DRSP-containing oral contraceptives for prevention of pregnancy outweigh their risks? Do you believe the current DRSP labels adequately reflect the risk/benefit profile for these products (U.S. Food and Drug Administration 2011a, 14)?

The suggested questions for consideration focus almost exclusively on issues of scientific methods (study design, etc.), product efficacy and basic regulatory adherence. The actual

bodies implicated by the safety and efficacy of YAZ are referred to only as users. They are positioned, both in these questions and in the larger document, in techno-scientific terms that privilege their bodily processes over more complete understandings of them as social, cultural, and political subjects. Though this meeting was ostensibly held to review safety and efficacy data on the YAZ family of contraceptives as a mode of protection for users of these contraceptives, the report speaks little of actual women and, instead, favors issues of scientific accuracy. Where women are invoked, they are largely interpolated through the process of the body as means to understand how the contraceptive functions in terms of its safety and, more specifically, its relationship to blood clot formation.

The report is heavily laden with tables and graphs that represent the results of the various studies under discussion. Readers never encounter narrative accounts of the women who participated in these same studies and used a DRSP contraceptive with either success or failure. We understand these women only as numbers interpreted as "hazard ratios" and "incidence rates". Anni Dugdale poignantly describes this elision of women's subjectivity in reproductive technology research and design when she writes

> A standardised IUD required a standardised body. The stories each woman has to tell of pain or pleasure, freedom from worry or increased worry as health deteriorates, are erased when the clinic participating in the trial fills in the follow-up form, reducing each woman's experience to a continuing trial participant or a closed-out case in one of the categories. The body survives only as two series—numbers of months of IUD use and closeout category. This is inscribed back onto the bodies of IUD users as any pain and suffering they encounter is lived as a 'side-effect', and even serious damage such as uterine perforation, tubal pregnancy and pelvic inflammatory disease is experienced as 'rare', their bodies as unlucky to succumb to such an unlikely risk (Dugdale 2000, 173).

Dugdale's account of risk incidence mirrors the discussion of risk assessment in the Yasmin/DRSP COC safety studies. In Bayer's "Drospirenone-Containing Combination Oral Contraceptives Briefing Document," the company is keen to point out that though

the use of all COCs carries with it the increased risk of Venous Thromboembolism (VTE), "pregnancy and the postpartum period confers among the highest attributable risk for VTE in women of reproductive age, with estimates of a 5-10 fold increase over the non-pregnant state in otherwise healthy individuals" (Bayer HealthCare Pharmaceuticals 2011, 11). In other words, the briefing document argues that the real threats to women's health are women's own bodily capabilities, i.e. pregnancy. According to Bayer the use of contraceptives like YAZ present a minimal, read unlikely, risk to women's health when compared to the VTE risks of pregnancy. Bayer's logic seems to imply that YAZ actually protects women by preventing pregnancy and thus exposure to pregnancy's increased risk of VTE. This is the same approach to women's bodies and their health seen in the "Beyond Birth Control" advertising campaign where women's bodies, as sites of bloating, acne, moodiness and more, are depicted as negatively interfering with their lives. Moreover, it is yet another example of the mechanisms by which Bayer dodges accountability for its actions and products and actively projects guilt and blame onto those on whom it relies to either prescribe or consume its products. In the case of Baycol, Bayer argued that it was the prescribing practices of doctors that necessitated the recall as opposed to the unsafe use of the drug. If venus thromboembolism is the primary health concern associated with using YAZ, then Bayer argues the contraceptive was safe for women when compared with the higher VTE risk incidence associated with pregnancy.

A close examination of the discourse of governmental advocacy on behalf of patients and consumers reveals that even the mechanisms put in place to protect consumers, like safety labeling and patient package inserts, are instead used by pharmaceutical companies like Bayer to further evade responsibility by arguing that

patients were duly informed of the drugs, efficacy, safety risks and side effects. In its "Briefing Document," Bayer argued that the COC safety "label clearly states that the use of COCs is associated with increased of VTE, as well as arterial thromboembolism (ATE), especially in women with other risk factors for these events" (Bayer HealthCare Pharmaceuticals 2011, 10). To argue that the label "clearly states" the drug's associated risks indicates that the company is confident that women were adequately and duly warned about the risks associated with the use of any COC and the YAZ family of COCs in particular. Yet, the idea of pharmaceutical safety labeling stating anything clearly is debatable. With the inclusion of increasingly complex medical and scientific jargon, patient package inserts have moved away from their origins in the women's health and consumer rights movements of the mid-to-late sixties (Watkins 2001; Takeshita 2011). These documents better reflect attempts to protect pharmaceutical companies and prescribers rather than efforts to critically inform potential and actual users of a drug. Takeshita argues, that protecting providers was always a central component of patient package inserts and informed consent (Takeshita 2011). She cites a 2002 case, Snyder v. Ortho-McNeil Pharmaceuticals – in which a couple unsuccessfully sued an IUD manufacturer after the IUD failed – as an indication of the ways in which user protection measures shifted to shield not only doctors but also pharmaceutical corporations. The court ruled the couple had no standing under the relevant state consumer protection statutes as the wife had signed the informed consent document that came with the IUD, indicating she read and understood its associated risks, including contraceptive failure and uterine wall perforation, both of which she experienced. Takeshita notes that this case signals the inclusion of pharmaceutical companies in the population protected by

informed consent practices (Takeshita 2011).

Patient inserts and safety labels are, in part, a product of the women's health movement and evidence of a desire to empower women to make informed healthcare decisions. They are also, more directly, the product of the 1970 Nelson hearings, in which Senator Gaylord Nelson held U.S. Senate hearings to investigate the safety of the oral contraceptive pill. The Nelson hearings explicitly excluded the voices of women who had used the pill despite the fact that Nelson was moved to hold the hearings after reading Barbara Seaman's (1995) influential text *The Doctor's Case against the Pill*, which was originally published in 1969. Seaman wasn't even asked to testify though she was an integral part of helping Nelson and his supporters prepare for the hearings (Watkins 2001). Instead, Nelson and the U.S. Senate privileged the testimony of male experts and invited the pharmaceutical companies that manufactured contraceptive pills to come and speak on their own behalf. Elizabeth Watkins reports that women who had used the pill and/or experienced adverse side effects were not invited to testify because "'Nelson…didn't like that way of doing things…He wanted to keep the hearings on a high level'" (Watkins 2001, 107). Apparently, when women show up to advocate on their behalf and give voice to their experiences, the political process is somehow cheapened and debased. Nelson's belief that a higher level of discourse about women's health wass only possible without women seems to draw on age-old ideas of the mind/body split.

Feminist body theorists (Bordo 2003; Price and Shildrick 1999) have explored the traps of Cartesian dualism by theorizing the ways that gender and race are deployed in order to align whiteness and masculinity with the mind and non-whiteness and femininity with the messiness of the body. As Janet Price and Margaret Shildrick argue,

> The very fact that women are able in general to menstruate, to develop another body unseen within their own, to give birth, and to lactate is enough to suggest a potentially dangerous volatility that marks the female body as out of control, beyond, and set against, the force of reason. In contrast to the apparent ordered self-containment of the male body, which may then be safely taken for granted and put out of mind, the female body demands attention and regulation…In short, women are just their bodies in a way that men are not, biologically destined to inferior status in all spheres that privilege rationality" (Price and Shildrick 1999, 3)

Through Nelson, the State takes up this approach to women's health and the bodies at the center of that health. Women's bodies are, apparently, out of control and, as such should be acted upon, not imagined as fully speaking subjects with ideas and best practices for their own welfare. When women aimed to push back and challenge these faulty approaches to their health and bodies in the Nelson hearings, they were quickly silenced. A group of women from the D.C. Women's Liberation group disrupted the Nelson hearings by shouting, "Why have you assured the drug companies that they could testify? Why have told them they will get top priority? They're not taking the pills, we are!" and "Women are not going to stay quiet any longer! You are murdering us for your profit and convenience" in the Senate chamber (as quoted in Watkins 2001, 112). These women's words demanded recognition and accountability from the State and the governmental agencies purporting to represent them as well as from the pharmaceutical companies whose drugs were the at the center of the hearings. Though these women dared to literally and figuratively disrupt the narrative, they were quickly silenced when they were ejected from the hearing chamber and not allowed back in. Eventually, four women were officially invited to testify during the second round of the hearings but three of them were physicians and the fourth was a former Executive Director of the Population Crisis Committee (Watkins 2001). They were not invited as representative women but as techno-scientific experts who happened to also be women. In this role, they were able to

simultaneously invoke womanhood as a signifier of representational authenticity while their medical and scientific expertise is what actually made them "valuable" as witnesses.

In addition to the exclusion of women's voices from the pill hearings, they were systematically excluded from the decision making process that produced the format and wording of the first patient package insert. The original insert began as a 600-word document that used plain, jargon-free language to describe the purpose and risks of oral contraceptive use. Elizabeth Watkins writes that the original pamphlet worked to assure "women of the competence of their doctors…Ten of the fifteen paragraphs in the proposed text referred to the doctor as the proper authority on oral contraceptives…" (Watkins 2001, 121). Yet, this was language was not enough to ease the anxieties of most physicians over what they thought would be disruptions to the sanctity of the doctor-patient relationship. In addition to resistance from physicians, the FDA received a great deal of resistance from the pharmaceutical companies who believed that the insert unnecessarily highlighted the risks of the pills, which could prevent potential users from seeing their value. In the end, the interests of the pharmaceutical industry won out and the 600-word insert was reduced to 100 words, referenced just one health risk associated with oral contraceptive use and strongly encouraged women to seek out their doctors if they experienced adverse side effects and to request a longer booklet that provided further information on the pill. The origins of patient safety labeling reveal how small of a factor patients, and specifically women, were in the decision making process of regulatory bodies like the FDA and the U.S. Senate. Both then and now, it seems, patient and consumer protection are euphemistic *cover stories* for the power and influence of "experts" and multi-billion dollars industries over our access to and experience of health

and health care.

The Nelson hearings remind us that governmental advocacy on behalf of women's health has always been limited and rarely included the women actually affected by the issues at hand. The FDA's 2011 special hearing on the safety of combination oral contraceptives containing drospirenone (i.e. the YAZ family of contraceptives) evoked the spirit of the Nelson hearings in its exclusion of women's voices. Like the Nelson hearings, the drospirenone safety meeting privileged the voices of technocratic experts, a point powerfully demonstrated as 39 of the 42 formally recognized individuals attending the hearing were either medical doctors or held a PhD in a comparable field and 19 were men. These individuals, in turn, drew on their areas of expertise in general medicine, obstetrics, gynecology, pharmacology and epidemiology, to name a few, and focused primarily on questions of study design and methodology of the eight completed studies of DRSP contraceptives. Through prioritizing study design and its attendant issues, the joint committee attempted to identify criteria by which one study might be deemed more reliable than another. This, in turn, would help them decide between studies that showed elevated risk of VTE as a side effect of DRSP COC use and those that did not. Though important, a nearly exclusive focus on study design allowed the committee to engage in a "clean" and "unencumbered" assessment of DRSP COCs as the women affected by these contraceptives remained anonymous and alienated as numbers on a graph or one of many reduced to the undifferentiated group "users." This technocratic approach also allowed the joint committee members to largely sidestep the ethics questions raised by the fact that Bayer funded the studies that indicated little to no risk of VTE. One committee member did ask the Bayer representatives present at the meeting to address "allegations

that Bayer had been withholding data or that it major studies suffer from conflict of interest" (Orza as quoted in The Food and Drug Administration 2011b, 297). The company's response was "to the best of our knowledge, we've always had a very open communication. We've responded openly to all requests for information from the FDA, and the information we're presenting today is in total openness" (Plouffe as quoted in The Food and Drug Administration 2011b, 300). While well crafted, Bayer's response still failed to address to the potential impact of their funding on the results from the studies they sponsored. Moreover, there were no follow up questions on the matter to push the pharmaceutical company to account for the conflict of interest.

The committee also appeared less interested in the overall safety of the drug and more interested in the particular bodies taking it. Again, the "wrong women" invoked in Takeshita's analysis of IUD safety reemerge in the YAZ safety debate (Takeshita 2010). By focusing on users' profile (family history, smoking habits, BMI, etc.) the committee attempted to create a taxonomy of "safe" and "unsafe" users. This approach treats YAZ and the rest of the DRSP contraceptive family as neutral and, in turn, makes women's bodies the agents of risk and adverse effects. Stated otherwise, the committee seemed to think that if the "right" women use the pill then VTE risks would almost be a non-issue. In a powerful turn, women who had previously used DRSP contraceptives as well as the families of women who died as a result of complications associated with DRSP contraceptive use were present at the joint meeting and they were allowed to speak briefly during the public comment portion of the meeting.

The testimonies of these women and their families were limited to three minutes each but in that short time they were able to, at least momentarily, disrupt the dominant,

sanitized narrative of the proceedings. These women and the mothers, as it was almost always the mothers, of the deceased women, turned the committee's unspoken but well referenced "ideal user" on her head. The women who spoke embraced the "ideal user" as a discursive strategy to demonstrate that it was drug that was dangerous, not the women who used it. Shala Byers, a former YAZ user who suffered "bilateral pulmonary embolisms and a massive DVT [deep vein thrombosis] in [her] upper right shoulder" addressed the joint committee (Byers as quoted in The Food and Drug Administration 2011b, 231). Ms. Byers disrupts the right body/wrong body dichotomy when she informs the committee,

> I have been an athlete for as long as I can remember. In fact, only six years ago, I was a starting varsity field hockey player for Dartmouth…I had been on oral contraceptives without any problems for years, but was convinced by a doctor to try the new product on the market, YAZ. I was exactly the demographic they were looking for: nonsmoker, athlete, no history of any major medical issues, normal BMI (Byers as quoted in The Food and Drug Administration 2011b, 231).

Emily Moore, who was diagnosed with DVT after using YAZ for almost a year, told the committee "I am a registered nurse…I was and am a nonsmoker and athletic. I run, lift weights, ride my bike, or practice yoga five to six times a week, and I'm height and weight proportionate" (Moore as quoted in The Food and Drug Administration 2011b, 246). Represented by these two women, the ideal user is reduced to the ideal body: thin, athletically fit, generally healthy and young[5]. Ms. Byers and Ms. Moore effectively

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[5] Here I use the term "user," as that was the language of the FDA Joint Committee, instead of the, perhaps, more appropriate consumer. Consumer might indeed be a more precise term as it captures the dual nature of an individual's role in the consuming a particular medication. In this way, people who use medications are literally consuming them as they swallow the pill or liquid and introduce it into their bodies. They are also consuming it in the sense of the marketplace as they must purchase it and, in the case of COCs, choose between a variety of options for purchase. Yet, the language of "user" is important as it points to how the joint committee and the scientists behind DRSP COCs imagine the women using the product. These women, as I note in the chapter, are

argue that their bodies did not make trouble for the drug, rather the drug made trouble for their bodies. The ideal user/body is, of course, inextricably linked to the model women's health patient. Terri Kapsalis argues "in most cases the ideal patient is one who compliant, passive, and accepting rather than active questioning, a composite of proper womanly performance" (Kapsalis 1997, 6). Like the model patient, the ideal body does not cause challenges; it too is a blank slate waiting passively to be acted upon by the drug in question. Ms. Moore also calls on her own technocratic expertise by identifying herself as a nurse. As nurse and a YAZ user, Ms. Moore is able to speak with the authority of medicine and science as well as her own experiential authority. Through identifying themselves as the "right" bodies that still had the "wrong" experiences, these two accounts challenged the dominant narrative of the meeting. However, they leave untroubled the very categories of right and wrong bodies. Elizabeth Locafuerte, on the other hand, actively claims the wrong body yet still demands recognition and representation: "Yes, I'm overweight, and yes, I'm older than 35. I asked my provider about the risks she was willing for me to take. 'It's a low dose,' she said. 'The benefit will outweigh those risks.' So believing in her, I trusted her professional opinion" (Locafuerte as quoted in The Food and Drug Administration 2011b, 263). Locafuerte asks that the committee not only to consider the responsibility of the pharmaceutical companies in producing safe drugs but also the responsibility of the doctors to be well informed and prescribe responsibly.

The testimonies also challenged other important and established discursive trends

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understood as "users" and, as a result, are understood only in relation to the medication as user implicates both the individual using but also the object being used. The word user also helps to homogenize the women in question, erasing their subjectivity and agency and reducing them to a collection of bodily and compliance practices.

of the hearing. In focusing on the technical aspects of the studies, the committee members were able to reduce women who used DRSP COCs to the homogenous category of users. In this category women became statistics and averages and the life stories that gave context to their DRSP experiences were completely lost. The testimonies offered from users of DRSP and their families refused this strict separation and insisted on communicating the humanity of the women impacted by DRSP COC use. Katie Anderson, who suffered a pulmonary embolism and deep vein thrombosis at the age of 16 as a result of using YAZ, told the committee of being taunted as a result of the damage to her leg from the DVT: "I've been called 'Brown Leg' and made fun of because of the compression stocking I have to wear" (Anderson as quoted in The Food and Drug Administration 2011b, 252). Ms. Anderson also wanted the committee to understand she had been lucky to survive the side effects of YAZ, but she was still experiencing them in other, long terms ways,

> Despite my best efforts not to let it, YAZ has affected me in more ways than I want to admit. I've had to give up on my dreams of becoming a cosmetologist because I'm not supposed to stand for more than an hour at a time…YAZ has also affected my dream to one day become a mom. If I ever get pregnant, I'll have to be on blood thinners and on strict doctor's supervision, and I don't know if I can go through all of that again (Anderson as quoted in The Food and Drug Administration 2011b, 252).

Ms. Anderson, rightly, appealed to the FDA for protection and advocacy, while Cindy Rippe, whose poignant quote begins this chapter, shifted the focus of the public comment session by directly addressing Bayer in her testimony.

Rippe clearly held Bayer, not DRSP COC users, accountable for the drug's failures. By calling Juergen Dinger by name, the Principal Investigator on the three Bayer sponsored studies of DRSP COCs that found no risk increase for blood clotting disorders, she also troubles the protective anonymity of large pharmaceutical

corporations and the individuals who make decisions for those corporations. Finally, through the figure of the daughter, Rippe further refuses the anonymity of "users." To be a daughter clearly situates the deceased Elizabeth in a lineage and in a community. The daughter's words are used in Ms. Rippe's testimony to invoke the larger social and national family. Elizabeth Rippe is not only the daughter of Cindy Rippe, she is also the symbolic daughter of America and, thus of the people in the room as they act as agents of the U.S. State. Invoking the mythology of the national family in this way simultaneously invokes patriarchal ideas about the protection we are supposed to afford (white) daughters of both the immediate blood family and of the State. To emphasize this point, she reminds the FDA, "remember your mission, to protect the public and ensure the safety of products" (Rippe as quoted in The Food and Drug Administration 2011b, 236). Finally, Ms. Rippe refuses the detached language of science and commerce when she asserts, "These are our children. They are not your customers. They are not numbers in a study, and they are not numbers on a balance sheet. We did not raise them to make money for Bayer, and we did not raise them because a drug company has a drug that shouldn't be on the market" (Rippe as quoted in The Food and Drug Administration 2011b, 235–36).

