

Is Depo-Provera Birth Control?

by

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Is Depo-Provera Birth Control? Feminist Regulation at the Intersection of Reproduction Self-Determination and Social Control

Table of Contents

Acknowledgments.....3

Introduction.....4

Chapter One: *The Shifting Status of Contraception in the Tumultuous “Marriage of Birth Control and Population Control”24*

Chapter Two: *Weighing Risks and Benefits on an Individual Scale: Embodiment, Abstraction, and Women’s Values.....63*

Chapter Three: *The Inevitability of Depo-Provera Abuse and Women who Cannot Use Birth Control.....95*

Chapter Four: *Toward a Situated Regulation.....131*

Conclusion.....155

Epilogue: *Of Science, Ideology, and a Black Box.....170*

Works Cited.....177

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Introduction

The controversy over Depo-Provera suggests one way in which what began as a technical discussion can increasingly become a political one...Where technical questions remain unresolved...growing public sensitivity to issues of consumer health and discrimination against less developed countries has politicized the process of new drug introduction of this process. As a result of this process, Depo has come to be a highly charged symbolic issue for civil rights organizations, consumer health groups, women's groups, critics of U.S. development aid, Congress and the population agencies (Gold & Willson 1980: 160).

The name Depo-Provera has become synonymous with violations of women's reproductive rights" (Forna 1998).

Nearly thirty years ago, on March 7, 1978, the FDA sent a letter to the Upjohn Company, a pharmaceutical corporation, indicating that it would not approve its drug, Depo-Provera, for use as a contraceptive in the United States. Depo-Provera, the trade name for depot-medroxyprogesterone acetate, a synthetic derivative of the female reproductive hormone progesterone, was considered by many an "ideal" contraceptive:

For years, women around the world have wished for a contraceptive that would be reliable, long-lasting, convenient, reversible, and free from serious side effects. Family planning professionals have shared this desire too...In 1967, the Upjohn Company believed it had achieved this breakthrough (Sun 1982: 424).

The drug is delivered by intramuscular injection (it is therefore "provider-controlled," i.e. a woman cannot inject herself), and hormones remain sufficiently high in a woman's system to prevent pregnancy with 99% effectiveness for three months. Given many women's difficulty remembering to take a contraceptive pill every day, and others' inability to use estrogen-based contraception because of health contraindications (smoking, age), this product seemed a welcome addition to the

hormonal “contraceptive cafeteria.”¹ Other contraceptive drugs and devices available at the time posed different problems: intra-uterine devices (IUDs) often proved dangerous; not all men could be relied upon to use a condom; barrier methods inserted by a woman, such as the diaphragm and cervical cap, were difficult to use properly and required that a woman be comfortable touching her genitals. Depo was a quick four-shot-a-year solution to pregnancy prevention. Why, then, was it not approved in 1978?

By 1978 Depo was already being used by millions of women worldwide, mostly in developing nations, and was frequently prescribed “off-label” to American women.² Four years earlier the FDA had indicated that it was preparing to approve the drug for U.S. women, but this prompted an outcry from politicians, consumer advocates, and from a relatively new contingency in public policy: women’s health activists. “Depo-Provera sounds too good to be true. And, not surprisingly, Depo-Provera turns out to be less than the ideal contraceptive. It has many serious risks and side effects” (Levine 1980: 101). Data indicating the Depo caused breast cancer in beagle dogs, endometrial cancer in monkeys, and possibly cervical cancer in women,

¹ Many involved in birth control research or policy argue that the best results in contraception are achieved when women have access to the widest possible range of options: barrier methods (condoms, diaphragms), IUDs (intra-uterine devices), hormonal methods (the Pill, patch, ring, injectable, implant, *ad infinitum*), and even natural methods (charting fertility and avoiding coitus on fertile days). Different women have different contraceptive needs at different times in their lives, and data shows that many cease to use contraception when available methods fail them. Depo opponents insisted that some methods are simply too dangerous to be put in the cafeteria at all.