Though compelling, the disruptions these women's stories enacted were heavily policed and silenced whenever possible. The committee claimed to place great importance on public opinion, yet they allotted only one hour, out of the nine-hour agenda, for the public comment portion of the meeting. During the public hearing, each speaker was allowed only three minutes to present their case and the time limit was strictly enforced as participants were cut off when they exceeded it. Bayer, on the other

hand, was given just under two hours for their official presentation and they were given additional time to present their case when they were asked by the joint committee to answer questions about their presentations. Unlike the Nelson hearings, women were allowed to address this joint committee, but the terms by which they were allowed to speak were not their own. Addressing the committee was treated as a privilege not a right. The individual women and advocacy organizations that spoke during the meeting had no power to question Bayer or the FDA and when they did so anyway it was simply a rhetorical device as answers to their questions were never offered.

At the end of the meeting, the committee took a vote on two questions to decide their course of action regarding YAZ. When asked "Do you believe that in the general population of women who desire contraception, the benefits of DRSP-containing oral contraceptives for the prevention of pregnancy outweigh their risks," 15 committee members voted yes and 11 voted no (U.S. Food and Drug Administration 2011b, 401). This vote would mean that YAZ would remain on the market as viable contraceptive option for women despite multiple studies linking it to increased risks of blood clotting disorders. When asked, "Do you believe the current DRSP label adequately reflects the risk/benefit profile for this product," 21 committee members voted no and five voted yes. The DRSP family of contraceptives was not recommended for market removal; the committee did recommend stronger, more comprehensive safety labeling.

When asked to explain her "yes" vote on whether the benefits of DRSP COCs outweighed their risks, Dr. Valerie Montgomery-Rice answered,

> I voted yes because I believe that the risk, if present, is a small absolute risk. But when you compare that to the risk associated with an unintended pregnancy, I think that it's greater. And I believe that women should always have a choice so that they can make decisions on how they want to provide prevention of

> pregnancy (Montgomery-Rice as quoted in U.S. Food and Drug Administration 2011b, 406–07).

Dr. Montgomery-Rice's appeal to choice and the protection of choice was a recurring theme for the joint committee members who voted yes on the questions of DRSP COCs benefits. At least three other voting members identified "choice" as a compelling concern that influenced the direction of their vote. The currency of choice is particularly powerful as it is the linchpin of the abortion debate in the U.S.. To "protect" women's choice is important work. That the word is laden with political and cultural significance also allows it to escape scrutiny such that we fail to question what kinds of women's choices we are protecting and what kinds we fail to protect. As in seen in the previous chapter, the rhetoric of choice was central to the marketing of YAZ as a means to signal feminist sensibilities concerning women's empowerment as consumers, without embracing feminist politics. Choice reemerges in governmental and regulatory discourse as a means to protect YAZ and other DRSP COCs by claiming that removing them from the market would violate women's choice. In both instances, choice is at the service of the product, either promoting or protecting it, while women's political and social relationship to the broad act of choice fades into the background. The four voting members who saw themselves as guarding against the erosion of women's reproductive choice by voting to keep YAZ on the market were really protecting market and consumer choice. There were other modes of choice invoked at the hearings that committee members chose not to protect. For example, when women asked to be critically informed about the benefits and risks of contraceptives, they were asking for informed choice. When women asked for safer contraceptive options across the board, they were asking for healthy and ethical choices. Yet, those choices were, apparently, not as important to the

committee as consumer choice. Clearly, choice needs a qualifier. Otherwise it is employed as a hollow code word intended to invoke progressive struggles in support of women's bodily autonomy and agency without actually supporting those concepts or the communities in need of them. The committee's appeal to a limited notion of choice was not the only area where it failed to meet the expectations of feminist health advocates. After the hearing, two separate advocacy organizations sent letters to the FDA taking issue with the joint YAZ safety meeting.

A month after the joint committee voted and made recommendations to the FDA, the Project on Governmental Oversight (POGO) issued a letter to FDA Commissioner Margaret Hamburg questioning the relationships of four voting members of the committee to Bayer Pharmaceuticals. An appointed member of the FDA's Drug Safety and Risk Management Committee, drug safety advocate Dr. Sidney Wolfe was not allowed to vote in the DRSP meeting as a result of what the FDA called an "intellectual conflict interest" based on Wolfe's previous advocacy against YAZ. In 2002, Wolfe's Organization, Public Citizen, included Yasmin, a member of Bayer's DRSP family of contraceptives, on a list of pills not to use. Though the FDA was keen to err on the side of caution and avoid any conflict of interest issues by excluding Dr. Wolfe, they failed to exclude Dr. Paula Hillard, Dr. Julia V. Johnson, Dr. Elizabeth Raymond and Dr. Anne E. Burke as these individuals had all received money from Bayer or one of its subsidiaries at some point in the past. The POGO letter requested that the December 8, 2011 vote be dismissed and the joint committee meeting be reconvened with new temporary committee members to replace the four members with financial ties to Bayer or with those four members being subject to the same rules as Dr. Wolfe and unable to vote on the matter.

An additional letter was sent to Ms. Hamburg in March 2012, this time from four women's health advocacy organizations, Jacobs Institute of Women's Health, National Research Center for Women & Families, National Women's Health Network , and Our Bodies Ourselves. This letter echoed many of the concerns noted in the POGO letter but also mentioned that committee members' rationales for their votes seemed contradictory and/or noted a lack of comprehension of the questions asked. What is particularly interesting about the letter from the women's health advocates is that it stands in stark contrast to another stalwart of women's health advocacy in the U.S.: Planned Parenthood. Vanessa Cullins, Planned Parenthood Federation of America's (PPFA) Vice President for External Medical Affairs testified at the joint committee meeting during the public comment section. While other women's health advocates including representatives from the National Women's Health Network and Our Bodies Ourselves testified at the meeting in favor of pulling YAZ and other DRSP contraceptives from the market, Ms. Cullins testified to the opposite. Ms. Cullins appealed to what she termed "science-based decision making" and testified that DRSP "products should remain on the market without FDA-imposed restriction because a twofold risk is still extremely rare, and it is dwarfed by the VTE risk that is seen in pregnancy and during the postpartum period" (Cullins as quoted in The Food and Drug Administration 2011b, 240). PPFA's response, as it appears to advocate putting women's health at unnecessary risk, seems to be at odds with its role as one of the most visible direct service providers of reproductive health care and advocacy in the U.S.. Moreover, an appeal to "science-based decision making" on the part of PPFA through Vanessa Cullins, an African American woman, is ironic as science, particularly gynecological science and medicine, have never benevolently served women

and certainly not women of color. The next chapter engages this split among women's health advocates over YAZ and the DTC marketing that made it so famous. In a close comparison of the rhetoric and advocacy of Our Bodies Ourselves and Planned Parenthood, Chapter Four tracks the shifting character of women's and feminist advocacy regarding women's reproductive health needs.

Chapter Three:
Up for Sale (?): Women's Body Knowledge and Feminist Health Advocacy

In evaluating the controversial alliance of Margaret Sanger and white supremacist eugenics advocates in the early birth control movement legal scholar Dorothy Roberts argues that "Sanger's shifting alliances reveal how critical political objectives are to determining the nature of reproductive technologies – whether they will be used for women's emancipation or oppression" (Roberts 1997, 58). Yet the critical nature of political objectives is also central to determining the kind of advocacy, more specifically feminist advocacy that will be deployed around reproductive technologies.

Feminist health advocates occupy a difficult position in advocating for women's health and wellness. On the one hand, they fight for and defend our collective access to reproductive health options like oral contraceptives and abortion. On the other, they must also be called on to offer critiques of the very things they work to defend when those options are presented in ways that run counter to women's empowerment and control over their reproductive health. How feminist health advocates respond to particular reproductive technologies has everything to do with what they are trying to accomplish at a given time. In a social and political climate that looks for any loose thread on which to pull to unravel the fragile fabric of women's reproductive freedoms it can be dangerous for advocates of women's health to launch critiques against the very methods and procedures that underlie those freedoms. Critiques of oral contraceptives, abortion practices and other reproductive technologies can be a slippery slope for feminist health advocates but they are nonetheless desperately needed. Feminist health activists cannot afford to cede critiques of women's reproductive health care to anti-choice community. Moreover, it was the power of critiques of the medical industry that spurred women's

health activism to begin with. This chapter takes up this tension between political objectives, the politics of representation, women's bodies and feminist health advocacy in the case of oral contraceptives in the U.S..

More specifically, this chapter addresses the divergent responses to the public face of marketing for the oral contraceptive YAZ by two icons of women's and feminist health in the United States, Our Bodies Ourselves (also referred to as the Boston Women's Health Book Collective) and Planned Parenthood Federation of America. These organizations are two of the most well known advocates of women's health in the U.S.. Yet each has, to date, offered decidedly different responses to the onslaught of DTC advertising for oral contraceptives in general and YAZ in particular. While timely and provocative, this tension between the responses of these two organizations has yet to be taken up by feminist health studies, feminist science studies or feminist body theorists.

Judy Norsigian, Executive Director of Our Bodies Ourselves (OBOS), has been a particularly outspoken critic of DTC advertising and the YAZ family of contraceptives. Planned Parenthood, on the other hand, has been largely silent about DTC advertising and YAZ. However, the latter organization has indicated, through press releases and educational programming, its own investment in marketing as an important part of the public presence of reproductive health and its ability to be an effective tool in women's health promotion and education. Additionally, Planned Parenthood also released its own broadcast and print marketing campaigns, Planned Parenthood Golden Gate's "Safe is Sexy" and Planned Parenthood New York's "Planning is Power." Both campaigns were aimed at young adults and further indicate Planned Parenthood's overall investment in broadcast and print advertising as an effective and necessary tool in health promotion and

advocacy. This chapter will explore the responses of both Our Bodies Ourselves and Planned Parenthood to health media, offering an analysis of the rhetoric each organization uses in its response to media, reproductive technologies and women's health. Additionally, the chapter asks fundamental questions about knowledge production and dissemination in women's health advocacy. Finally, the chapter explores a third framework for engaging media as both an object of critique and a tool in women's health advocacy and agency.

Our Bodies Ourselves and Feminist Epistemologies of Health and Advocacy

Founded under the leadership of birth control activist and pioneer Margaret Sanger, Planned Parenthood offers both reproductive rights advocacy on behalf of women as well as direct reproductive health services to women. Our Bodies Ourselves, on the other hand, was an organization born out of women's desire to generate alternative knowledge and women-generated knowledge practices regarding women's health. While Our Bodies Ourselves is credited with providing something of an "owner's manual" for women regarding their bodies, they have never offered direct medical services. The success of the book did, however, help the organization grow into the advocacy and educational work it is well known for today.

Officially incorporated in 1972, the work of the Boston Women's Health Book Collective began at least three years earlier in 1969 when the first group of women met at Emmanuel College in a conference session titled "Women and their Bodies." The women continued to meet after the conference as the "Doctor's Group," later changing their name to the Boston Women's Health Book Collective (Davis 2007). This small group of young white women initially researched, wrote and circulated papers on various

health topics among themselves for discussion during the year following their initial meeting in 1969. This collection of papers would come to constitute the group's first publication, *Women and their Bodies*. This publication was the first iteration of *Our Bodies, Ourselves.*[6] Like Roe v. Wade, OBOS emerged out the of the 1970's as a literal and figurative symbol women's desire to take authoritative control of their bodies and health. Kathy Davis writes that the early book

> Combined a scathing critique of patriarchal medicine and the medicalization of women's bodies with an analysis of the political economics of the health and pharmaceutical industries. But, above all, OBOS validated women's embodied experiences as a resources for challenging medical dogmas about women's bodies and, consequently, as a strategy for personal and collective empowerment (Davis 2007, 2).

Moreover, the early book is important particularly as a result of the historical context in which it emerged. In 1970, abortion was still illegal in the U.S. and scholars such as Sandra Morgen (2002) cite 1969 as the beginning of the women's health movement. The early work of *Our Bodies, Ourselves* emerged out of a barren landscape in regards to women's health, reproductive or otherwise.

As the U.S. landscape of women's health has shifted in the last forty years, OBOS has attempted to remain relevant through frequent revisions and reorganizations of its seminal text. The organization has also developed a web presence as a companion site to the text. The development of the companion site reflects "…the information explosion about the safety and efficacy of medication, medical devices, and technologies" with which the book's editors have had to contend (Davis 2007, 42). According to Kathy Davis, this shift from a standalone text to a text and web presence worked to help OBOS

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[6] Both the organization and the text are known as Our Bodies Ourselves. To avoid confusion, here the text will be italicized and include a comma (e.g. *Our Bodies, Ourselves*). The organization will be listed as Our Bodies Ourselves without italics or additional punctuation.

"keep women adequately informed and ensure that the information it provided would stay relevant for a longer period of time" (Davis 2007, 42). As a part of its efforts to address new and emerging issues in women's health care OBOS has devoted significant attention to addressing both doctor-focused and direct-to-consumer marketing.

As early as 1998, just a year after the shift in FDA regulations regarding broadcast DTC advertising, OBOS included multiple sections on the pharmaceutical industry. These early analyses addressed the role of the pharmaceutical industry in the high cost of prescription medication in the U.S., citing advertising as an important factor in the cost and overall business of prescription drugs. The 1998 edition of OBOS identified the gendered dimensions of pharmaceutical development and sales. The text argued that "women receive about two-thirds of all prescription drugs, and the most profitable drugs made by the industry worldwide continue to be oral contraceptives, injectable contraceptives…and prescription mood-altering drugs—all risky in some ways and all targeted mainly to women" (The Boston Women's Health Book Collective 1998, 691). Subsequently, the next edition of OBOS, published in 2005, identified DTC advertising as an important "new battleground" for healthcare in general and women's healthcare in particular (The Boston Women's Health Book Collective 2005, 729).

One of the organization's earliest interventions in the growing direct-to-consumer trend in medical marketing occurred in 2001 with a response to the marketing of the cancer treatment drug Tamoxifen. At the time, the pharmaceutical company AstraZeneca was attempting to promote Tamoxifen as an effective cancer prevention drug. The pharmaceutical company suggested women who had not been diagnosed with breast cancer should use the drug as a means to help prevent its onset at a future time.

Judy Norsigian responded with an article originally published in an issue of *Sojourner: The Women's Forum* and reprinted on the OBOS website, in which she unpacks not only AstraZeneca's claims for the medication's effectiveness but also the company's marketing strategy for the drug. Asking important questions about the particular implications of DTC advertising for women and issues of gender Norsigian writes, "In 1999 alone, the pharmaceutical industry spent $1.8 billion on consumer ads, and estimates for the year 2000 put the figure over $2.5 billion. How has this affected women in particular, and what can we do about it" (Norsigian 2001)? Only five years after the change in FDA regulations that allowed for broadcast direct-to-consumer marketing of pharmaceuticals, OBOS was on the forefront of highlighting the gendered dimensions of this new medical marketing approach. Norsigian calls our attention to the kinds of drugs being promoted through DTC advertising as well as the specific practices being employed in the respective DTC campaigns. In 2001, five years before YAZ comes to market, Norsigian foreshadows the controversy over the popular oral contraceptive when she wrote,

> Predictably, DTC advertising has led to an increase of consumers and patients who request a wide range of prescription drugs from their doctors. In many cases, people are responding to advertising hype that greatly overstates a drug's benefits while downplaying its risks and problems. Most lay people -- and even many physicians -- are unaware of the hundreds of letters sent out each year by the FDA requiring drug companies to retract their ads (and rarely do we see rectifying statements) (Norsigian 2001).

In response to AstraZeneca's marketing of tamoxifen, Our Bodies Ourselves and six other health advocacy organizations formed the Prevention First Coalition. The coalition, aimed to

> Promote a view of public health that stresses primary cancer prevention – healthy food, water, and air -- over narrowly focused risk reduction through pharmaceutical interventions that are individual precautions not available to

> everyone. By drawing the public's attention to the dangers of tamoxifen for healthy women…we will educate the public about the dangers of simplistic pharmaceutical approaches to disease prevention which focus on reducing your chances of getting one disease while increasing the dangers of getting another" (Brenner 2001).

OBOS and the Prevention First coalition advocated what they called an "approach based on the precautionary principle of public health -- keeping our air, food, and water free from pollution and healthful" (Brenner 2001). Education was a large part of their initial platform, aiming to educate the public in general and women in particular about healthy living as an early intervention for breast cancer protection. Also important is that the Prevention First Coalition took a broad view of prevention and healthy living, one that was not narrowly focused on individual women's lifestyle choices but on larger social, economic and environmental issues like clean air and water.

In more recent years, Judy Norsigian and OBOS have turned their attention to other direct-to-consumer marketing campaigns, including Bayer's "Beyond Birth Control" campaign for the oral contraceptive YAZ. For Norsigian, the YAZ "…ads should never have been out there" (Norsigian as quoted in Singer 2009). OBOS staff blogger Rachel Walden links YAZ and its treatment of PMDD to the drug Sarafem, introduced in 2000 by pharmaceutical company Eli Lilly. The link between the two drugs is important because Sarafem's active ingredient, fluoxetine hydrochloride, is the same active ingredient of Eli Lilly's successful anti-depressant Prozac. Lilly introduced Sarafem just as their exclusive patent, and thus market share, on Prozac was due to expire. As Walden writes "You see, YAZ is approved for 'PMDD' – premenstrual dysphoric disorder, a diagnosis essentially of severe PMS with depression-like symptoms that entered the general consciousness when the patent on Prozac was running out and so its maker repackaged the drug as Sarafem" (Walden 2009). In other words, PMDD

emerged in the popular media not so much as a condition in desperate need of medical and scientific attention because of its impact on women but as a way to extend a pharmaceutical company's exclusive market share of a very popular and profitable drug. Both Norsigian and Walden put into practice the ethic of education, advocacy and "healthy skepticism" that Norsigian describes when she warns that women should

> Be most skeptical of heavily advertised drugs and those that come with coupons. They are the newest, most expensive drugs with the shortest track records of safety…To reduce unnecessary risk, women should seek independent sources of evidence about medicines, particularly new ones. Being skeptical about drug ads and promotions is smart: it can protect both our health and our wallets" (Norsigian 2007).

Norsigian is advocating a kind of gender and health specific media literacy. OBOS's response to DTC advertising in general and YAZ in particular promotes critical engagement on behalf of women as patients and medical consumers. Moreover, this approach to DTC advertising is rooted in the organization's overall approach to women's health; an approach that moved to empower women through knowledge about their bodies instead of solely as medical consumers wielding the power of the purse.

Though the book *Our Bodies, Ourselves* is the hallmark of the organization, it was not intended to be a book at all but an interactive course on women's health. One of the original collective members explains, "It's important to remember that these first editions were not a book but course material to be used in a group discussion. They were never considered a finished product…Its paradoxical that the material later became a book to be read alone by a woman in her own room" (Davis 2007, 23). The original authors of *Our Bodies, Ourselves* saw the course as part of women coming to and collectively creating knowledge about their bodies, health needs and experiences. Kathy Davis identifies this as the foundation of OBOS' investment in women's bodies and

women's experiential knowledge of their bodies. Moreover, for Davis OBOS' investment in women's body knowledge makes it a critical epistemological project. Davis argues that an epistemological project is one "that centers on knowledge and knowledge practices" (Davis 2007, 124). She goes to assert "as an epistemological project, OBOS has taken the female body as a starting point for understanding the condition of being a woman in a social order hierarchically organized by gender and other intersecting categories of inequality" (Davis 2007, 124). Davis presents OBOS' epistemology as a three pronged paradigm that (1) recognizes the female body as "a complex, dynamic, multilayered entity;" (2) attributes "authority to women's embodied experience;" and, (3) "treats women as active knowers rather than passive objects of the knowledge practices of others" (Davis 2007, 124–5). Davis' argument works to establish education as the main impetus of OBOS's thirty-plus year career as a women's health organization; which is particularly helpful for considering why DTC advertising and the YAZ campaign in particular became such a significant site of critique and advocacy for the organization.

Since OBOS is committed to creating and empowering women to create what I would call liberatory body knowledge, advertising should raise red flag for the ways that it functions as an educational and epistemological project of its own (Kilbourne 1999; Jhally 1995; Giroux 2004). By liberatory body knowledge I mean knowledge that encourages women to see their bodies as sites of value rather than lack and that promotes women's of ownership of and expertise in the care of their bodies. As Norsigian states

> The drug companies claim that DTC advertising is good for consumers because the ads educate the public and encourage people to be more involved in their medical choices. But drug companies have a serious conflict of interest when it comes to educating consumers: The more people take their drugs, the larger the

> drug company profits. Because of this vested interest, ads for prescription drugs are often misleading and sometimes unethical" (Norsigian 2007).

Direct-to-Consumer advertising does work to educate people about available health care options in the form of medication. Yet, to be a successful marketing tactic, DTC ads need not only disseminate information about health care options but also inform consumers about a product and convince said consumers to find and purchase the product. Moreover, DTC campaigns must also teach the patient-consumer about their very own body. George Lipsitz argues that in order "…to market products effectively, they must be presented as commodities, as essentially vehicles for creating and preserving affection, intimacy, and interpersonal relations" (Lipsitz 1997, 16). Educating patient-consumers about medication is to educate them about what the medication can do for their bodies, how the medication can manage or transform their body into an ideal and how that ideal body will function in producing their ideal life. The pedagogical and epistemological work of YAZ and the Beyond Birth Control campaign operates on three distinct levels: (1) educating the consumer about the ideal modern, feminine lifestyle marked by metropolitan spaces, professional employment, youth, whiteness and leisure (2) educating about the body and its relationship to the ideal, modern, feminine life and (3) educating about the product and its intervention/role as a liaison between the body (impediment/imperfect vehicle) and the lifestyle (idealized and always, already available).

In the case of YAZ, the ads aim to offer information about the product but also about women's reproductive health more generally. In order to educate women to the point that they are convinced to buy a particular product, a commercial has to effectively communicate that their bodies are going through processes that require an intervention,

which comes in the form of the featured pharmaceutical product. Here lies the motivation for OBOS's critical intervention. Whereas OBOS constructs an epistemological project that positions women's bodies as the conduit for information, DTC advertising for YAZ replaces the female body with the product and it is through the product that information about the body emerges. In the epistemological work of DTC advertising women's bodies are only intelligible in relation to symptoms and the corresponding pharmaceutical interventions.

Each YAZ commercial encourages potential consumers to "track their symptoms" in order to figure out if YAZ is "right" for them. To encourage this "tracking," potential YAZ customer were able to download a body diary widget from the YAZ promotional website. The very idea of a body diary calls to mind the work of OBOS and other activists in the U.S. women's health movement, which encouraged women to be in conversation with their bodies through activities such as cervical self-exams. In this context, women were asked to think of their bodies not as foreign entities shrouded in a mystery that could only be penetrated by speculum wielding doctors but as sites of knowledge, opportunity, experience and memory that women themselves were best, or at least equally, suited to engage. Moreover, in the context of the women's health movement, women's individual explorations of their bodies were also seen as the foundation of collective knowledge building about female bodies. Sandra Morgen describes the uses and significance of cervical self-examination for the women's health movement when she writes "the women practiced cervical self-examination together weekly, and they began to demonstrate the procedure for others in the community" (Morgen 2002, 8). This group of women Morgen writes about, who later found the Los

Angeles Feminist Women's Health Center, also embarked on a twenty-three city tour in the early 1970's to further disseminate the concepts, tools, and methods of self help for women's health.

Conversely, YAZ's epistemological approach also asks women to share the body knowledge they glean from their body diary but in radically different ways. According to YAZ the appropriate party with which to share one's body knowledge is a doctor and it is not offered in order to develop a collective account of female bodies but as proof that one's individual body is need of a particular kind of pharmaceutical intervention and management. Moreover, the act of "sharing" this body knowledge is rhetorically presented as an act of agency and self-advocacy. Through YAZ's body diary and the tracking of symptoms, women are positioned as being able to talk to their doctors, armed with their own "knowledge" and confidently assert, "I need this medication" or "I want this medication." This declaration is to be followed by "I've been tracking my symptoms and according to them I think I have PMDD." Should the doctor protest, the patient/consumer need only produce her body diary as definitive proof that she and it have captured the truth/reality of situation.

Yet the YAZ body diary is not like the pastel pink, blank paged books of women's youth, complete with a little gold lock and key. It is an online interface, featuring guided pages or screens on which women "click" their symptoms. The opening screen introduces the user to the contradictory tension of the relationship between this tool and their bodies with the greeting "Welcome to the YAZ ® (drospirenone and ethinyl estradiol) Your Body Diary." How is the diary both the property of the user, as in "Your Body Diary," and simultaneously the property of Bayer Pharmaceuticals via the

YAZ brand, “the YAZ® (drospirenone and ethinyl estradiol) Your Body Diary?” The welcome screen further exacerbates the confusing questions of ownership and authorship by assuring users “Now you can quickly and easily enter your premenstrual symptoms in your private diary.” Yet, it is clearly not a “private” diary since it is developed by, owned and provided by Bayer Pharmaceuticals. In light of its ongoing issues with the FDA’s regulation of the “Beyond Birth Control” marketing campaign YAZ pulled its promotional website for YAZ and the body diary. As a result, the body diary was no longer available for download or use by those who had downloaded it previously, effectively answering the question of who the body diary really belonged to: the company or the individual women encouraged to use it.

Since the ownership and authorship of the diary are clearly not the sole domain of the user, users of the YAZ body diary are not free to employ whatever language they find best describes their “symptoms,” rather they are given a set of terms through which to describe themselves. Clicking on the “get started” button at the bottom right of the screen takes users to the first “entry” page in the diary where users click on the day of the month they are tracking and then they are asked to indicate whether they are menstruating, spotting or neither. The next five screens ask users to answer a series of questions based on a rating of 0 to 5. To avoid confusion on the meaning of terms, the page includes a key to the scale where “0: not at all 1: normal 2: mild 3: moderate 4: severe 5: extreme.” The diary includes questions about whether the user “felt depressed, sad, ‘down’, or blue or felt hopeless; or felt worthless or guilty” or “felt anxious, tense, ‘keyed up’ or ‘on edge.’” The last screen instructs users to “save your body diary.” At the bottom of each screen are three hyperlinks that will take you to pages for “patient

prescribing info," "physician prescribing info," and "important safety information about YAZ." To the right of the main screen on each page of the diary is small box indicating the tracking day of the 56-day guide (e.g. Day 1/56, Day 5/56, etc.) and bearing the question "How do you feel today?" Through this small sidebar, users can also "print report" or what might alternatively be called the contents of their diary.

The issue of language is critical in understanding the significance of YAZ's Your Body Diary. The diary performs a number of semantic maneuvers in order to acknowledge the trademarked ownership of the diary by the YAZ brand and its parent company, Bayer Pharmaceuticals. It also works to convince the women using the tool that it is *their* body diary, available to record and reflect the truth of their individual bodies. Yet, the diary fails to include any space for women to write, without prompt or guide, about their bodies and bodily processes. Moreover, the language provided for users of the body diary is filtered through over-arching project of tracking symptoms. The very act of tracking one's symptoms always already imagines the body as a problem to be solved. Symptoms are always signs of disease or illness and can only be resolved through appropriate medical intervention. Through the tracking of symptoms, women immediately become sites of management, the online tool simply helped to figure out the extent of management each body requires.

The body diary tool is perfect example of the epistemological work of YAZ's DTC advertising campaign. Under this framework women and their bodies are not capable of naming and describing their experience. Instead they require the specific language and prompts offered by YAZ through the diary to clearly bring voice to their bodily experiences. As a result, the epistemological approaches of Our Bodies Ourselves

and YAZ's marketing campaign are fundamentally at odds. The former understands women as valid arbiters of knowledge about their own bodies, the latter positions women as consumers capable of decoding the body through medical and pharmaceutical intervention. While OBOS has dedicated significant attention to DTC advertising, Planned Parenthood has taken something of a different approach. OBOS Executive Director Judy Norsigian has argued that the YAZ campaign should not have been released, yet Planned Parenthood has in at least two instances argued that there is not enough commercial visibility of contraceptives in broadcast media.

Raising the Public Profile of Contraceptives and Women's Reproductive Health

In 2004 Communications Consultant and Media Researcher Sheila Gibbons published a short commentary on plannedparenthood.org entitled "A Brief History of Modern Contraceptive Ads." The article was aimed at what Gibbons called "The Boob Tube Contradiction" of allowing commercials for erectile dysfunction and provocative TV shows while banning contraceptive ads. Gibbons argues "the networks apparently do not see the paradox of encouraging sex on the one hand and discouraging contraception on the other" (Gibbons 2004). For Gibbons the omission of "contraceptive ads is particularly troubling because television is a such a popular source, and often the principal source, for many Americans' information about health and sexual behavior" (Gibbons 2004). Gibbons argument further supports understanding advertising as a source of education and an epistemological project. Furthermore, her argument rings all-too-true when we consider the impact of abstinence-only curricula on an individual's ability to look for, identify and discriminate between sources of information on sexual and reproductive health and safety.

Ultimately, Gibbons is right in that marketing campaigns for sexual and reproductive health products do fill a very large public void. A void marked by very few public health campaigns and a contentious and longstanding debate about comprehensive sex education in the nation's schools. A national debate was sparked by the 1996 welfare reform legislation, Personal Responsibility and Work Opportunity Reconciliation Act, which dramatically increased funding for abstinence-only education programs at the state level. Funding for abstinence-only curriculum has continued to be supported by both new legislation and the renewal of relevant provisions in the original 1996 legislation. The spike in funding was the beginning of intense social and political debate about the value of abstinence-only sexual education curricula versus comprehensive sexual education curriculua. As a decision left up to the states, there is no standardized national sexual health curriculum. Some states choose abstinence-only curriculum, some choose abstinence with some contraceptive information while other choose comprehensive models, which include information on abstinence-only options. According to the Guttmacher Institute (2012), media, in addition to friends and parents, is a chief source of information on sexual and reproductive health. That peers and parents, in addition to media, are apart of teenagers' efforts to locate accurate sexual health information is reassuring. Yet, a 2004 study on parent's knowledge of condom and oral contraceptive efficacy found that a substantial number of the parents interviewed possessed inaccurate knowledge (Eisenberg et al. 2004). A public environment in which individuals may not have accurate, standardized and accessible public health information on sex and reproduction is an environment where DTC advertising potentially thrives as a pedagogical tool for both young people and adults.

Given the national environment concerning sexual and reproductive health information, Gibbons is justified in her insistence on highlighting the double standard of representing men and women's sexuality on television. To remedy these concerns, Gibbons calls for a reconsideration, on the part of broadcasters, of their policies of silence and exclusion concerning women's reproductive and sexual health products. What Gibbons fails to take up, however, is a critique of the content of the very promotional materials of which she would like to see more. For example, she cites the 1997 DTC advertising campaign for the injectable oral contraceptive Depo-Provera as an example of how the broadcast double standard impacts both the visibility of and access to pertinent information concerning women's reproductive and sexual health. Gibbons argues that the early Depo-Provera promotional campaign was significant because it was the first female contraceptive to be advertised after the FDA shifted its stance and guidelines on DTC broadcast advertising. According to Gibbons "the company [Pfizer] said it ran into steep resistance getting the campaign on the air, with a number of stations rejecting it because they had policies prohibiting birth control advertising, and others agreeing to run it only when children weren't likely to be watching (Better for kids to watch Cialis and brewski ads)" (Gibbons 2004). However, Gibbons' analysis of the conservative impetus behind the hesitation or all-out refusal to air the Depo-Provera campaign is complicated when we consider the troubled career of Depo-Provera prior to and including its broadcast debut.

Gibbons fails to mention in March 1998 Pfizer, then Pharmacia Upjohn, received a warning letter from the Food and Drug Administration regarding their broadcast commercials for Depo-Provera. The warning letter identified the ads as "misleading and

lacking fair balance because the risk information disclosed as part of the required 'major statement' is not presented in a manner comparable to that used to present the information relating to efficacy" (U.S. Food and Drug Administration 1998). Stated otherwise, the commercial chose to play up the effectiveness of the product while downplaying its potential risks and side effects. Yet, information about the risks and side effects of Depo-Provera was particularly important for women to have since it is an injectable contraceptive and once injected, it cannot be removed. Unlike the pill, which women can stop taking at any point, "Depo-Provera gives women suffering from side effects no recourse until the drug wears off" (Roberts 1997, 145). As mentioned in Chapter Two, Dorothy Roberts (1997) uncovered a particularly troubling history of serious abuses regarding coercive administration of Depo-Provera, primarily to women of color in the U.S. and the global south. Though the dangers and critiques of Depo-Provera were both documented and well known at the time of Gibbons' writing, they did not find their way into her appeal.

Three years after Gibbons' call for increased broadcast visibility of hormonal contraceptives, Planned Parenthood President Cecile Richards issued a similar challenge to Fox Broadcasting and CBS. Both CBS and Fox refused to air commercials from the Trojan Condom EVOLVE campaign, which featured bar prowling pigs that eventually turned into handsome white men upon obtaining a Trojan condom. CBS and Fox each cited vague arguments about the appropriateness of the commercial for viewing audiences and about the ad's explicit link, or lack thereof, to public health concerns like HIV and other STIs as the reason for the decision not to air the campaign. In letters penned to the presidents of both networks, Richards takes up Gibbons arguments

regarding the irony of allowing advertising "for drugs like Viagra and showcas[ing] sex-saturated, primetime programming like Temptation Island and The O.C., which included an average of 6.7 sex scenes per hour" (Richards 2007). Richards challenges Fox Broadcasting's faulty logic that "contraceptive advertising must stress health-related uses rather than the prevention of pregnancy" by, rightly, pointing out that pregnancy, particularly unintended pregnancy is both an individual and public health concern (Newman 2007). What Richards and Gibbons are arguing for, at its core, is visibility and, more specifically, publicly accessible visibility of reproductive and sexual health information. Planned Parenthood websites, for example, provide a plethora of information on birth control options including, but not limited to, condoms. However, in order to access that information one must go looking for it. Broadcast commercials, on the other hand, do not require the same kind of intent, one must simply be in the proverbial right place at the right time or rather be any place at any time as advertising is an omnipresent factor in our current media world.

The heightened presence of media causes us to look it to as an important site of public information precisely because of its visibility. Yet, in acknowledging the importance of media, and specifically advertising, to the contemporary visibility of public health concerns, sexual and reproductive health advocates must also be able to offer a critique of it as an imperfect, if necessary, space. Both Gibbons and Richards come dangerously close to overstating the value and responsibility of media in relation to public health without offering an attendant critique. According to Richards, broadcast corporations "have a responsibility to promote good public health practices, including using condoms to prevent unintended pregnancy and sexually transmitted infections"

(Planned Parenthood Federation of America 2007). Yet, in Gibbons' Depo-Provera example, we see the limits of contraceptive advertising when we when recall that Pharmacia Upjohn was cited by the FDA regarding their marketing of the injectable contraceptive. So while the availability and accessibility of sexual health information is of the utmost importance, the content/quality of that information is equally, if not more, important. With this kind of double-edged analysis missing in action, we continue to see failures in media's ability to fully grapple with the complicated and nuanced nature of women's reproductive health and sexual practice(s). Planned Parenthood's vehement defense of advertising as a crucial component of public health information sharing provides an important context for thinking through the organization's virtual silence over the troubled career of YAZ. Moreover, it also helps to explain Planned Parenthood's own investment in developing mainstream marketing campaigns, like their "Planning is Power" campaign and the "Safe is Sexy" campaign.

Marketing Safe Sex

While not a broadcast campaign, Planned Parenthood New York's 2006 campaign "Planning is Power" is also significant in thinking about the organization's response to the role of advertising in women's reproductive and sexual health. Mainly a print campaign distributed via poster, postcard and mass transit billboard, "Planning is Power" aimed to "look at birth control in a new way that didn't just talk about types of birth control available, but also presented why women and couples would choose to use birth control" (Planned Parenthood, NYC 2006). The campaign featured images of women alone, with a heterosexual partner or a child. Each image was accompanied by copy explaining the reason that particular woman or couple chose birth control.

The first featured a young woman of color in a graduation cap and gown smiling and embracing another woman also in graduation regalia. The accompanying texts read "I plan to be a great mother some day. 'Til then, I'm using birth control." A second image featured a young heterosexual couple of color and stated "We plan to be great parents some day. "Til then, we're using birth control." A third poster showed a smiling young white woman laying on the grass with a book in one hand and the accompanying text read "Birth control makes all my other choices possible." The final image was of a young black woman in pearls and a suit jacket with a caption that stated, "My future is up to me. That's why I use birth control." These images are significant because they return, yet again, to the rhetoric of choice, rhetoric eerily similar to that deployed by Bayer Pharmaceuticals in the BeYAZ campaign. The campaign attempted the critical work of linking women's ability to plan pregnancies to making a range of important life decisions,

> At Planned Parenthood, we know that birth control isn't just about preventing unintended pregnancies. It's also about being able to choose when to start a family and when to add to a family. It's about being able to provide for the family you already have. It's about every child being a loved and wanted child. We wanted to create a campaign to express all of these reasons for using birth control (Planned Parenthood, NYC 2006).