² Dr. Everett J. Rhoades, director of the Indian Health Service which frequently prescribed Depo to Native American women, many of whom were mentally disabled, explained the practice of “off-label use” in his testimony to the House in 1987. “It has long been the policy of the FDA that it is not a violation of the Federal Food, Drug, and Cosmetic Act when a physician chooses to prescribe or dispense a drug under conditions of use not specifically described in the FDA approved labeling for that drug...physicians under their own responsibility may exercise judgment for the use of an approved drug for unlabeled indications when they are satisfied that there is medical-scientific support that such use may be of benefit to their patient” (21). Depo was approved to treat endometrial cancer and therefore eligible for the above practice.

led Depo opponents to ask how the drug could *possibly* be approved as “safe.” Further, they insisted that, as a provider-controlled, long-lasting injection, Depo was uniquely well-suited to be imposed by those in power on groups of women whose fertility they had an interest in limiting: women of color, the poor, and the mentally disabled. (Indeed, the drug was used on precisely these populations). In essence, they identified it as a population control device, a highly effective, provider-controlled tool which could be used by those interested in limiting the fertility of certain groups of women. Their arguments were compelling enough to prompt the FDA to consider the question for four years, until that March day when it asked Upjohn to withdraw its application. Testifying before Congress in August of that year, the president of Upjohn, Dr. William Hubbard, insisted that the decision had no basis in fact and had been unduly influenced by “special interests.” “We respect and endorse the opportunity for both congressional and consumerist questions about the availability of drugs...however...we believe that it is the careful judgment of experts in the field that must guide the final decision” (House: 28). The subtext is not difficult to read: politics has no place in the realm of drug regulation.

But politics has always had and continues to have a very strong influence on drug regulation, particularly when it comes to reproduction. For example, on August 31, 2005, Susan Wood, the assistant Food and Drug Administration commissioner for women’s health, resigned from her prestigious position after the agency announced it would, once again, delay its ruling on whether or not the morning-after pill, then available only by prescription, should be approved for over-the-counter use. The drug contains hormones similar to those in birth control pills, and is taken up to seventy-

two hours after unprotected intercourse in order to prevent conception. Opponents argued that the change would make women more promiscuous; proponents insisted that it would reduce abortion rates. These political and moral concerns are not the FDA's priority; the agency is responsible for concluding whether or not the drug is medically safe enough to be taken without a doctor's input. Yet Susan Wood resigned to protest how the FDA has been infiltrated by ideology. "The scientific and medical evidence was ignored. The process and the professional staff at FDA who are normally counted on were completely overruled and at certain points completely cut out from discussion. Also, the decision was clearly not in the best interest of women and families" (*Business Wire* 2006) The policy director for the conservative group Concerned Women for America commented, "thank goodness there is now one less political activist at the FDA who puts radical feminist ideology above women's health."

It is a cliché that we are meant to learn from the past, but the continuing public struggle over the nature of contraceptive drug regulation, which is always implicitly tied to the regulation of women's sexuality and reproductive capabilities, should prompt academics, activists, and policymakers to consider the tactics of previous actors engaging with the same difficult questions. Are FDA decisions governed by scientific evidence and expertise, or politics? Does political activism—"radical feminist" or otherwise—have a place in drug regulation? And perhaps most importantly, which regulators make decisions that are "in the best interest of women"? Analyzing the Depo regulatory debate, which stretched from the early 1970s until 1992, when the FDA concluded it did not cause cancer and was therefore

safe for contraceptive use, elucidates the effects of political and ethical interests on regulatory decisions. This is one instance where theory clearly goes into practice, as feminists' conception of what is best for women prompted their sustained opposition to Depo. It is difficult to say how strong an influence feminist activism had on delaying Depo approval for two decades. Although Depo supporters, family planning journals, and the mainstream media all complained about the influence of "consumer interest groups" who gummed up the regulatory process, my instinct is that had good data indicated Depo's safety before 1992, it would have been approved. Yet there is little doubt that women's health activists made a significant intervention into the terms on which regulatory decisions affecting women's reproductive health and freedom would be made.