While these are important points to make, it is inadequate to do so at the expense of acknowledging other factors that might also impact women's abilities to choose particular life paths and plans.

Each of the campaign's images and the text that accompanies them position birth control as the arbiter of not only women's reproduction but of their life potential more broadly. Yet, as I argued of the YAZ commercials, to claim "birth control makes all my other choices possible" ignores the multiple systems that women, and men, may face that

have the power to structure, grant and deny opportunity. Approaching birth control advocacy from a feminist perspective must include a larger systemic critique that refuses to reduce women's social and economic experience to issues of personal responsibility and planning.

In 2006, the now defunct Planned Parenthood Golden Gate of San Francisco launched its edgy and controversial "Safe is Sexy" broadcasting marketing campaign. The campaign featured four different commercials and ran until February 2008 mainly on cable networks such as MTV. The campaign was significant for its slick and stylized look, which rivaled the more well funded and polished marketing campaigns for condoms and hormonal contraceptives released by major pharmaceutical corporations. It is also important for the ways that it both mirrored and differed from mainstream birth control marketing campaigns, both aesthetically and substantively. Like the "Beyond Birth Control" campaign, the "Safe is Sexy" campaign was equally invested in identifying its target audience of young adults and potential clients as well as narrating their ideal lives. Moreover, through employing similar tropes of modernity, e.g. youth, whiteness, urbanity, "Safe is Sexy" aimed to carry out the same kind of epistemological project at work in the YAZ campaign. Unlike the YAZ campaign, however, sexuality and heterosexuality in particular are much more explicit in the "Safe is Sexy" campaign. In this campaign, sex, and certainly heterosexual sex outside of marriage, are explicitly presented as a norm of the young and modern lifestyle. Whereas in the YAZ campaign, the ideal lifestyle centered on body management in the name of social interaction, the "Safe is Sexy" campaign identified body management, for fertility and disease prevention, as the foundation of sexual interaction; which it acknowledged as an

important part of social interaction. And in contrast to the YAZ campaign, the "product" or intervention offered in the "Safe is Sexy" campaign is not for a particular contraceptive or disease prevention product but for the services of Planned Parenthood. In this campaign, Planned Parenthood was positioned as the intervention, the conduit between the body and idealized life, which centered on sexual activity.

The first commercial released in the campaign aired in April 2006 and used a construction theme, urging viewers to choose the "right tool for the job." The commercial opens with a young female construction worker operating a jackhammer in front of a construction zone. Rock music plays in the background and a female voice-over informs viewers, "My father always told me to use the right tool for the right job" as a woman uses a large drill to cut through a piece of wood and attempts to saw through a large pipe. These scenes give way to the same young woman entering a bedroom still wearing her blue construction jumpsuit, tool belt and yellow hardhat. The jumpsuit is magically ripped from her body as she walks through the doorframe. The hard hart and tool belt remain and beneath the jumpsuit she wears blue underwear and a white tank top emblazoned with "Safe is Sexy" in comic book style lettering and graphics and resembling the infamous "S" of Superman in both color and style. The background music switches from rock to a softer more seductive tune while a man, also wearing a yellow hard hat, sits up and waits expectantly in bed. Our protagonist tosses her own hard hat aside and seductively, thanks to slow motion, shakes out her long dark hair. The man holds the blanket up and she dives underneath and across his lap to the other side of the bed where her hand peeks out from the beneath the blanket to open a red metal tool box full of multi-colored condoms, on of which she grabs. The scene gives way to a

dimly lit room with a figure, shrouded in blankets, sitting up high in the bed, likely on top of someone else. Here, the female voiceover returns remarking "Ooooh, nice tool." There is a quick cut to a black screen with the red toolbox, above which reads "Planned Parenthood Golden Gate is your toolbox," underneath reads "for an appointment call 1.800.230.PLAN or visit www.ppgg.org." The commercial ends with a large version of the same "Safe is Sexy" logo seen on the woman's tank top in the center of the frame.

In this commercial, protected sex is not just safe or more logical; it is sexy, literally oozing with sexual energy and innuendo. Moreover, here the woman appears to be in control of the condoms, an item that has largely been seen as the exclusive domain of men. Like the YAZ commercials described in Chapter Two, the woman is the center of the commercial and she is presented as self-assured and in control. Unlike her YAZ counterparts she is also represented as sexually confident and active, something sorely missing from the YAZ campaign. This campaign takes up the same manner of address as the "Beyond Birth Control" campaign through its use of a young, conventionally attractive, confident white woman as the focus.

The second commercial moved from the construction zone to the research lab, positioning Planned Parenthood as the Principal Investigator, if you will, of heterosexual "experimentation." This commercial begins with soft romantic music playing and as the camera pans up from the lower left corner the viewer finds a woman sitting on a man's lap. The pair kiss and embrace in what looks like a living room reminiscent of a converted warehouse or loft apartment with large windows overlooking a cityscape. The woman abruptly falls off the man's lap as he reaches forward for a condom on the coffee table. The man opens the condom but somehow snaps it like a rubber band, hitting

himself in the eye and falling backwards off the couch and knocking a lamp down on his way backward. The woman jumps up from the floor and awkwardly, and ultimately, unsuccessfully opens a birth control Dialpak sending little white pills flying into the air and all over the floor, upon which she then slips.

A female voice-over chimes in with “Meet Brad and Karen, a new couple volunteering in our crash course on birth control.” Here the camera pans out, leaving the room with the couple, and revealing a white lab facility. The couple can be viewed in the “living room” through a window above which a sign reads “Interactive Testing Room” complete with a flashing red light. Standing in front of the window is a young, thin white woman wearing glasses and a white lab coat carrying a clipboard. The female voice-over belongs to her. She moves to the side of the viewing window and continues, “They are determined to be responsible and are starting to take matters into their own hands. Discovering that safe is sexy.” By now the back of a shirtless Brad is pressed against the viewing window and we see Karen jump onto him and put her arms around his neck. The lab assistant takes one last look at the couple and pulls down the blinds so that they can be seen no more.

The commercial cuts to the final scene which takes place in the “living room” with a seemingly naked Brad sitting on the couch and a partially clothed Karen sitting on his lap. The two are looking into each other’s eye. This time they are joined on the couch by the Lab Assistant, who sits formally and erect to their right and slightly in front of them. She is also fully clothed with clipboard in lap. She asks the audience to “Remember, it takes two.” On cue, Brad and Karen turn to face the camera and each flashes a contraceptive method: Brad - the condom and Karen - the birth control Dialpak.

This is a noticeable departure from the previous commercial as it returns to the traditional gendered division of contraceptive labor. Again, the Planned Parenthood contact information appears at both the top and bottom of the frame. The top reads Planned Parenthood: Golden Gate. While the bottom reads "Visit Planned Parenthood and skip the research. 1.800.230.PLAN. www.ppgg.org."

Like the first YAZ commercial set in the rooftop bar, this commercial offers an interesting recasting of women's relationship to science and medicine through the use of a female lab assistant. Unlike the YAZ commercial where viewers are asked to imagine the white coat that denotes medical and science personnel, this commercial explicitly invokes the signifiers of modern medical science. Pioneering white male scientists of contraceptive technologies, like Gregory Pincus and John Rock are replaced in the lab setting with this nameless white woman who stands in to represent the role of science in creating the opportunity for safety to be sexy and sex to be safe. Much the like infamous 1930's Lysol marketing campaign, "Frank Talks with Eminent Women Physicians," the lab and the science it produces are represented as more in tune with women's health and well-being by virtue of featuring women in roles traditionally reserved for men. As Andrea Tone notes of these depression-era contraceptive marketing campaigns,

> Dispelling consumer doubts by invoking the approval of the scientific community was not an advertising technique unique to contraceptive merchandising…What was exceptional about contraceptive advertising, however, was that the experts endorsing feminine hygiene were not men. Rather, they were female physicians whose innate understanding of the female condition permitted them to share their birth-control expertise 'woman to woman' (Tone 2001, 160).

The Planned Parenthood commercial nearly explicitly employs this logic when it urges viewers to "visit Planned Parenthood and skip the research." The commercial encourages viewers to cede authority over sexual health needs by "skipping the research" and visiting

Planned Parenthood. While, as the commercial hints, research on and deciding among the varied contraceptive methods can be daunting, what Planned Parenthood seems to offer is not simply help but rather willingness to stand in as a proxy that will do the difficult research and work for you.

Encouraging women to "skip the research" fails to position them full agents of their sexual health, instead it asks them to rely on the "expertise" of others, more qualified than themselves, for right guidance on their sexual health needs. It might seem that relying on Planned Parenthood, a long noted advocate of women's health, would be decidedly different than relying on a for-profit drug or marketing company for information and guidance on making sound health care decisions. However, it is not simply a matter of the source but in the very act of encouraging women to turn over their decision making in the name of science and modernity that the failure occurs. Eliciting this kind of unquestioned trust from women in regards to their sexual and reproductive health has not historically served them well. In the case the Lysol ads mentioned earlier, investigations by the American Medical Association found that the "eminent women physicians" of the series were all fabricated in addition to the fact that douching with Lysol was not, by any stretch of the imagination, an effective contraceptive and many women experienced serious bodily injury at its hands (Tone 2001). In the contemporary moment, choosing to make decisions for women instead of educating and empowering them to make appropriate decisions for themselves continues to leave women ill-equipped to engage the rapidly changing nature of health cultures and scientific and medical technology. For Planned Parenthood in particular this was an unethical and irresponsible suggestion as just two years after this commercial aired, doctors and

clinicians working with Planned Parenthood Golden Gate complained of poor working and service conditions, which included "shortages of critical supplies, including intrauterine devices, [which] meant some patients were turned away" (Mieszkowski 2010).

Moreover, just as it was in the early Lysol campaign, the contemporary advertising attempts to re-imagine women's relationship to and role in medical science in order to tell a better story about products. If nothing else, this long history of commercial imagination speaks to the enduring themes of modernity, in/fallibility, expertise and trust in representations of women's reproductive and sexual health. The story of women's relationship to scientific innovation seems to have changed very little, while the technologies that constitute those innovations have changed dramatically. Indeed, we can now talk openly about pregnancy prevention in contemporary contraceptive marketing instead of being limited to the catch all euphemism of "feminine hygiene." Yet, that same "openness" is limited as the contraceptive capabilities of hormonal birth control are minimized in contemporary advertising in order to both avoid public engagements with women's sexual practices and to emphasize the role of oral contraceptives in properly managing the female body in manners beyond fertility (i.e. mood, weight, skin, etc.).

The third commercial in the Safe is Sexy campaign, "Guardian Angel," opened with a young, white and heterosexual couple in bed, engaging in foreplay. A scruffy white male "angel," identified by his white bodysuit, wings and halo, sits above on the headboard eating popcorn and watching the scene below like a steamy movie. As the interaction between the couple unfolds, the woman awkwardly asks about protection but is silenced by her partner who suggests they "not ruin the moment" by entertaining such

mundane business. Another angel appears, this time a young woman of color, to chastise the male angel for letting this unsafe sexual interaction take place, asking him "Aren't you supposed to be the guardian angel of safe sex?" He reassures his celestial colleague with "keep your halo on! Watch this," at which point he uses a remote to rewind the "scene." Upon second watch, the young woman confidently inquires about "protection," her partner complies and she affirmatively responds "Amen." Crisis averted, the male angels turns his amorous attention to his female counterpart who, literally, shuts him down with a click of his supernatural remote.

The fourth and final commercial in the campaign, "Mile High" was released December 2007 and was slated to run through Feb 2008. The commercial's title and theme were a cheeky play on the colloquial term "mile high," which refers to individuals who engage in sex on an in-flight aircraft. The thirty-second commercial opens in a nicely appointed airplane with a young Black male flight attendant who enacts the stereotypical and problematic trope of effeminate, read as queer, masculinity. The flight attendant pops up from behind a service cart and introduces himself with "Hello and Welcome Aboard. I'm Steven." The light changes and music begins to play, making the plane look more like a disco than an in-flight passenger plane. In response to the lighting and music changes, Steven informs the passengers, "We've reached our cruising altitude of one-mile high." To which everyone on the full flight cheers. The camera cuts to a young white couple. The woman licks a heart shaped lollipop while the gentleman looks on and then leans in to kiss her. From behind her seat, Steven appears, "Hey guys! Just want to make sure you've got the pill, patch, condoms. We're all about choices. Have some more. BAM!" At this point, the emergency overhead compartment opens and,

instead of air masks and life vests, drops an array of contraceptive and STI prevention options. The scene freezes with the couple and Steven surveying what's just fallen into their laps. The words "The Friendly Skies Just Got SAFER" appear over the frozen scene. The words disappear, the scene is unfrozen and the couple smiles at their treasure trove with the man picking up a condom. A quick cut shows a plane flying through dark night sky. Another cut brings the viewer back to the plane, but this time to the cockpit where Steven sits on a white pilot's lap. The Planned Parenthood (Golden Gate) logo is positioned at the very top of the frame and "(800) 976-PLAN. www.ppgg.org" sits at the bottom. The airplane intercom notification bell is heard in the background and Steven declares, "On behalf of Planned Parenthood Airlines you are now free to make sweet, sweet love." Steven laughs, perhaps suggestively, while looking down at the pilot, who returns the sentiment with a sly and suggestive smile of his own.

In response to the campaign, then CEO and President of Planned Parenthood Golden Gate, Dian Harrison, stated

> PPGG created this campaign to stress the importance of sexual health in a creative way and one that break free from the old ineffective paradigm of relying on fear-mongering tactics to inspire desired behavior changes…We want young people to take control of their sexual health and well-being by using prevention every time they have sex. This ad's message normalizes pregnancy prevention and safer sex in a healthy, cool and humorous way (Planned Parenthood, Golden Gate 2007)

Yet, the commercials do not show young people making informed decisions. When the young couple is presented with the multiple options that fall from the overhead compartment, the viewer does not get a sense of how, if at all, they might go about deciding which methods to use. The viewer is not exposed to informed and agentic decision-making on the part of the young people featured in the ad. Instead, the viewer again finds Planned Parenthood positioning itself as the conduit of heterosexual sex,

literally offering its permission to “make sweet, sweet love.”[7] The viewer of these ads never sees the commercials’ subjects ask questions about which contraceptive and disease prevention methods are best suited to their needs.

In the “Guardian Angel” commercial, the viewer is exposed to a young woman attempting to negotiate a safer sexual encounter when she inquires about using protection. However, in the initial interaction, her partner successfully silences the woman when he tells her not to ruin the moment. It is only after a third party, represented by the white male guardian angel, intervenes and “rewinds” the sexual encounter that we see a more positive result. It is also important to note that neither of the individuals involved in the sexual interaction intentionally seek out a second chance, rather they are granted one, literally, from above by an unseen, at least to them, third party represented as the guardian of safe sex. Moreover, the celestial second chance these two lovers are granted is still void of a strong example of sexual agency and health negotiation. The second time around, as the woman asks about protection the man replies “of course,” to which the young woman says “amen.” Since the audience never actually sees the form of protection the young man references, we get no sense of what type of protection it was or if it was acceptable to the woman. Harrison’s argument for safer sex campaigns that refuse to dabble in the politics of fear and stigmatization is an important one and the “Safe is Sexy” campaign certainly achieves that goal. However, it is not enough to make messages about safe sex fun without corresponding content that encourages women and men to see themselves as authorities in the health and well being

[7] Though there is potential to read the inclusion of Steven as a nod to acknowledging the sexual health needs of queer individuals, I am hesitant to promote that reading given that the majority of the Safe is Sexy campaign focuses explicitly and exclusively on heterosexual encounters.

of their bodies.

Crafting Alternative Engagements with Media in the name of Feminist Women's Health Advocacy

While Planned Parenthood overinvests in media, particularly advertising, as a critical source of visibility and information on women's reproductive health, Our Bodies Ourselves seems to eschew it altogether. Yet, OBOS' approach to the role of media, specifically advertising, does not serve women's reproductive health advocacy. Media and certainly advertising is an inescapable part of our contemporary social, cultural, and political environments. It is impossible to completely ignore media. Disavowing it ignores its powerful possibility as a tool of education and empowerment. Though a thorough critique is needed, women's health activists cannot afford to completely dismiss media.

What is needed is a framework for analysis that balances a "healthy skepticism" of media and an investment in its potential as a robust pedagogical and epistemological tool. While a number of organizations address the implications, effectiveness and ethics of DTC advertising, such as the Media Education Foundation, both Planned Parenthood and Our Bodies Ourselves are in a unique position to be able to engage the gendered nuances and implications of DTC advertising and the products they represent. Women's health advocates can and should partner with critical media literacy initiatives as they develop frameworks that balance both critique and endorsement of media. Critical media literacy frameworks draw from and are bolstered by the important work of cultural studies as well as feminist, critical race and other social justice theories. Each of these theoretical sites offers a methodological grounding that privileges marginalized voices

and works to create the conditions under which those voices can speak, be heard and effect change.

Critical media literacy should be clearly understood as a social justice practice. It is not simply a framework for critiquing media; it is also a framework making connections between media representations and the materials conditions under which we live as real embodied people and citizens and for simultaneously exploring media as a site of resistance. Because critical media literacy moves beyond the frame and asks questions about production, distribution, circulation and reception, it is particularly equipped for thinking through how these very processes can be disrupted and redeployed in non-hegemonic ways. Taking its direction from Black feminist theories on the importance of voice and its relationship to agency and action (Collins 2000), critical media literacy becomes a tool with which marginalized individuals and groups can name their experiences and analyses of the world in relation to media. The act of naming, of making intelligible one's claims to authoritative knowledge, is a fundamental prerequisite to action and to the practice of radical, democratic citizenship (Giroux 2004; Kellner and Share 2005). Ultimately, the practice of democratic citizenship is important for thinking about how we participate in health advocacy and activism on local and national levels.