Through their direct involvement in the Depo debate, testifying at Congressional hearings and a special Public Board of Inquiry to review the scientific evidence, and in writing and debates amongst themselves, these women's health activists developed a complex critique of the regulatory status quo and contraceptive priorities. They were opposed not simply to one contraceptive drug, but to male domination at all levels of contraceptive development, regulation, and administration; the accompanying ignorance or delegitimization of women's expressed needs in these realms; the influence of population control ideology on officials' conception of what constitutes acceptable or ideal contraception; and the failure of these officials to consider the structural constraints on women's reproductive choice. Activists insisted that the meaning of Depo-Provera, and the consequences of its approval, must be considered from women's perspective, and understood in the context of a nation

which had repeatedly ignored or violated women's right to reproductive self-determination.

Although they never framed their work as such, it is my contention that feminists' opposition to Depo-Provera may be understood as part of a larger project of developing *feminist regulation*. These activists implicitly and explicitly asserted that regulating from women's perspective ensures a decision that best addresses women's needs. Whereas a disinterested drug regulator would simply consider whether a potential contraceptive was safe and effective—Does Depo safely control birth?—feminist regulators reframe the question—Does Depo contribute to birth control? Birth control in a feminist sense does not refer to fertility reduction as its end, but rather as a means to improving women's health and expanding their control over their lives. From the perspective of the Depo opponents whose work I will discuss in this thesis, *Depo-Provera is not birth control*. It has detrimental effects on women's physical and mental health, and is intended for and pushed at particularly disempowered women. Therefore, it should not be added to the contraceptive cafeteria. As will become clear in the ensuing pages, I take issue not only with activists' conclusions about Depo's inevitable danger, but more importantly, with the theoretical foundation of that conclusion. I do not recommend Depo opposition as a model for interested, feminist regulation, but rather as a case study in the possibilities and pitfalls of regulating as women, for women.

The Depo-Provera debate provided a forum for a remarkable number of feminist issues which we still grapple with today. Is encouraging "choice"—both women's "right to choose" and increasing the number of contraceptive options—a

sufficient approach to expanding reproductive freedom? How does the content of “reproductive rights” vary by race or class? Who can “represent” women, and which women? To what extent do women need to be protected from drugs? from doctors? from themselves? I believe the most intractable theoretical and political problem at the center of the Depo debate is to what extent feminists—or any regulators—are justified in limiting contraceptive choices in the name of protecting women. One woman framed the dilemma as such: “Increasing the number of options in order to respect individual differences and give autonomy to individuals seems to conflict with the concern that some contraceptives may entail such risks to the whole body...that they ought never to be offered. *In short, the conflict is between regulation and free choice*” (Holmes 1980: 17-18, emphasis added). As Holmes implies and Rosalind Petchesky states explicitly, this is a theoretical question that has direct political ramifications. “For feminists, however, it is not an academic conflict but one that lives and breathes in the history of the movement and of the treatment of women by those who exercise power...Neither individualism—formulated as the ‘right to privacy’ in liberal constitutional tradition—nor paternalism has ever provided adequate solutions to women’s collective oppression” (Petchesky 1984: 191). I cannot offer a resolution to this dilemma in the ensuing pages. What I attempt to do, through an evaluation of women’s health activists’ discourse, is discern which justifications for regulation might be compatible with a commitment to recognizing and meeting the needs of a diversity of women, and which, as they were applied in the case of Depo, and more importantly, if they were to be applied in other contexts, would impede attempts to expand disempowered women’s access to birth control.

Of course, this leads to another dilemma underlying this thesis and Depo opposition: do new contraceptive options truly expand women's choice? Women's health activists argue that, within an oppressive social context, provider-controlled contraceptives like Depo-Provera are used to abuse vulnerable women, not improve the conditions of reproductive choice and freedom. They emphasize the need to remove obstacles to women's reproductive freedom by combating sexism, racism, and poverty, and call for a transformation of medical practice such that women are taught about their bodies and able to use safer, low-tech contraceptive methods. Under these conditions, women will choose birth control without pressure, without risky hormonal methods. Of course they are correct that structural change is necessary, and I have learned a great deal from their identification of oppressive interests at every level of contraceptive development and distribution. Nevertheless, as feminists work toward an ideal (or at least more just) world, I believe it is crucial to meet women where they are, to make available technologies that create options where there were none. Depo-Provera does not address the vast structural inequalities that impede women's control over their bodies, but neither does its absence.

Depo Opponents and Proponents

As a 21st century feminist I have difficulty referring to Depo opponents as "feminists" or "women's health activists" as though their theory and practice reflected that of all actors who might fall under these rather broad categories. Whether one is speaking of the contemporary period or of the 1970s, it is crucial to recognize that there are many feminisms and many women's health activisms. Yet for lack of better qualifiers I use these terms throughout this work. I would like here to

clarify about whom I am speaking and why they might be understood as a unit. Mainstream feminist organizations such as NOW were not involved in the Depo debate; one can infer that the anti-Depo position conflicted with the liberal feminist doctrine of increasing access and women's "right to choose." Thus Depo opposition was produced primarily by a particular incarnation of feminism, women's health activism. In the first chapter I will discuss how this movement originated in and was inspired by work demanding patient information for the Pill and establishing regulations to prevent sterilization abuse. Prominent women's health activists such as Judy Norsigian, Barbara Seaman and Norma Swenson, affiliated with the National Women's Health Network and Boston Women's Health Book Collective, conducted the most organized opposition to Depo-Provera. Anita Johnson of Ralph Nader's Public Citizen's Health Research Group and radical feminist Gena Corea both contributed important testimony to public hearings. A few men, particularly Senator Edward Kennedy and consumer activist Stephen Minkin joined this side of the debate.

Out of the limelight, academics and feminist healthcare providers debated the drug's merits. The report from the Hampshire College workshop on Ethical Issues in Reproductive Health Technology provides a unique window into the variety of opinion expressed by this eclectic group of like-minded women—some vehemently oppose hormonal contraception altogether, while others support Depo use. A number of these women testified at an FDA Public Board of Inquiry evaluating the risks of Depo. In general, those I call Depo opponents fought approval as a matter of defending women's health from a drug whose long-term risks were not well studied.

While some felt that better data might convince them of Depo's acceptability, others insisted that its form rendered it inevitably abusive. In *all* cases, however, they fought Depo as part of a larger project of ensuring contraceptive safety and women's control over their own fertility. For this reason I consider their work feminist and designate them as feminists (a label I doubt many or any of them would contest.)

Although Depo opponents differ from one another, I would identify an important strain of thought informing their work: cultural feminism. Most of these women ascribed to the notion that women, as women, have different values from men, and that these values generate more ethical and more accurate analyses of reproductive technology. They believed that if more women were involved in drug development, regulation, and administration, contraceptives would be safer and contraceptive users better protected. The ring of essentialism implicit to this view resonates less well in this postmodern moment than it did in the heyday of second-wave feminism. Nevertheless, the embrace of "women's values" was an important divergence from the classic liberal feminist view that women are essentially like men, only oppressed; given access to male-dominated institutions they would perform essentially like men. Depo opponents insisted that women would perform differently, and *better*, and that by extension those institutions would have to transform as well. Similarly, whereas mainstream reproductive rights feminists, who advocated primarily for women's *access* to abortion and contraception, conceived of women as potentially free consumers who are simply barred from the cafeteria, Depo opponents insisted that many, if not most women need protection from, not access to, certain contraceptive practices.