I articulate critical, feminist and health-focused media literacy as the appropriate intervention in feminist advocacy's use and critique of media. Feminist health media literacy builds on the above definition of critical media literacy by locating the marked body (i.e. marked by race, gender, ability, etc.) along with questions of bodily agency and integrity at the center of the framework. Using the material and discursive body as a point of pivot, a feminist and health conscious critical media literacy begins its analyses

of media forms from the body. Feminist and health conscious critical media literacy asks (1) how is the gendered body figured in a given piece of media; (2) what kind of bodies show up; (3) how are they being represented; (4) what are the gendered nuances of those representations; (5) how are those nuances further shaped by issues of race, sexuality, etc.; (6) what, if any, are the historical legacies and/or trajectories of those representations; and, (7) to what contemporary event(s) can those representations be connected and to what ends? Bringing feminist health and science studies together with critical media literacy, goes beyond the traditional "hot topics" of women's health, i.e. abortion and contraceptives. Instead, this approach to media literacy asks critical questions about how we conceptualize women's reproductive and sexual agency in media and how, in turn, those conceptualizations impacts women's material realities with respect to their reproductive and sexual realities. As a result, critical feminist and health-focused media literacy exceeds the capabilities of the more traditional and liberal reproductive rights framework and, instead, falls more in line with reproductive justice frameworks.

Distinct from more familiar reproductive rights frameworks, reproductive justice goes beyond the dominating issue of choice in women's reproductive health debates. As Andrea Smith (2005) argues, "the pro-life versus pro-choice paradigm reifies and masks structures of white supremacy and capitalism that undergird the reproductive choices that women make…" (Smith 2005, 120). Smith and others (for example, Silliman et al. 2004; Roberts, Ross, and Kuumba 2005) have argued that reproductive justice frameworks widen the analytic frame of women's reproduction to examine the multiple factors that impact and influence whether and under what conditions women become pregnant,

become parents and raise children. Under this expansive framework, policies and social systems that are not normally linked to women's reproduction are reconsidered for their direct and indirect connections to women's reproductive possibilities and realities. In order to map a better understanding of just and ethical reproductive and sexual lives for women, reproductive justice engages areas as diverse as environmental and economic justice. Furthermore, reproductive justice frameworks are best suited to accommodate critical, feminist and health-focused media literacy because they "recognize that the control, regulation and stigmatization of female fertility, bodies and sexuality are connected to the regulation of communities that are themselves based on race, class, gender, sexuality and nationality" (Silliman et al. 2004, 4). Through a focus on stigmatization, reproductive justice frameworks take seriously the role of representations of women's reproductive health and its relationship to social practices.

Through reproductive justice, the feminist health media literacy framework is able to rethink the current category of medical consumer as the primary identity from which individuals can advocate for their health care and access to quality health care information and service. My earlier discussion of Sheila Gibbons' commentary on the Planned Parenthood website is a good example of the limits of the medical consumer model for advocacy. Gibbon's remedy of airing more contraceptive commercials was caught in a familiar trap from the outset. In calling for the increased commercial visibility of contraceptives, she makes products the preferred site for representing women's reproductive and sexual health in popular media. Gibbons could have potentially furthered the discussion of public engagements with women's reproductive health and sexual practice by advocating public-service announcements, documentaries

or fiction films that address women's health, for example, as potential disruptions of the "boob tube contradiction."

Relying on contraceptive commercials as the preferred intervention further entrenches us in the capitalist based model of privatized health information direct from corporations. In this model, "wealth determines citizenship. Instead of people governing, markets govern – it is not citizens who make decisions, it is consumers. So those who lack economic capacities are noncitizens"(Mohanty 2004, 184). Mohanty's argument regarding the emergence of "citizen consumers" underscores the limitations of this model for women's health advocacy as the current landscape of health advocacy routinely speaks of medical consumers. Even if networks complied with Gibbons' demands, all women would not be represented nor benefit as their visibility, and thus advocacy, would be primarily tied to their ability and desire to consume the contraceptive products advertised. A critical, feminist and health-focused media literacy works to acknowledge the multiple ways women interact with health care systems and with their own health care on a personal individual level. This approach recognizes women as consumers, yes, but also as patients, embodied knowers and as citizens who engage reproductive healthcare as a personal or material reality but also a political and social reality.

The critical connection between media justice and reproductive justice is beginning to be recognized by organizations such as Atlanta, GA's SPARK Reproductive Justice NOW, which hosts an annual Media Camp for LGBTQ youth of color in the south. SPARK maintains that "By providing queer and trans youth of color with hands on experience working with various media forms, we hope to encourage and inspire them

to critique mass media by reclaiming their own histories and lived experiences and allow them the opportunity to build new relationships with other Southern queer youth" (SPARK Reproductive Justice Now). SPARK's approach to the relationship between media and reproductive justice takes a broad approach which privileges both learning to deconstruct existing media and produce alternative media that perhaps speak back to dominant media approaches. Moreover, May 2012 saw the first of what will hopefully be an annual conference on media and reproductive justice in New York City hosted by the NYC Reproductive Justice Coalition, in collaboration with Women's eNews. These two events work to demonstrate the increased awareness of the important links between media and reproductive politics and advocacy, both for organizations and individuals.

This chapter joins the work scholars such as Jaworski (2009), who are also beginning to address how reproductive rights and justice advocates can use media to create images and messages advocating for women's agency and autonomy in their reproductive and sexual health. Moreover, feminist health media literacy constitutes an important scholarly intervention as it contends that women's health advocacy must include a systematic critique of media's treatment of women's reproductive health. My work, in particular, intervenes in its focus on advertising in general and direct-to-consumer advertising, specifically, as a particularly important site of feminist intervention and critique. Analyzing the responses of two stalwarts of women's reproductive and sexual health advocacy, Planned Parenthood and Our Bodies, Ourselves, I argue that each organization takes a position on the role of media, specifically advertising, radically different from the other, which works to contextualize their responses to the fame and public fallout over the oral contraceptive YAZ.

Ultimately, I contend that while each approach has some merit, a new and distinct approach to media is desperately needed in women's reproductive and sexual health advocacy and activism. Bridging the theoretical and methodological work of critical media literacy, reproductive justice frameworks and feminist, anti-racist & cultural studies, I propose a framework of critical feminist health media literacy. Through privileging the gendered body and its relationship to multiple markers of difference, this mode of media literacy functions as a tool to unpack, resist and create alternative images to the dominant media representations of women's reproductive health and sexual practice. Moreover, using the work of critical democratic theorists, the practice of a gender and health aware critical media literacy is central to the practice of a radical and informed democratic citizenry, which impact women's ability to advocate and lobby for their reproductive health needs on a political level. The following chapter takes up this approach to health and media by addressing individual women's responses to the public life of YAZ, as I have discussed it in the previous three chapters. Chapter Five will explore the responses of a small number of women in the Atlanta, Georgia area as they discussed their preferred sources of reproductive health information and their processes for making important reproductive and sexual health decisions.

Chapter Four:
Crafting Epistemic Authority: Women's Approaches to Contemporary Reproductive Health Information and Decision-Making.

The first four chapters of this project investigate the ways in which information about women's reproductive and sexual health is constructed in contemporary U.S. public discourse. More specifically, they reveal how various sites of discourse come together to form a polyvocal, dynamic and shifting public pedagogy of women's reproductive health. In the absence of other formal sites of health curricula and learning, the public comes to learn about women's reproductive health through this informal public pedagogy. What emerges from this analysis is not only an understanding of public pedagogies of women's reproductive health but a map of the major concepts and identities central to these pedagogies.

In Bayer's "Beyond Birth Control" marketing campaign, women are represented as empowered agents of their social lives through using YAZ. Conversely, in the rhetoric of Bayer's engagements with the FDA, representations of women vacillate between disembodied users stripped of social and corporeal agency and a population in need of a paternal-like protection. Alternately, in women's and feminist health advocacy, women are imagined as agents capable of managing their reproductive health care but in need of direction in order to be critical consumers of either reproductive health products or reproductive health information. At the core of all of these varied identities for women reproductive health consumers are the issues of expertise and choice. Each of these constructed identities proposes the appropriate stewards and experts of women's reproductive health. Choice is also at the heart of these identities. As I argued in Chapter Three, the concept of choice carries both emotional and political currency in discussions

of women's reproductive health. Choice is also absolutely and fundamentally critical to how and if at all women can experience and exercise reproductive autonomy and justice. The identities seen in debates over YAZ are always about choice, variously conceived as consumer choice, informed choice, political choice, ethical choice and available choice, to name a few. Feminist bioethicists (Roberts 1996; Holloway 2011) have argued that these dimensions of choice cannot be separated from one another. All of these dimensions must be present and equally so for all individuals in order to achieve informed consent, which serves as the foundation for the way we think about ethical engagement of patients and consumers in healthcare. This chapter further scrutinizes these dominant identities and their approach to choice and expertise by engaging with women's own self-identification regarding their relationship to and management of their reproductive health. In this chapter, I discuss three main themes that emerged from a series of interviews I conducted with women: information gathering and decision-making practices, the role of media in those practices, and the identities that women enact as stewards of their reproductive health. I have quoted the respondents in my small interview study at length as a part of a feminist methodology and feminist health activism that seeks to center and privilege the voices of women as worthy of being heard and as experts on their own experiences.

Engaging women's voices directly is an important contribution of this research. The discursive sites discussed in the previous chapters often made assumptions about women's reproductive health needs but rarely included input from women who might actually be using a particular product or service. Privileging women's experiences with and analysis of individual reproductive health care management aims to correct the

exclusion of their expertise from dominant public discourse about reproductive and sexual health. Highlighting women's experiences as critically informative draws on feminist theories of the importance of women's and feminist standpoints in disrupting hierarchies of dominance and systems of marginalization.

Feminist standpoint theory argues that people's perspectives are situated in particular historical, cultural, economic, and geo-political locations. As a result of this "situatedness," all perspectives are partial and incapable of a totalizing or omnipresent view. The partiality of one person's perspective requires that it be in constant dialogue with others in order to map a fuller, more nuanced sense of any particular issue being addressed. Feminist standpoint theory further acknowledges that these diverse and partial perspectives are not treated equally as they are embedded in oppressive hierarchies based on the dominant politics of racism, sexism, heterosexism, ableism, classism and other marginalizing systems. As a result, perspectives rooted in identities privileged by oppressive politics (i.e. whiteness, maleness, heterosexuality, etc.) will likely be invested in maintaining the status quo, which benefits them. Alternately, individuals located, either completely or partially, in identities disadvantaged by the prevailing politics of marginalization may be more willing to engage in visions and actions that seek to disrupt the status quo, rendering their vision privileged in the service of liberation and justice.

This last component of feminist standpoint theories works to center and privilege the voices and experiences of women and other individuals marginalized in relation to dominant identity structures, such as racism, sexism, etc. As Mary Mahowald argues in her critique of health care and bioethics,

> Standpoint theory is based on recognition that each one's point of view, expertise, and authority are situated and partial. It implies the need for attention to views

> that are often neglected, such as those of women. A feminist standpoint serves as a corrective to the overall neglect of women's interests, experience, and insights in contemporary health care and bioethics (Mahowald 1996, 98).

However, the epistemic privilege granted to marginalized individuals via standpoint theory has been critiqued as being reductive. To grant epistemic privilege to marginalized individuals could potentially ignore the ways in which people are often simultaneously privileged and marginalized. As Donna Haraway argues,

> There is no way to "be" simultaneously in all, or wholly in any, of the privileged (i.e. subjugated) positions. The search for such a "full" and total position is the search for the fetishized perfect subject of oppositional history, sometimes appearing in feminist theory as the essentialized Third World Woman (Haraway 1988, 586).

Haraway also points out the way that granting epistemic privilege can essentialize marginalized individuals and groups by assuming that they will automatically challenge the status quo. As she argues, "the standpoints of the subjugated are not 'innocent' positions. On the contrary, they are preferred because in principle they are least likely to allow denial of the critical and interpretative core of all knowledge" (Haraway 1988, 584). Haraway still privileges the knowledge of marginalized people yet, she refuses the assumption that subjugated standpoints are automatically oppositional. Instead she argues that marginalized individuals and groups are likely but not guaranteed to advocate oppositional and social justice perspectives.

Likewise, Linda Alcoff complicates the issue of epistemic privilege without abandoning it. She writes,

> But if a privileging of the oppressed's speech cannot be made on the grounds that its content will necessarily be liberatory, it can be made on the grounds of the very act of speaking itself. Speaking constitutes a subject that challenges and subverts the opposition between the knowing agent and the object of knowledge, an opposition that is key in the reproduction of imperialist modes of discourse (Alcoff 1991, 23).

As a solution, Alcoff and Haraway advocate for an attention to location or, what Haraway

calls, a "politics and epistemologies of location," which recognizes the situated and partial nature of knowledge and, as a result, recognizes the need for multiple standpoints and locations to inform, challenge and nuance one another (Haraway 1988, 589).

The inclusion of women's stories of reproductive health care management in this research draws on Haraway's theory of situated knowledge as well as both Haraway's and Alcoff's negotiated relationship to epistemic privilege and subjugated standpoints. Women's voices are privileged in this research because they have been so thoroughly disavowed in the majority of public debate and dialogue. Subjects in my research are afforded an epistemic advantage not solely based on their identity but because of their position vis-a-vis mainstream discursive structures, organized as they are by systems of racism, classism, sexism, heterosexism, and ableism. In this way, as Alcoff advocates, the knowledge my study participants offer about the management of their reproductive lives is privileged as a result of its exclusion from dominant discourse. Including and privileging those voices here challenges fundamental assumptions about subjectivity and agency. Moreover, the exclusion of women's and female assigned at birth people's experiences has resulted in a critical gap in the relevant knowledge about the reproductive and sexual health needs of these individuals. Their voices are then further privileged as a result of their ability to address that gap, either in whole or in part. Ultimately, I contend that a discussion of women's reproductive health is fundamentally incomplete without including women's varied perspectives.

In order to determine women's self-identification in relation to their reproductive health, I interviewed twenty English-speaking people aged 18-35 in the metro Atlanta, GA area. Eighteen of the interviews were completed in person and two were completed

via phone.   Each interview lasted between 45 minutes to an hour and a half.   Participants were recruited via study announcements distributed via email and on relevant web-based list serves and announcements at local venues. The majority of participant recruitment occurred through snowball sampling, in which existing participants referred friends and acquaintances to the study. Just over half of the participants identified as black or African American, seven identified as white and two identified as Latina or mixed-race Latina. Sixteen of the participants in my study self-identified as heterosexual, while the remaining four participants identified as queer. Eighteen participants used woman or female to describe their gender identity while two participants identified themselves as gender queer. All individuals who participated in the study had at least a bachelor's degree, with half also having at least one advanced degree. Finally, all the names of participants have been changed to pseudonyms in order to protect the confidentiality of the individuals who generously gave their time to participate in these interviews.

Each interview broadly covered topics related to women's reproductive health, contraception and popular media in the U.S.. Respondents were asked a series of questions about their opinion and attitudes about women's reproductive health in the U.S. as well as their own decision-making about their reproductive health.

My questions included, but were not limited to the following:

- How would you describe your reproductive health?
- Where do you get information about your reproductive health in general?
- Does media impact your reproductive health care practices? If so, how?
- How do you compare and judge different information sources
- Who do you consider to be an excerpt about reproductive health in general and your reproductive health in particular?
- Are you in conversation with any individual(s) in particular before making decisions about your reproductive healthcare? If so, who and why?
- What are three words you would use to describe yourself as a steward of your reproductive health?

Additional questions were asked based on each individual's answers to the previously determined list of questions.

The results of the interviews I conducted reveal complex epistemological frameworks and practices that emerge from women's reproductive health information gathering and decision-making. These epistemological practices negotiate individual and institutional expertise and validity and draw on each woman's individual and collective identities. For example, one woman who identified herself as a Christian cited the Bible as an important source of meaning in her reproductive health decisions. In the vast majority of the interviews, media did play a role in each individual's respective epistemological approach, even when they did not explicitly recognize it as such. Several participants initially said that media did not factor into their reproductive health information gathering but upon further reflection often identified at least one instance where media was a factor in some aspect of their reproductive health information sourcing. It was also often the case that media that explicitly addressed women's reproductive health failed to map the range of health needs and concerns with which respondents in my study identified. More specifically, most media focused on contraception and abortion, while participants in the study were grappling with a number of reproduction and sexual health concerns including infertility and premature menopause. What follows is an exploration of women's reproductive health epistemologies, taking into account who can know, what can be known and, finally, how to evaluate both the knower and the known in terms of expertise, accuracy and applicability.

Information-Gathering and Decision-Making Practices

"The biggest one would be the Bible and what that states according to whatever specific issue I'm having, whether it be an irregular thing or just a monthly cycle, whatever it happens to be. And then following that if there's an issue or a problem that's going on and I take my doctor's advice in consideration with, according to how its phrased in the bible; so to take their opinion and act upon it or not. And then last would be Internet sources and just kind looking things up for my own sake." – Mary, 23

The above quote is the response of one of my study participants when asked how she compared and ranked the various information sources she sought on her reproductive and sexual health. This participant's quote is characteristic of many of the individuals that I interviewed. It demonstrates how women and female-assigned at birth individuals seeking reproductive health information are using multiple sources that they weave together to form a fractured and imperfect whole. These sources include family and friends, health practitioners and multiple media sources. This response is unique in its explicit reference to Christianity, though another respondent did cite prayer and meditation as important to her overall to reproductive health.

Of the women who said that they relied on family and friends for information, several individuals noted that female friends, in particular, were an important source of information. More specifically, participants recognized their friends as possessing some sort of expertise, whether professional or experiential. Participant Rachelle named her best friend as both a confidant and also a source of information for reproductive health as her best friend is a nurse practitioner. Nora noted that when she did talk to friends about personal reproductive health issues, she chose

> …certain female friends that I know, you know, are kind of up on their – up on their stuff and so it tends to be you know I'll look things up – you know check my different sources or whatever and then talk about it and talk about what I found with you know my roommate or my friend and – so it's other females that I know are kind of up on the same thing, interested in the same thing, have similar experiences…

While friends figured as important for some respondents, family figured prominently for others, including for Shelly. When asked about resources that have allowed her to have the kind of reproductive health care practice that she wants she responded, "…certainly like, um, my conversations with my mother of her being like 'don't do this, don't do this,' you know like certain particular things that like run in my head sometimes like 'hmmm, that's probably not the safest thing.'" Shelly later stated that, as a teenager, she challenged her mother with what she called her "rebellious" ways. In turn, she says that her mother had to "jump up to stop being super Catholic…so she started reading articles about like, um, you can get HPV orally. You can get STDs that way and she would be like 'I read this and so don't touch them with your mouth, you know use your hand'." Shelly's mother intentionally developed a level of familiarity with sexual health care so that she could be a credible information source for her daughter as she was going through a period of sexual experimentation. Nora, on the other hand, recognized her mother's expertise as a pharmacist in a women and children's hospital but noted that she would be hesitant to seek out that expertise because it would complicate her relationship with her mother:

> I think because it's – my mom and I'm you know and like me and my mom do have a pretty open relationship and you know and I feel like if I really needed anything and it was you know if I got pregnant or whatever I could be like mom I need you to go into like friend/professional mode for a minute you know and I feel like we do have a really good relationship but at the same time it's you know it's like I don't want my mom to know I'm having sex. No, no I mean I think she does but that's – like confirm it or you know tell her when.