When I speak of Depo proponents, I refer to the Upjohn Company, and its president, William Hubbard; population control agencies like the International Planned Parenthood Federation or the Agency for International Development; family planning expert Malcolm Potts; and many of those called to testify at a number of Congressional hearings on the use of Depo-Provera or contraceptive development. They are virtually all men, excepting a few women who are either doctors or former employees of population control agencies. I think the gender division in position on Depo—mostly women opposing, mostly men supporting—is less interesting than the broader power divisions. Depo proponents are high-level government, medical, or family planning officials; in the 1970s and 1980s these powerful persons were generally male. It must also be said that, by virtue of being involved in regulatory decisions, most of the actors discussed in this thesis, including women’s health activists, have a degree of power or influence not afforded most women, particularly those most likely to use Depo. The voices to whom I have access in reports from Congressional hearings, NWHN newsletters, feminist anthologies on reproductive technology, and the Hampshire Conference, are quite limited. The few “lay” persons whose insight appears in the Depo debates are “users” who have had either a good or bad experience with the drug. They do not speak as advocates, as proponents or opponents, but as authentic witnesses speaking experiences which either support or contest the acceptability of Depo. The tokenization of testimony is an issue for another thesis, although the use of experiential knowledge and “the user perspective” as possible feminist regulatory tools will be discussed in the final chapter. Nevertheless, I want to emphasize that those debating Depo speak *for* and *about* poor,

institutionalized, or Third World women, and women of color; virtually none of them fall into any of these categories.

A Note on Geography

My subject here is the debate that took place among feminists and between Depo opponents and proponents in the United States, concerning the approval of Depo-Provera for use as a contraceptive in the United States, primarily between 1974 and 1992. However, Depo-Provera is an inevitably international topic. The drug's influence abroad has been enormous since as early as 1967 and a great deal of feminist and family planning literature has been produced either hailing the drug's success in reducing fertility or condemning the way Third World women have been abused by it. Further, as will become clear in chapter one, approval of Depo by the FDA had enormous implications for the use of the drug in the Third World by U.S. government-funded development or population control agencies. Depo opponents and proponents implicitly and explicitly had Third World women in mind when they discussed the consequences of Depo approval for American women. Additionally, knowledge of the drug's use abroad informed Depo opponents' stance that Depo enacted a population control agenda and was more often than not administered without informed consent. Thus I will occasionally refer to Depo use abroad or regulators' characterization of that use.

On my Love/Hate Relationship with Women's Health Activists and being Radicalized by Research

Six months into my research I stumbled upon another use of Depo-Provera. A consent form from the Arlington Hospital and School in Tennessee, an institution for mentally retarded girls, reads in part: "This drug is to be injected every three months for the purposes of preventing menstruation, thereby making resident more comfortable and to lessen nursing care" (Senate 1973: 109). Depo was used in women for *hygienic purposes*. I felt that I could no longer defend my project of critiquing women's health activists' opposition to Depo-Provera on the grounds that they often failed to ground their feminist regulation in context, and therefore failed to recognize the potential contributions of Depo to women's reproductive freedom. Why was I defending this drug? Over and over again it was used under terrible circumstances for terrible reasons. Norma Swenson's words from 1987—"it may be impossible to use it at all in a responsible way"—are difficult to contest given the history informing her conclusion (House: 136). Perhaps Depo has "theoretical" potential for good, but why swim against the tide of evidence, evidence presented by activists whose interests I share and Congressmen whose commitment to protecting women tempered my cynicism about the government, demonstrating that in practice, the Depo experience has often been quite ugly? I wanted this work to be more than a detached intellectual exercise, especially as I realized that I was writing about the radical potential of an *interested* regulation, one that grows from political commitment or experiential knowledge. Feminist activists' opposition to Depo-Provera is political and righteous and tied to the political moment; my critique is two decades away and primarily

academic. Their purpose is to influence policy; mine is to produce a work of feminist theory. What is the epistemological or ethical status of feminist theoretical work so far removed from “the ground”? Where do my interests lie, and why?

I came to this project serendipitously; while doing research for a paper on low-income women’s access to contraception, I consulted data demonstrating that Depo-Provera is disproportionately used by women of color and poor women.³ A smattering of internet research later I realized I had tripped over the exposed nub of an enormous boulder, that the development and use of Depo has always been defined by race and class divisions, and that one can locate the liberatory and oppressive potential of family planning and contraception precisely in this synthetic compound. Having volunteered in the recovery room of a family planning clinic, I had watched a number of post-abortion patients receive their Depo injection but had never before considered the significance of that “injection moment,” the intentions it might be enacting, the inequalities it might encourage. Yet these injection moments are also instances of taking control; a woman who has just had an abortion, an experience frequently minimized by women’s health activists, who quite likely became pregnant following a contraceptive failure—a broken condom, a missed pill—is now protected for three months.

³ Like many feminists or sociologists I am perpetually frustrated by semantic limitations when it comes to discussing the sex-race-class triad of oppression. As Kimberle Crenshaw and other Black feminist theorists have pointed out, oppressions intersect, and it makes little sense to speak of one without the others. Population control doctrines are raced-sexed-class; the conditions of women’s Depo-Provera use can inevitably be traced to their race-sex-class. The very *meaning* of each category is interpenetrated by another. Nevertheless, I must on occasion write unwieldy category lists that artificially distinguish the status of “poverty” from being “of color.” I wish someone would invent words that encompass the relationship between oppressions while still acknowledging the important distinctions in content.

In Depo opponents' testimony and writing, the injection moment is inevitably abusive, an attack on a woman's health and a removal of control. Although the history of Depo-Provera is indeed characterized by abuses, I cannot shake the sense that there is a great deal missing from these accounts; the experiences of thousands of women in the U.S. for whom uninformed use of Depo-Provera—an abuse in activists' eyes—perhaps offered them their first experience with effective birth control and the reproductive freedom that can accompany it. Perhaps I am overly wedded to the notion that health risks are worth taking in exchange for effective birth control, and exaggerate the importance of contraceptive devices in the overall scheme of reproductive health and freedom. Neither I nor, I believe, women's health activists, have access to the “reality” of birth control, to the needs of women facing the oppressions of poverty, racism, and even sexism in ways I cannot purport to understand. Nevertheless, I have a sense that the idealized understanding of birth control and the somewhat abstracted conception of disempowered women informing Depo opposition fails to take into account the complex negotiation between a woman and an injection, or the person holding the needle.

Through this research a number of previously “intellectual” ideas have become flesh. It was not until I researched Depo that I really understood what is meant by “structural constraints on women's choice,” that in the face of institutions and officials whose interests are either oblivious or diametrically opposed to women's interests, “the right to chose” must mean more than increasing the number of contraceptive options. I perhaps knew in theory that reproductive choice includes the right not simply to prevent pregnancy, but the right to have children, the right to

reproductive health, and the right to information, all of which are denied an enormous number of women in this country and in others as the result of intersecting racism, poverty and sexism enacted by state and medical authorities, or even parents, boyfriends, and peers. I do not just understand now, but *know*, that Rosalind Petchesky was right when she concluded from her study of the sterilization:

For feminists, socialists, and health activists concerned with universalizing genuine reproductive choice, the strategic implications of this analysis are both clear and ponderous. No less than the equality of women...the extension of childrearing and birth control responsibilities to men...the complete socialization of medical care; and the establishment of a state that provides decent child care and health services are the minimal social changes that reproductive freedom would require (1981: 80).