Nora, Shelly and Rachelle, along with several other study respondents, each sought out friends and/or family for reproductive health information. However, like the quote from Mary that begins this section, the information gained from friends and family was almost

always put in conversation with other sites of knowledge production including media, sexual partners and doctors.

In addition to the inclusion of female friends and family members some participants did say they talked to their sexual partners about reproductive health matters, particularly when making decisions. Participant Leslie reported that in her marriage, contraception is a joint responsibility as their contraception needs have changed at different points in their relationship, including before and since their marriage. Though Leslie includes her husband in reproductive health deliberations and decisions she did note that she exerted more influence at times, such as in the case of their decision to use home birthing for their two children. Moreover, in the case of a difference of opinion between her and husband regarding her reproductive care, particularly in regards to contraception, Leslie said that her husband is generally happy to defer to her desires. Martha on the other hand, maintained a strict "no partner" rule for her reproductive health care and practice:

> …my last partner – he is just not – he's just very woozy like one time I was getting my blood drawn and the doctor was like "are you okay?" I'm like "I'm fine" and they were talking to him 'cause he was about to pass out behind me looking at the blood. So then I kind of put a kibosh on having [him there]…'cause it's like he would want to come in 'cause he's all nervous and scared but then he couldn't handle it… which maybe even has led me to…now why I don't involve especially male partners into the medical...

Martha expresses apprehension at including male partners who might not be able to offer the necessary support for negotiating reproductive health care. Moreover, in the situation Martha describes above, the medical staff had to shift their attention from her to him in order to make sure he was alright; so not only was he unable to support Martha himself but he also distracted her other sources of care.

While partners, female friends and family members were central to the gathering of information, many of the individuals interviewed identified doctors as the individuals they sought out most when it was time to make a decision. As participant Katherine noted,

> If it was [sic] actually doing something, I would talk to my doctor before actually doing something. A lot of it is following guidance but if it's that I'm gonna take an extra supplement or something like that I would talk to my doctor first. But if its, you know, an emotional type thing or something like that, I would listen to my friends and I would listen to their guidance. I mean making a decision would be something between [my partner] and I, I guess. But anything that like a medical thing, you would talk to your doctor, I would talk to my doctor first. But a lot of it is just their advice and their experiences in terms of friends and family.

Like other respondents, Katherine acknowledged the importance of family and friends to her reproductive health decision-making but categorizes that value in terms of emotional support. "Real" decisions or as Katherine puts it, "actually doing something," requires an expertise beyond the experiential and emotional knowledge of family and friends. Mary echoed Katherine when she mentioned that she goes to family and friends for "closure and comfort" but not necessarily for scientific and medical information.

Not every person I interviewed deferred to doctors in the same way, however. In her interview, Josie revealed that she had not seen a doctor in approximately eight years and, instead, researched alternative health care practices. She emphasized natural and holistic approaches and eschewed seeking a doctor's care unless the circumstances were dire,

> I don't tend to get sick so I don't have to go to the doctor and I don't have any health problems. I workout like 5 times a week and I try to um you know and I honestly like back in grad school I did have some weird stuff going on but it kind of went away after a while so I didn't go to the doctor…I feel like I guess like deep down inside I knew that it was a stress related thing from graduate school 'cause I was nearing the end of the process with the dissertation and um under a lot of pressure um and so I just decided – I kind of new that a lot of diseases and illness are stress related um it wasn't really chronic but I think if it was worse then

> I would've um gone to the doctor. But I guess for me it'll have to be like more serious because uh I don't really see how they help people long-term. I want a long-term holistic approach to my wellness.

Though Josie advocated a more holistic approach to her reproductive health care, she still negotiated a framework for assigning meaning, value and expertise. When asked whom she considered an expert on women's reproductive health she replied,

> I would probably say women…I would say a lot of elders like – older women especially those who like generations of herbalists or people who have you know studied it either in a official way through a herbal program or even it could be a medical approach as well like an MD program but I don't know I guess I haven't really thought about that but I guess it could be men too but I think women like themselves are probably the most in tune as far as being experts…

Even as she acknowledged the value of alternate health practices, Josie clearly still locates authority and expertise with formal training, regardless of whether it's in an MD program or an alternative health care program.

The individuals I interviewed also harnessed the doctor's professional knowledge by putting it into conversation with the knowledge they'd gained in other discursive spaces. Shelly describes asking her doctor about YAZ after seeing a commercial for it and deciding against the contraceptive after the doctor indicated it wasn't a good option for her. While discussing her use of online sites of health information, respondent Erica explained, "if I, um, wanted information about diagnoses I would – I wouldn't just trust WebMD like oh just do – no I – if I had a true concern I would go to the doctor without hesitation." Erica and Shelly take information from online and broadcast sources to be vetted by their physicians. Martha, however, takes information from friends and alternative medicinal practices. Describing her struggles with premature menopause, Martha said that she pays attention to friends who follow Eastern medicine and has begun to research acupuncture and other therapies not commonly used in Western approaches to

medicine. When asked if she discussed her research on alternate therapies with her doctor, Martha replied,

> Yea, we actually sat down and had a whole conversation about it…She was totally – I mean she totally understood and you know said everyone's at different places in their lives and was very much honest with like – she cannot give me any definite answer. She can't say in 5 years, 2 years, 1 year all the eggs will be gone or all these symptoms are going to go away if we do x y z and she was also and I – when I explained that I wanted to do a lot of natural stuff she was very pro…

Martha, Erica and Shelly demonstrate how women use doctors to vet different types of information, from sources as different as online media and the word of mouth testimony of family and friends. Sexual partners, family, friends and doctors make up the nexus of individuals who figure most prominently in women's epistemological framework. Another important component in contemporary women's reproductive health epistemologies are the diverse and expanding roles of media in communicating health information.

The Role of Contemporary Media

"The Internet messed everybody up!" – Leslie, 31

Leslie offered the sentiment expressed in the quote above as we discussed the role of media in women's reproductive health information gathering and decision-making. Leslie explained that both the access and sheer volume of information granted by the Internet has been both liberating and burdensome for consumers of health information. Her words underscore how the ubiquitous nature of popular media makes it an important source for many women's information gathering practices. Whether they explicitly aim to, women are consistently hailed as audience members as they encounter media in multiple ways and in multiple locations. When initially asked about her media consumption in relation to her reproductive health information gathering, Katherine

indicated that she rarely referred to media sources for health information. Katherine identified Dr. Sanjay Gupta's writings for CNN and CNN's health features as the only media sites she used for health information. After a follow up question, Katherine reflected a bit more and added,

> I probably am, like, paying more attention to things now that you say that and not realizing. Or maybe, I'm seeking it out and not consciously seeking it out. I wonder if that's what I'm doing. I don't, I haven't thought about it until right now but I probably am seeking things out and not consciously doing it because it's around me a lot and I'm not realizing that I'm doing it. Hmmm. Because I will be, like, flipping through a magazine and be reading through and find an article about pregnancy and reading it. Or be flipping through the radio and listening to something. Yeah. You're right, I'm being…I didn't even realize that I'm totally, I am and it's so funny that I didn't even realize it…That I am probably totally susceptible to marketing and don't even realize it.

Katherine considered herself to be a much more discerning consumer of health media but recognized that her exposure to such media was often beyond her control.

When asked about the role of media in her reproductive health care practices, Leslie claimed that while television shows and movies were not particularly impactful, commercials played an important role for her. Leslie noted that commercials are "…how I find out about new things; they'll give, you know, say some information on the commercial that will pique my interest." Shelly named the women's magazine *Cosmopolitan* as an important factor in her early reproductive health education, saying "…in Cosmo like it's actually probably where I learned most of [it] come to think of it." Leslie alerts us to the ways in which media may serve as an important site of visibility for health information and health products. Broadcast and print media, however, do not constitute the whole range of women's options for reproductive health information in media.

Respondents identified digital media as a major resource for their reproductive health information gathering. In addition to increasing exposure to media sources, digital media has also increased access for those individuals explicitly seeking particular types and sources of media. By digital media, I am referring to websites that provided some type of health information, these could include websites that specifically addressed health issues such webmd.com but it could also include other websites that were not specifically focused on health but at times include health content such as jezebel.com or cosmopolitan.com. Nora described her reliance on web-based resources like the search engine google.com,

> I think the biggest thing for me is the Internet. Like um I all through college and now like I don't have a TV in my um in my apartment so I may not see commercials for birth control as much but it's very much – and I think too because I'm interested in this topic like I Google everything you know…Yes, pretty much you know it's like Google this type of method. Google the side effects. Google um and you know Google where you can get an STD test for cheap. You know does your insurance cover it like you know Google everything.

Nora's response highlights the access that online media sites can provide women looking for health information. Nora's quote also describes the varied types of information for which women may be searching, including pharmaceutical side effects, financial concerns like insurance coverage and the cost of standard procedures like STI testing. The variety of information sought also highlights a two-tier approach to using online sources. Women use search engines such as google.com and bing.com to seek out a diverse range of potential information sources to match the diverse range of questions or concerns they might have. Search engines provide users with links to multiple sites in response to the search terms used. Users, in turn, must employ their own epistemological framework in order to determine which of the sites offer them the best information. Study respondents named a diverse set of websites including online forums,

mayoclinic.com, webmd.com, as well as the websites of the National Institutes of Health and the Centers for Disease Control. The diversity and availability of web-based health media, like the specific sites mentioned previously, make it an understandable staple in women's health information gathering. Moreover, the privacy and anonymity granted through online research makes it another viable option for researching issues as potentially sensitive as sexually transmitted infections, infertility and contraception.

As a result of the pervasive and dynamic nature of contemporary media, many of the respondents in my interview study developed informal criteria for assessing the value and credibility of types of media and their sources. The criteria often drew on notions of "high" and "low" health media, which correlated with accuracy and credibility. Fiction media, including television shows, films & advertising, were not as highly valued as sources that were deemed more sociological or scientific such as information from particular websites, newspapers or news shows. Even among media considered "serious," respondents created individual ranking systems, like the one Nora describes,

> I think – really if it's on websites I try and find one that's associated with a health institution of some sort you know has a .edu address somehow, um, you know is associated with the health department, um, goes along with kind of what I know. You know, kind of like doesn't say anything that I think, you know, that I don't – doesn't like make sense to me. Um, anything where it's like a forum you know where people have responded and stuff, I'm like 'nope' or you know write letters to Dr. Whoever that's associated with, you know, some other magazine, like... not to look at those, you know.

Nora's preference for a "health institution" and an ".edu" web address reveals an investment in formal institutional, medical and scientific knowledge. Her distrust in "forums…where people have responded" and "letters to Dr. Whoever" further illuminate her preference for formal expressions of medical and scientific expertise over anecdotal or experiential knowledge.

Whereas Nora attempts to create standards by which some media can be deemed trust worthy, Delia expresses a general sense of skepticism for media even where official gatekeepers of medical authority and information, i.e. doctors, are present. Responding to a question about advertising for women's reproductive health products, Delia said that while she held little confidence in the information offered in marketing campaigns there were other sites of popular media that she found to be more trustworthy. However, even in spaces she deemed more reliable she maintained a strong sense of skepticism,

> I guess – the other time I would think about maybe like reproductive health…would be on like a – talk show so like The Doctors or something like that where they would talk about that kind of thing which, I might trust a little bit more but again it's like it's – a talk show and I know they're doctors but they're on a talk show so…I think in terms of ads or anything related to reproductive health on TV I am very skeptical of. I would not…trust like right off the bat of oh yea that's – that sounds accurate okay…I guess it seems different to me because when you're in the exam room with your doctor it's one on one. It's you and the doctor um talking about whatever is bothering you specifically, whereas they're on this talk show it's being broadcasted to however many millions of people. There's hundreds of people in like this audience and they're just kind of giving like what seems to me is just very general information um and I would never think that they would give false information but that's – it's kind of like I feel like when it comes to medical information nothing is right for everyone so you know they can say like "yes, um this type of contraceptive is great. It has very few side effects. It helps you know regulate your period" or something like that but that's not the case for everyone you know and um so that's why I think I wouldn't trust it as much because when you're one on one I – think the doctor is more focused on you specifically like you the patient…what is wrong with you. Whereas they're kind of like yes this pill you know cures like all of these things…but, that's not the case for everyone so I think it's very misleading.

Delia's words illustrate the limits of media as an information source on reproductive and sexual health. Media generally appeals to the lowest common denominator in order to secure the largest possible audience. In this way, information offered through mass media outlets is often quite general and fails to map the vast diversity and specificity of women's reproductive health needs. Women and female-assigned at birth individuals who have reproductive health concerns that extend beyond pregnancy, contraception,

abortion and, in a very limited way, STIs generally do not find their concerns represented in mainstream health media. Finally, Delia rightly calls our attention to the political economy of media when she explain her distrust in advertising, "I think I am extremely skeptical of any kind of ads related to like contraceptives or any sort of reproductive health maybe like medication because at least for the medications it – seems like there's kind of an ulterior motive behind that advertisement." Delia's distrust is rooted in questions of who produces particular types of media and for what purposes. As information seekers, women are constantly negotiating the line between medico-scientific expertise and anecdotal experience constituted by the testimony of friends and family or the experiences of other women as reported on internet forum boards and in comments sections, etc. This preference for formal medico-scientific information is also reflected in the above discussion of the role of doctors as women's preferred decision-making partners in reproductive health matters. Conceptualizations of authoritative health information are still largely rooted in narratives of scientific and medical training and mastery.

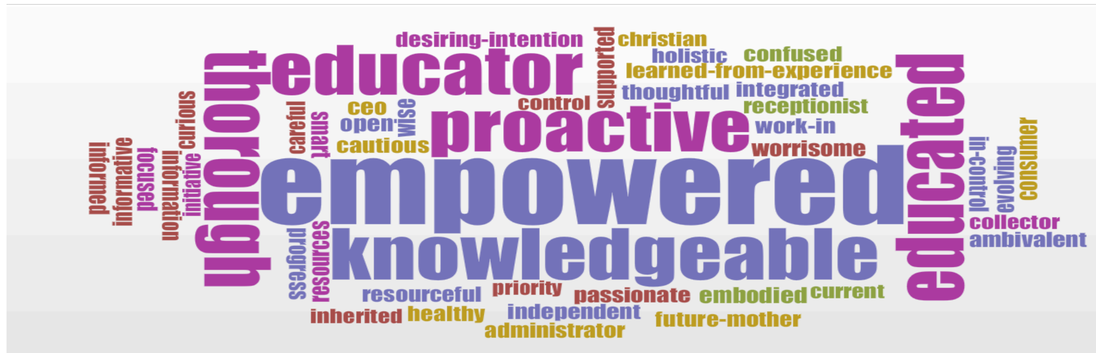
Women in the interviews often struggled with the tensions between recognizing women's experiential and cultural and generational body knowledge and deferring to the more formal and technocratic knowledge of doctors and medical professionals. At the heart of these tensions are cultural discourses around the prestige and value of medical education but there are also issues of responsibility. In the neoliberal discourse of contemporary health care, the consumer is primarily responsible for his or her own good health and wellness. They are expected to enact that responsibility by seeking medical care and taking advantage of the medical and scientific advances available to them. In

this context, to choose to value the experiential knowledge of lay people over the formal recognized and conferred knowledge of doctors is to, perhaps, betray that responsibility. The push toward scientific expertise is also, however, a longstanding feature of women's relationship to their health and the medical establishment. The 1930s Lysol advertising campaign "Frank Talks by Eminent Women Physicians," mentioned in the previous chapter, traded on the cultural currency of medical expertise but also exploited women's anxieties regarding their own expertise and knowledge compared to that of male doctors. One advertisement in the series admonished women with copy that read

> It amazes me…in these modern days, to hear women confess their carelessness, their lack of positive information, in the so vital matter of feminine hygiene. They take almost anybody's word…a neighbor, an afternoon bridge partner's…for the correct technique…Surely in this question of correct marriage hygiene, the modern woman should accept only the facts of scientific research and medical experience. The women who does demand such facts uses 'Lysol' faithfully in her ritual of personal antisepsis (as quoted in Tone 1996, 496).

Without question, this ad privileges scientific and medical expertise and actively discredits women's informal ways of knowing by characterizing the neighbor and the afternoon bridge partner as just "anybody." Women's engagement with medical and scientific expertise is one piece of understanding their overall relationship to reproductive health. Women actively craft identities for themselves that aim to capture not only their relationship to their health but also their larger relationship to the public sphere and their role in it as citizens and consumers.

Crafting Strategic Identities



At the end of each interview, I asked individuals to give three words describing who they were in relation to their reproductive health. The word cloud above is the combination of several participants' answers. Of the fifty-four words in the cloud, 47 of them are unique. The only repeated words are empowered (x3), educated (x2), educator (x2), knowledgeable (x2), proactive (x2) and thorough (x2). The frequency of word usage is interesting because it suggests that women construct multiple and decidedly different, if similar or related, identities in relation to their reproductive health. In other words, each individual I interviewed crafted an identity for themselves that was specific in relation to the other study participants. Equally telling are the different combinations of terms and phrases that each individual offered. One participant described herself as Christian and thorough but also confused. When asked to explain her inclusion of confused, she remarked that her body often confused her in terms of her hormonal changes and the resulting physical complications. Another participant described themselves as knowledgeable, ambivalent and desiring more intentionality. They explained that their sense of ambivalence stemmed from having

> …a whole body approach that I'm thinking about so my reproductive health isn't necessarily something that I go to first when I'm thinking about my health. It's something that I think about if I have an issue but it's not something that's at the

> forefront of my mind or what I'm thinking about so that's why I'm like "eh, you know" like it's, it's something that I'm not particularly consciously doing work around.

They later mentioned that they would like to develop a more intentional approach, hence their inclusion of "desiring intentionality," but did not say that they were actively building that intentionality at the current moment.

The identities expressed by each participant were both products of and strategic tools for engaging their reproductive health care practices. Some respondents were rendered confused or ambivalent by the very thing they sought to understand. Others aimed to use curiosity or wisdom as tools with which to find and use reproductive health information. When asked to offer three words that described her relationship and approach to her reproductive health Tabitha replied,

> I'm the CEO. I am the administrator/receptionist, and I am the actual team player or the – or should I say the – person who goes out and does all the work or something you know so I am the whole operation. I'm the whole business…it's a system. You have to – 1 you got – you have a CEO so they have the idea or they have the wisdom or knowledge and then you got to have someone who actually goes out and – does everything for that person so you got the administrator who is making the appointments and you know making sure everything goes right and that the person is sticking to the timing of whatever they have setup or – and then you have the person who actually – who's in the field, the actual worker who's out there doing it so you got to – it's a job.

Tabitha uses a familiar business model to describe not only her approach to managing her reproductive health care but also to describe the attributes, such as wisdom, she employs in that management. Tabitha's use of CEO, receptionist and worker also highlights the amount of work and responsibility involved in managing one's individual health.

The identities expressed by study participants often mapped how and what kind of information they sought. For example, respondents who identified themselves as "science-y" or "science nerds" often prided themselves on seeking out science, as

opposed to socially based, information from official sources, including doctors. Alternately, respondents who identified themselves as “natural” or “holistic” sought and valued information and practices that prioritized “natural” or nonmedical approaches to bodies, illness and wellness. All of the various identities expressed by participants were fluid, dynamic and, at times, alternately complimentary and contradictory.

As study participants created specific identities in relation to their reproductive health care and management, they also imagined identities for themselves in relation to other people, including the general public, their own family, friends, sexual partners, their doctors and other health care professionals. Leslie spoke about her experiences with pregnancy and specifically about her decision to use a home birth plan for the birth of her two children as particularly thorny topics to discuss with strangers, her family and some friends. She explains

> I realized just by talking to other people, that they really don’t understand reproduction and what it takes. Like people are really clueless on pregnancy and what goes on during pregnancy and what to expect. I mean I guess if somebody hasn’t had a child, they probably wouldn’t understand all of it. They don’t really understand the details of what is going on with your body hormonally and the symptoms you’ll experience during pregnancy. People really don’t understand due dates, especially when it comes to natural pregnancy. I guess since so many people are getting C-sections these days that the concept of “you could go into labor at any time” doesn’t really click with a lot people because truly there’s like a five week window that you could have a baby that would be considered full term and healthy, that’s a long time…I found myself having to educate a lot of people because they just don’t get it.

Leslie began to separate herself from the other people she talked to by virtue of her “knowing” what pregnancy and reproduction are like. As represented in the word cloud shown in the beginning of this section, knowledge and information are key themes for women in the management of their reproductive health. Information really emerged as a key piece of currency and cultural capital for participants in this study. As a result, to

encounter people she deems ignorant of the basic processes of pregnancy and birth works to set Leslie apart in important and valuable ways as a result of her knowledge of those processes.

Leslie also notes that her decision to use natural birthing was a sore spot with both doctors and family members.

> It's more exaggerated because I decided to use a midwife and not go to a hospital…It seems like a lot of people who talked to me about that only think, you know they think that the only way is to have a baby with drugs. The concept of having a natural delivery was so foreign…I'm even getting this from my own family and then the next thing I ask them was 'where were you born?' And, our parents and grandparents were not born at the hospital, none of them were.

Leslie points out the irony/hypocrisy of family member's seeming disapproval of her decision to home birth when many of them were born at home. Her words also highlight the silent working of narratives of modernity and progress, as it was often older familial generations (e.g. "our parents and grandparents") that were unable to be born in hospital. For many older generations, particularly of people of color, home birth was less of a choice and more of product of circumstance, including economic or geographic restrictions or segregationist laws that barred people of color from using certain facilities including hospitals. Leslie goes on to say that when

> Talking to family and friends, it really just depended on how they decided to go about their conversation. But mostly I let them know 'I'm not doing this by myself, I do have somebody – but this is what I've chosen for me and you don't have to choose it for you.' I let them know some of the reasons why and this is what we're going to do. But people, the first pregnancy, they were constantly asking 'So, you're still going to have the baby at home?' Like all the way up to, 'you're still going to do it?' And the second pregnancy, same thing, 'you're going to do this again?' As if, I did it the first time to prove something to myself and now I can do it like a normal person. It's just so weird to me. They don't know anything else… Like TV and media, when we took our birthing class, one of the early classes we looked at videos, like clips from movies of how giving birth was portrayed in the media and they were all 'Oh my God! My water broke! Let's run to the hospital right now! [mimics hysterical screaming] Slap my husband, curse at him.' And so that's what people think it is and it's totally not.

Again, Leslie is able to establish her identity via what she knows as opposed to what others around her do not know. Leslie's response to family and friends helps provide context to her description of herself as proactive, decisive and cautious/safety-minded when I asked her to give three words that described her approach to her reproductive health caretaking. Leslie is able to demonstrate her decisiveness when she holds fast to her decision to home birth in the face of misunderstanding and contempt from family, strangers and health practitioners alike. Moreover, her self-representation as cautious and safety-minded is perhaps a response to individuals, particularly health practitioners, who cautioned her against home birth on the basis of safety; particularly since those cautions seemed to imply that if she went forward with her home birth plan she was not properly concerned about the health and wellbeing of her unborn/newborn child.

While the absence or presence of information is key to how Leslie establishes her identity vis-à-vis her community, for Mary it's the type of information individuals seek that makes a difference. When answering a question about how her identity and background impacted her approach to reproductive health care, Mary invoked her college training in the biological sciences and responded,

> Whenever I'm researching or anything online, I go to a scientific mind frame where, oh, well I'm gonna put in technical terms and you know try to look for an actual answer where I get more information than a common person would be just looking for a solution, where I'm really looking for some type of scientific mechanism that happens in the background so I think that's the different view when I look for things online.

Mary differentiates herself from "a common person" by the type of information she assumes they seek. She aligns herself more closely with the scientific training and expertise of doctors by virtue of her preference for technical terms and scientific explanations. Mary understands herself as seeking to understand the root of a particular

issue while others, as she sees them, generally seek a simple solution. Both Mary and Leslie's identity formation and representation is dialogical and in relation with others. Both women are able to establish and justify their identities by explaining the assumed identities of others they either imagine or with whom they actually interact.

As Mary and Leslie's responses demonstrate, women establish identities in relation to their health care providers. As other responses in this chapter have shown, some participants chose to closely identify with doctors in order to align themselves with medicine's technocratic expertise. Other respondents, like Josie, chose to align themselves with approaches to reproductive healthcare that they saw as being distinct from traditional Western medicine. The relationship between participants' self-identification and the identities attributed to their doctors and other care providers was most evident in responses to the questions of who they considered to be an expert on women's reproductive generally and their reproductive health specifically.

When asked who was the expert among the multiple sources of information she sought out, Erica responded, "Doctors…possibly nurses. I think nurses also have a lot of knowledge as well but like if I um wanted information about diagnoses I would – I wouldn't just trust WebMD like oh just do – no I – if I had a true concern I would go to the doctor without hesitation." Erica is clear that doctors are the experts and the appropriate sources for "true concerns" or real problems. When defining herself in relation to doctors, Erica notes

> I'm not a doctor. I have – I mean – I was – a science dork when I was kid and everyone was 'like oh you're going to be a doctor, right?' And I was like nope…I will never be a doctor and I stand by that and so like I do – again I think I have the capacity to pick up knowledge and, again, when I read WebMD I actually understand what they're saying. I can pick it up on the terminology but I don't have that knowledge base…

While Erica recognizes her own capacities for expertise, capacities rooted in her familiarity with official scientific discourse, she ultimately defers to the expertise of doctors. Her self-identification as a "science dork" is articulated in relation to the real arbiters of scientific and medical knowledge, her doctors. "But, I'm not a doctor" or "I'm not a doctor, but…" were relatively common refrains used by participants in the interviews. These statements were usually used when participants considered exercising their reproductive health knowledge and talked about whether to make decisions based on what they knew and what they thought was happening with their body at a particular time. The statements served to signal the limits of participants' identities as experts or arbiters of reproductive health knowledge and those limits were usually marked by the figure of the physician.

Even when women, as in the case Erica, conceded reproductive health expertise to physicians and other health practitioners, they often still established their own expertise in terms knowing themselves from vantage points other than the biological. While doctors were able to say what was best for each individual medically, biologically, scientifically, the women themselves reserved the right to say what was best for themselves socially, financially, spiritually, politically, in terms of family etc. As Shelly explains of her process for choosing contraception with her physician, "When I went to the doctor's they never brought [Seasonale] up really as an option so I guess – and then that's when I'm like okay this is who I am and this is what I want and then they give me like well these are probably the best options for you…." Though Shelly seems to defer to the advice of her doctor regarding which type of hormonal contraceptive she should use, she also appears to set clear parameters, about who she is and what she wants, in which

the doctor must make their recommendation. Shelly's seems to be a negotiated expertise in which both she and the health care practitioners are responsible for bringing their respective knowledge to bear on her healthcare in order to produce the best possible solutions and outcomes.

In addition to their self-crafted and strategic identities, study participants also negotiated multiple social and political identities, including race, class, sexuality, ability, etc., that impacted their reproductive health care. Martha talked at length about her struggles with an undiagnosed condition that brought with it bodily changes resembling premature menopause. Her subsequent health care needs took her to several doctors and brought her in contact with different patient communities that demonstrated the intersectional realities of negotiating reproductive health care.

> I think when I was going to the you know – reproductive endocrinologist everyone in the space it was all either queer women, all – it was all queer white women that I saw in the space, like couples trying to get pregnant or older married couples and you could tell – not that – and I'm making an assumption by what they're wearing but general assumption…and how they carry themself, what they're wearing. I'm making the assumption that they were of a higher class for sure. And I was – and every time I had to go to the medical office I always noticed that I was the only single black woman, young woman by myself in that space going to do – deal with these things and so it just made me think of – I said I know I'm not the only single black woman who's had these things but probably the cost and not wanting to go alone and other reasons have like led them not to pursue to figure out what's going on with their bodies and other priorities in their lives. But I thought about that every time I went in. Every time I was like oh there's the gay couple and there's the older rich couple and it was just like me. It was so random like I thought about it every time. There was never – I probably went to that doctor's office I don't know 8 to 10 times but I never saw a single – not even a single white woman in that space. I think part of it is it's almost like only people who are in partnerships deal with, deal with reproductive challenges. It's a very emotional thing for sure.

Martha's description of the waiting room's identity politics highlights her own vulnerabilities as a single, African American woman. That her peers at the physician's office are able to harness, alternately, their race and class privilege in order to avail

themselves of the services of a reproductive specialist is not lost on Martha. Moreover, the sensitive nature of reproductive health care coupled with social norms surrounding heternormativity and/or monogamy results in women's support systems often being limited to their sexual and romantic partners. This arrangement of emotional and physical support leaves un-partnered women like Martha to manage these physical and emotional challenges alone. Martha's insights further illustrate her awareness of how her identity as a single, middle-class African American woman impacts not only how, and if, she is able to access particular kinds of reproductive health care but also impacts how she understands herself as a subject of reproductive health care.

While Martha explicitly noted the salience of socio-political identity, Mary was adamant that it factored very little in her reproductive health identity. When asked about how, if at all, her racial, class or sexual identity impacted her management of her reproductive health care, Mary responded "I think it's only an impact when other people are working with me. I don't necessarily identify myself as 'I am middle class, female…' you know, I don't think of myself that way." For Mary, class and gender identity did not impact her self-understanding in relation to her reproductive health care. She goes on to say to say that it is her college training in the sciences as well as her Christianity that holds the most influence over her reproductive health care practices. Though Mary argues that her racial, class and gender identities are not motivating factors for her, she does acknowledge how they impact other people's engagement with her. Mary described a visit to a Planned Parenthood where she interacted with a doctor she felt judged her based on her sexual history and health concerns. Mary worked to rationalize the doctor's behavior by arguing,

> I assume that's just because of the area, they see lots of people that have made poor choices and now have cause and effect issues. Um, and so it just seems as if it was a security thing 'Well, I'm just going to tell every single person, regardless of the severity of the issue that they need to be careful.' And so that was kind of – I didn't, wasn't really happy with that. That never happened with any of the private doctors that I've seen since getting insurance, since becoming a Christian where I'm very honest about my past because it's my health and I should be. And, there's been no criticism or judgment there.

Mary seems clear that a shift in her identity from uninsured to insured and engaged in a particular religious practice has altered how health care providers engage her. I would add that it has also shifted how she engages both health care management and health care providers.

Finally, many of the respondents in the study spoke specifically of negotiating a sense of responsibility around the prevention of early pregnancy. A sense of responsibility linked to narratives of class and cultural capital achievement as well as gender specific respectability politics. Shelly, a young white woman, describes this feeling well when she discusses balancing multiple familial and self-expectations,

> But like I've always known that you shouldn't [get pregnant] – you should get your degree…and so I have because I've been fortunate enough to like be brought up in a system that's like you need to succeed you know but I – work in teen pregnancy prevention because I'm like that would have been me…like I've always wanted to be a mother you know.

Shelly spoke specifically of simultaneously negotiating her father's "high intellectual expectations," the feminism of her older sisters, her mother's history and her own desire to become a mother. Shelly described her mother's family as one that was invested in close-knit familial community and often chose young marriage and family over college and other markers of modern economic success. Of her father's family Shelly notes that higher education is valued "in at least that side of the family." The tension between choosing motherhood or higher education and economic attainment is fraught for Shelly

as she was very open about her long-term desire to have children even as she recognized the value of waiting. As she is currently working to earn a graduate degree, Shelly clearly followed the path most influenced by the expectations and history of her father's side of the family. Though she appears to be genuinely satisfied with her choices she still feels strongly about her desire to become a mother but continues to struggle with how and when to pursue that goal.

Much like Shelly, Arlene spoke explicitly of a sense of responsibility to her family, particularly her mother, to delay pregnancy in order to pursue educational and economic achievement. Arlene first expressed her sense of familial responsibility as we discussed abortion rights and she remarked, "In the event that something would have happened, I would not have had a child 'cause I would not have wanted to disappoint my family and I would not have wanted to – accept the responsibility for something I wasn't ready for." When asked to talk more about her concerns about disappointing her family Arlene responded,

> I'm the first one on my mom's side of the family to graduate from college. I'm the second one on my dad's side to graduate from college and my cousin that graduated before me, she's biracial and her grandfather was a professor…So it ain't like she – and her mama went to college so—You know what I'm saying like – and I'm the first one to get a master's degree on both sides and my cousin on my dad's side got one right not long after I did but I'm just saying like I just felt like I couldn't do that.

Arlene specifically cites educational achievement as the motivating factor behind not wanting to disappoint her family. This motivation is further complicated by being the first, or one of the first, on both sides of the family to achieve these goals. By mentioning her cousin's mixed race parentage and family history in higher education, Arlene is signaling that despite her cousin's achievement she still feels a particular kind of pressure as that cousin was already privy to the cultural capital of higher education and class status

via her mother and grandfather. Arlene, however, had no such predecessors and represented new successes and possibilities for both herself and her family.

Arlene's sense of responsibility shifts to a one of obligation when she talks about her mother,

> 'Cause I mean like I just – want to be at a certain –like I want to be at a certain place and that is so important to me. Like some people want a child so bad that some of the other things are not as great of a priority to them but for me that is not the case. Like I'm – getting to know somebody that I really care for but at the same time like I already know if this went in the direction that I would like for it to go in a year or two, I still ain't going to be ready to have no kid. I'm just not. Like I feel like I need to – I feel like I owe something to – and I don't know where this comes from but I feel I like I owe something to my mom. Like I just want her to know like I – try to make better – you know what I'm saying? Like I feel like they've been kind of reliant on me in certain ways anyway and I feel like I have this responsibility to not disappoint them.

Even after earning a bachelor's and one master's degree, Arlene continues to feel the pull of family expectation and obligation. Arlene's sense of responsibility clearly goes beyond a simple explanation of feminine respectability as she remarks that even in the face of a committed relationship she would be hesitant to pursue motherhood if she felt she had not fully achieved her educational and professional goals. As an African-American woman and a first-generation college graduate Arlene's sense of responsibility also seems to go beyond her mother and family and extends to a larger sense of community.

> I'm accountable to something larger than my family. I feel like I have a responsibility to certain friends of mine. I have – a responsibility to young people like for a long time and I stopped um I used to volunteer for this um this nonprofit organization, actually two different ones, but I stopped volunteering with them because I am not – I don't – I can't be sold on abstinence until marriage…But I do still feel like I owe it to the next generation to make wise choices because I don't want to ever look at a young person and – say oh well you know I could say don't let somebody disrespect you but I've also not let anybody disrespect me. I'm not saying it from a place that I let somebody beat me down 'cause then I'm saying you know like I don't want to tell that story.

This sense of familial and community responsibility espoused by Arlene and Shelly is joined by the general sense of personal responsibility women are confronted with in terms of properly managing not only their fertility but also their health and bodies overall. Angela McRobbie (2009) has argued that a feature of contemporary economic and political appropriations of feminism is a "new sexual contract" in which women's economic and social potential is used to manage their reproductive and sexual behavior. Of early motherhood McRobbie argues,

> Young motherhood, across the divisions of class and ethnicity now carries a whole range of vilified meaning associated with failed femininity and with disregard for the well-being of the child…Middle-class status requires the refusal of teenage motherhood and much effort is invested in ensuring that this norm is adhered to. If the young woman is now envisaged as an assemblage of productivity, then she is also now more harshly judged for inappropriate reproductive activity (McRobbie 2009, 85).

McRobbie's read of contemporary demands on women's reproductive capacities maps Arlene and Shelly's experience of delaying motherhood in favor of pursuing educational and professional goals. Both women spoke of their personal and professional potential being negatively impacted by early and/or unplanned motherhood. Moreover, Shelly and Arlene's narratives demonstrate that concerns about unplanned parenthood extend beyond the teenage years and impact their current reproductive decisions as women in their late twenties and early thirties. McRobbie's argument is further complicated by the presence of family and generational achievement as a mark of progress as demonstrated by both Shelly and Arlene. These multiple entanglements with responsibility shape women's reproductive epistemologies by pushing them to consider the effects and implications of their reproductive health practices within and beyond their individual lives.

While the rest of the dissertation maps the public discourses that construct and circulate around women's health, this chapter asks women directly where, how and with whom they engage reproductive health information. The people who participated in my study spoke of complex and dynamic ways of knowing in regards to their reproductive health. They balanced the expertise, advice and derision of self, family, friends, partners and doctors simultaneously. They used multiple modes of media, including film, television, commercials and websites. The women with whom I spoke constructed epistemological frameworks through which to evaluate and integrate the various resources they engaged. These epistemological frameworks reflect the larger work of feminist theories of epistemology.

The project of feminist epistemology has long critiqued the dominance of the scientific method and positivism and their insistence on the autonomous, distanced & rational knower as they key to the production of valid and valuable knowledge. Feminist theories of epistemology have aimed to craft new frameworks of knowledge production. These frameworks have emerged from three major challenges feminist theorists have raised in regards to dominant knowledge production practices. One challenge feminist epistemology raises concerns the knowing subject. If traditional scientific models for knowledge production suggest the ideal knower is distanced and objective, feminist epistemology has argued for the exact opposite. Feminist epistemology posits that the preferred knower is fully embodied and embedded and that their objectivity stems from this "locatedness" instead of being hampered by it (Harding 1998; Haraway 1988). A second and third challenge to dominant epistemologies comes out of feminist approaches to what can or should be known and the value and validity of that knowledge. The well-

known feminist adage of the personal is political reflects an attention to the subject and value of knowledge. Feminist theorists and activists have argued that the daily realities of women's lives are a matter of public importance not private prerogative; through this insistence, feminist activists successfully politicized issues like intimate partner violence and sexual assault. The validity and value of publicly addressing these kinds of phenomenon is a direct result of feminist challenges to dominant epistemological theories of what counts as valid and valuable knowledge.

My study participants' epistemologies echo the work of feminist theories of epistemology. The responses of the individuals interviewed as part of this study work to challenge the knowing subject by identifying the expert of women's reproductive health as a shifting and dynamic identity. Respondents consistently negotiated the question of expertise by seeing it as a location that could be inhabited by a number of different individuals depending what type of information was being sought and what types of action were being considered. In this formulation, sometimes the doctor was the proper expert or knowing subject and at other times it might be the patient or another individual who had a particular experiential knowledge. Defining the expert of women's health as a shifting category reflects Haraway's (1988) investment in situated knowledge in that respondents made room for multiple knowers and understood that each knower's particular information was valuable and necessary, if not necessarily equally so. When asked about her expertise in comparison to her doctor, Erica felt that her doctor was more of an expert than she was but also noted "I need to be very direct with them and tell them what I'm feeling 'cause they can't diagnose, they don't know my body and what not." Erica recognizes her own particular expertise by acknowledging her unique access to and

knowledge of her embodied experience.

Furthermore, it is through her "locatedness" in her body, rather than her distance from it, that produces Erica's particular and necessary expertise. Using experiential knowledge as valid criteria for expertise clearly rejects notions of objectivity that require distance and disembodied engagement. The state of being located somewhere and in something is a critical component of feminist epistemological models. Study participants often noted that their reproductive health information seeking and decision-making was rooted in their life priorities. At times, those priorities were individually conceived and/or dictated by the physical body. At other times they were communally produced. Arlene and Shelly's sense of responsibility described earlier in this chapter demonstrates that their sense of belonging in families and larger communities shaped their reproductive and sexual health practice

Participants in this study also challenged what might count as valid and valuable information given the priority afforded experiential knowledge. Each participant spoke of the value of their own embodied knowledge even when they did not understand that knowledge to be more accurate or valuable than that of medical and scientific personnel. For example, when Shelly insists that her doctor match their knowledge of specific birth control with her knowledge of her personal preferences and needs, she is identifying social, economic, political and personal information as equally important in that moment as the biological and scientific information about a particular pill. These epistemological practices operate in a larger trajectory of feminist challenges to dominant knowledge production.

That these diverse epistemologies, taken together as a group, echo feminist

epistemological theory does not necessarily mean that each respondent identified as a feminist. Nor does it mean that each individual person's epistemology echoed feminist commitments. As noted earlier in the chapter, some participants were particularly invested in medico-scientific knowledge as the gold standard for all other health and body information. These participants might be able to see the value in embodied or experiential knowledge but not over and above the value of scientific research or a doctor's opinion. Points of contention and convergence prove that women's processes of information-gathering and generating meaning are much more complex and nuanced than imagined in popular discourse. The interviews presented in this chapter demonstrate that women's reproductive health epistemologies exceed the limits of disembodied users, empowered capitalist consumers and disenfranchised individuals in need of paternalistic protection. Alternatively, they construct a picture of engaged subjects always in the process of constructing ways of knowing and action that serve a responsible, accountable and successful reproductive health care practice.

Conclusion

In 2010 I encountered a recruitment poster for the New Choice birth control study being sponsored by Agile Therapeutics for their new transdermal contraceptive patch. More important to my work here is the recruitment poster rather than the study itself. The poster features several different images gathered into the shape of a woman's purse including multiple pairs of high heeled shoes, a feather duster, a hand broom and dustpan, two alarm clocks, a shopping cart, a computer, an iPod, make-up, hair accessories, perfume and a laundry basket filled with dirty clothes. Centered in all capital, large print lettering at the top of the poster, in between the handles of the purse, is the question "IS DAILY BIRTH CONTROL ONE TOO MANY THINGS TO REMEMBER?" Anticipating that the answer must be yes, the poster goes to on to invite the female viewer to participate in the New Choice Study "to assess the safety and efficacy of a low-dose, once weekly, investigational contraceptive patch" (Agile Therapeutics 2010). The poster is particularly striking in its characterization of contemporary womanhood: busy, stylish, simultaneously modern and traditional as marked by the inclusion of current technology (iPods, computers, etc.) and traditional signifiers of femininity such as make up and dirty laundry.

Like the YAZ advertisements discussed throughout this dissertation, the New Choice Study recruitment poster attempts to craft and communicate an identity for women in relationship to contraceptive choices. In the New Choice Study poster, women's lives are busy so a once-weekly contraceptive, in contrast to the standard once-daily options, would be an improvement and more in line with women's contemporary realities. Most interesting, however, are not only the poster's links to women's

contemporary realities but also its link to long-standing assumptions about women's mental capacities. It is women's (potentially poor) memory that the poster foregrounds rather than lackluster contraceptive options that require daily maintenance. The New Choice Study poster evokes the same sentiment as another contraceptive advertisement from several decades prior.

In the introduction to her book *Can't Buy Me Love: How Advertising Changes the Way We Think and Feel* (1999), Jean Kilbourne links the beginning of her interest and career in feminist media activism to a 1968 print advertisement in a medical journal for the oral contraceptive Ovulen 21. The advertisement features a smiling white woman on one side with seven boxes superimposed over her head. Each box is labeled with a day of the week and features a corresponding image including a roast, a laundry basket and an iron. On the top of the other side of the page in large print is copy that reads "Ovulen 21. Works the way a woman thinks, by weekdays not cycle days" (as quoted in Kilbourne 1999, 17). As Kilbourne states "…the ad was basically saying that women were too stupid to remember their cycles but could remember days of the week. And the days of their weeks were an endless rotation of domestic chores" (Kilbourne 1999, 18). Like the New Choice Study poster, the Ovulen 21 print ad offers a representation of womanhood germane to the time period in which it appeared. The ad crafts a representation of women as homemakers and identifies their primary sphere of action as the domestic space of home and family. Moreover both ads mark women's thinking as the primary issue to which contraceptive options should respond.

I begin with the New Choice Study recruitment poster and the Ovulen 21 print advertisement because they provide a compelling example of both the context and the

social, political and cultural stakes of my study. These two pieces of advertising inform us that characterizations of women, in relation to contraceptives and reproductive health, have changed very little in the forty plus years between 1968 and 2010. This crisis in representation that the Ovulen 21 ad and the New Choice recruitment poster reveal has been the subject of this dissertation. The dissertation has aimed to establish that media and other forms of popular representation are significant to women's health and wellness. The ways in which women are imagined, in the words of Andrea Tone (1996), as "contraceptive consumers" has everything to do with how they are imagined and treated as agents of and stakeholders in their own reproductive health and wellbeing. Media and popular representation are inextricably linked to other forms of representation, including political, advocacy and economic representation.

The purpose of this study was to examine how the discourses of medicine, law, politics, marketing and feminism converged and collided in the context of women's sexuality and reproductive health and to what ends? Using feminist theories of health, the body, sexuality, media and difference as well as critical media and cultural studies theory, I engaged the study's primary research question through a case study of the controversial oral contraceptive YAZ. My data included promotional materials from Bayer's "Beyond Birth Control" campaign, regulatory correspondence between the FDA and Bayer as well as between the FDA and other relevant drug manufacturers; minutes and briefing materials from the FDA's special joint committee meeting on the safety DRSP family of contraceptives; promotional and other written materials from Planned Parenthood and Our Bodies, Ourselves; and, the interview transcripts and recordings from twenty interviews conducted as part of the dissertation research. In each chapter, I

questioned the identities of the main actors and speakers in the respective discursive sites. Additionally, I sought to understand if and how public representations of female sexuality and reproduction in one site were invoked, challenged and/or affirmed by actors in the other sites. Each chapter considers how the technology of YAZ, as an oral contraceptive, is made to mean in the various spaces in which it circulates, e.g. in governmental regulation and in women's health advocacy organizations, and how those meanings shape and produce identities for and knowledge about women and their bodies in regards to reproductive health.

Beginning with an interdisciplinary and intersectional feminist research methodology, discourse analysis, in-depth interviewing and digital bread crumbing were the primary methods used in this research. These methods allowed me to make connections, identify patterns and note major themes in the rich assemblage of information provided by my data sources. With these methods I was able to focus on the literal discourse of the individual texts I examined in my work while simultaneously allowing me to connect the literal discourse to a more expansive approach to discourse, which sees it as a constellation of ideas, identities, practices, and narratives. Through this approach, my analysis links the structures and strategies of popular media and public discourses to the commodification of women's health through gendered product promotion, consumption and regulation. Ultimately, my analysis argues for the importance of critical media literacy for women in this new media environment and draws on reproductive justice approaches in order to articulate a "feminist health media literacy" framework.

My methodological framework and choice of methods allowed me to identify

three major processes at work in the public discussion of women's reproductive health in the context of YAZ: (1) the processes of identity creation and formation for and by women regarding their reproductive health; (2) the processes of knowledge production and circulation about women's reproductive health and agency; and, (3) the way that popular media impacts and shapes both of these aforementioned processes. Chapter One, "Selling the Single Ladies: Birth Control, Advertising and the Female Body," for example, examines how the marketing campaign for YAZ takes the contraceptive's medico-scientific properties as a treatment for Premenstrual Dysphoric Disorder and makes them culturally significant by linking them to women's ability to participate in public sphere leisure and consumption activities such as shopping, nightclubbing and exercising. In turn, I argue that the marketing discourse used to translate the science of YAZ and promote YAZ as a product, creates particular identities for women as potential consumers and users of the contraceptive and also produces a certain kind of knowledge about how women's bodies should behave.

The "Beyond Birth Control" marketing campaign, presented women as empowered via the control they exert over their bodies and social lives through their use of YAZ. In the governmental and legal discourse that structured Bayer's interactions with the FDA, women were often stripped of their bodily and social agency and rendered part of a nameless and faceless population of "users" or they are represented as a vulnerable population in need of the paternalistic protection of U.S. governmental regulation. In the discourse of women's and feminist health advocacy, women are again imagined as stakeholders and agents; however, that agency is seen as insufficient without the overarching guidance of health activists and advocacy organizations. At work in

these various identities and the discursive milieu that produced them are questions of choice and expertise. These constructed identities are all, in some way, identifying the appropriate arbiter of women's reproductive health knowledge and experience. Moreover, each of these negotiates some kind of relation to the broad act and concept of choice. The identities crafted and invoked in public discussion of YAZ and women's reproductive health more broadly are always engaged in negotiating choice as practical matter as well as an economic and a political matter. The conditions under which women exercise choice in addition to the kinds of choices available are central for understanding how agency, expertise and power are at work in the relationship between public debate on women's reproductive health and women's private meaning and decision making.

In order to examine the processes of identity creation and formation, bodily and health knowledge production and, finally, how media impacts these processes, my case study of YAZ began with an analysis of Bayer's "Beyond Birth Control" marketing campaign for YAZ. Chapter One, "Selling the Single Ladies: Birth Control, Advertising and the Female Body," interrogated the verbal and visual rhetoric of the campaign and revealed how the rhetoric of choice and the identity of the consumer came together to form the foundation of how potential consumers of YAZ were imagined and addressed. Through linking the rhetoric of choice and consumption, the chapter situated the YAZ campaign in a larger trajectory of the economic significance of women's reproduction. Finally, Chapter One also introduced the public pedagogical function of the YAZ marketing campaign in its ability to inform the viewing public about women's contraceptive options and normative ideas about women's proper embodiment and disposition.

Chapter Two, “Regulating YAZ: Governmental Interventions, Consumer Protection and DTC Advertising,” examined the U.S. Food and Drug Administration’s scrutiny of Bayer’s “Beyond Birth Control” campaign. This chapter mapped the winding history of YAZ and its predecessors and linked that history to YAZ’s contemporary missteps. The regulatory response of the FDA and resulting exchanges with Bayer Pharmaceuticals also produced their own ideas about the identities of the women being targeted as actual and potential users of YAZ. An analysis of the results of Bayer’s safety and efficacy studies of YAZ, for example, revealed the ways in which women were reduced to a set of biological processes when discussed in the context of scientific and medical discourse. The social and cultural aspects of women’s lives that animate their biological functions were excluded from the studies in favor of seemingly less subjective research variables. Yet, as the testimonies of former YAZ users and their families revealed at a special FDA meeting on the safety of YAZ, the chemical and biological impact of the contraceptive on women’s bodies fundamentally impacted the social and cultural dimensions of their lives.

Chapter Three, “Up for Sale(?): Women’s Body Knowledge and Feminist Health Advocacy,” compared and analyzed the responses to the marketing of YAZ by two icons of women’s health in the U.S.: The Boston Women’s Health Book Collective and Planned Parenthood Federation of America. By examining print and broadcast texts produced by these two organizations, Chapter Three revealed the limited response of U.S. women’s health advocates to the role of media in public discourse about women’s reproductive health. The Boston Women’s Health Book Collective, now known as Our Bodies, Ourselves, continues its legacy of guarded engagement with mainstream health

discourse by being critical of advertising for women's health products. Conversely, Planned Parenthood embraces media as an important tool with very little critical reflection on its limitations as well its possibilities. I argued that each organization's position on the role of media, specifically advertising, contextualizes their respective response to the public life of YAZ. This chapter rejected the either/or dichotomy that characterizes contemporary feminist health advocacy approaches to popular media and, instead, lobbied for a more expansive approach. In turn, Chapter Three presented the dissertation's scholarly intervention through its introduction of "feminist health media literacy." Feminist health media literacy sees media as an inescapable fact of the contemporary health landscape and as a useful resource for women's reproductive health agency. However, this framework also calls for an ongoing critique regarding health media production, its use in public discourse and its implications for women's health advocacy and activism.

Feminist health media literacy takes seriously the role of media and popular culture in struggles over women's reproductive integrity and autonomy. This mode of media literacy expands the concept of health media by including advertising and other moments of media production that are often dismissed as too ephemeral to warrant critical scholarly engagement. Health media, then, is defined as any media product that attempts to represent or explain the social, political, economic, and biological dimensions of contemporary ideas about health, wellness, illness and corporeal integrity and responsibility. This definition of health media could also include a televised political debate, news media, medical reality television shows, the well-known fictionalized medical television drama, advertising for health and beauty products as well as television

shows and films that address medical and health phenomenon even marginally.

In turn, feminist health media literacy interrogates health media by asking how gendered bodies are figured in media production; examining the types of bodies made visible and invisible; how those acts of in/visibility are achieved; exploring the gendered nuances of particular representations and how are those nuances are further shaped by issues of race, sexuality, etc.; and, seeking both the historical and contemporary trajectories of health media representations. This approach to media literacy asks how women's reproductive and sexual agency are conceptualized in popular media and what, if any, is the relationship between those conceptualizations and women's material realities regarding their reproductive and sexual health.

Chapter Four, "Crafting Epistemic Authority: Women's Approaches to Contemporary Reproductive Health Information and Decision-Making," presented the results of the dissertation's interview study with women that sought to map their engagements with reproductive health media and information. While the first three chapters of the dissertation examined public discourses surrounding YAZ and women's reproductive health more generally, chapter five sought the responses and thoughts of women on where, how and with whom they negotiated reproductive health information and care through a small in-depth interview study. Study participants demonstrated nuanced, shifting and thoughtful descriptions and analyses of their reproductive and sexual health care and management, which served to reveal their individual and collective critical epistemological frameworks. Like the other discursive sites examined in this dissertation, the responses of study participants also grappled with ownership, expertise, consumerism and choice. Their responses rejected the notion that the women's health

"expert" was a fixed identity available only to a technocratic elite or, alternatively, available only to individual women based on their personal health and body experiences. Instead, their collective responses argued that the identity of the "expert" in women's health was a shifting category and its inhabitant was also subject to change depending on the specific issue at hand, the purpose of the particular exchange and the audience. The interviews conducted for this chapter trouble characterizations of women as the disembodied users seen in medico-scientific discourse, as individuals whose agency stems from their ability to be consumers, and as a voice-less population in need of governmental or feminist protection. Instead, the twenty interviews that are the subject of Chapter Four revealed diverse epistemological practices that demonstrate the information-gathering and meaning-making processes of women and female-bodied individuals negotiating reproductive and sexual health care.

Future iterations of this research should include an expansion of the interview study. The current study includes twenty respondents and engages their responses for a sense of depth about their information-gathering and meaning-making practices. Additionally, a future project would be one that included an interview study with medical doctors and medical research personnel. The voices of medical personnel encountered in the FDA's DRSP safety hearings revealed both conflicting and complementary approaches to women and women's reproductive health needs. The project's criticism of the characterization of women in medico-scientific discourse would likely be deepened and productively challenged by more fully engaging the voices, priorities and conventions of medical research personnel. Additionally, former YAZ users have filed a number of lawsuits against Bayer Pharmaceuticals over the drug's safety and efficacy and

the company's failure to provide relevant health information to consumers. At the time of writing, these suits are still ongoing and, as such, an analysis of them at this point in time would be incomplete. The project should include an analysis of these proceedings as more information emerges about the major issues and actors as well as any subsequent judgments and settlements. Finally, given the polarizing public debate that has unfolded in the past three years in the U.S. over contraceptive coverage and insurance, future directions for this research must address the impact of the passage and implementation of 2010's Affordable Care Act on public discourse and action regarding women's reproductive and sexual health.

Generally, when I present my dissertation research people often chuckle at the broadcast and print advertisements I use to illustrate the contemporary environment of health media focusing on women's reproductive health. The audience often notes that representations in these ads, such as the New Choice recruitment poster and the Ovulen 21 ad with which I began this chapter, are so obvious and stereotypical that they are rendered absurd. Despite, or perhaps because of, their transparent and obvious pandering to overt stereotypes of normative femininity these ads and the images in which they traffic are culturally, politically and economically productive. This dissertation has argued that public representation of women's reproductive and sexual health determines the political, economic and cultural stakes of women's lives. Debates over state, federal and employer funding for women's preventative health services, women's access to contraception and abortion rights demonstrate the importance of this research. In the current political and media atmosphere in the U.S., women's health is often only visible as a political football intended to galvanize particular kinds of public support for various

political and economic agendas. In short, popular representations of women's reproductive and sexual health matter and must be seriously and critically engaged. They matter because they help to construct the context within which women must negotiate their reproductive and sexual health and identities. Their significance has been the subject of this dissertation in addition to ways to contest and transform them.

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