And yet, in the meantime, I continue to believe that the availability of highly effective, convenient contraception can offer women some room to move, a modicum of reproductive choice, and that it is unjust to limit the birth control market to only those devices accessible under the ideal conditions this strangely radicalizing academic adventure has taught me will be necessary. Petchesky also provides what I consider a guiding tenet of this thesis: “Necessity, not freedom, dictates choice” (1984: 161). Recognizing the truth of this statement might lead one to limit choices to only those one *would* choose under conditions of freedom; this is essentially what I believe feminist regulation, as theorized and enacted by women’s health activists, would do. Alternatively, one can support less than ideal choices for less than ideal circumstances, within a larger project of creating the conditions for substantive reproductive freedom.

What Follows

Chapter One

I begin with an overview of the historical context out of which the Depo debate, and Depo-Provera itself, emerged. I trace the expansion of birth control clinics and contraceptive development in terms of the intersecting histories of population control and feminist birth control, in order to demonstrate that contraceptive use in the U.S. has always occurred at the intersection of women's interest in reproductive self-determination and state interest in limiting certain women's fertility. Depo-Provera in particular has the potential to serve both interests, but Depo opponents frame it as always and only a population control device. I also explain the emergence of women's health and consumer activism in response to the widespread use of contraceptives, hormonal or otherwise, before the health risks of such drugs and devices were known and without any provisions for offering women information about the risks. Depo opposition also grew out of activists' work to end so-called "sterilization abuse" through government regulation. This history is important because it explains how women's health activists came to believe that not all contraception serves birth control ends when it conflicts with women's overall health or is used on disempowered women without their consent, informed or otherwise. They reconceptualized the standards for birth control, and entered the long and convoluted debate over FDA regulation of Depo-Provera with the aim of enforcing them. Finally, through an overview of the extremely complex regulatory

debate which took place from the late 1960s until Depo approval in 1992, I hope to show the complex interplay of interests at work as the drug was conceived of as both an ideal population control device, but also a method that could meet the needs of women not in the position to use other methods.

Chapter Two

Having sketched out the historical and theoretical arena in which the Depo struggle ensued, I move in for a close look at the content of women's health activists' opposition to the drug, beginning with what I call "the medical problem." While the animal and human data on Depo was notoriously sketchy, human and animal studies indicating its cancer-causing potential (carcinogenicity) were compelling enough to convince activists and the FDA that, at the very least, approval should be delayed until the data were clearer. I show that activists argued that the risk/benefit ratio of Depo came out positively only from a "population control" perspective which abstracts the consequences of risk to what they call "the individual woman" in favor of privileging the overall benefits to society achieved through fertility reduction by way of highly effective, though risky, contraception. A "dangerous contraceptive" is not birth control. Women's health activists ground their analysis in birth control or women's values, pointing out the influence of an interested perspective on ostensibly objective scientific determinations. While their analysis represents an important intervention into the regulatory status quo, which abstracts risk and conceives of the individual woman as a free choicemaker rather than someone embodied and vulnerable, I argue that activists' conception of "the individual woman" fails to take into account individual particularity, and the fact that differently situated women may

have different health needs, a point recognized by Depo supporters but framed in dubious ethical terms. A feminist regulation grounded in defense of an ironically abstract and universalized “individual” woman seems ill equipped to respect women’s contraceptive needs.

Chapter 3

Activists’ opposition to Depo was grounded not only in their concern about medical risks, but the “political problem” of Depo. As a provider-controlled injection intended for or aimed at women of color, poor, institutionalized, or Third World women, activists made a strong case for the drug’s “potential for abuse” as a population control tool that would be injected into uninformed and/or unconsenting women. In the 1970s the ethical importance of “informed consent” was gaining strength among politicians and activists alike, and the history of sterilization abuse—and the frequently unethical unapproved or experimental use of Depo throughout the 1970s and 1980s—gave feminists good reason to assert that the conditions for true reproductive choice were less than ideal. Yet, as I demonstrate, their claim that the only legitimate use of birth control is that which is fully informed and utterly free writes most women out of birth control practice altogether, and their belief that Depo is only and always used to abuse ignores women’s ability to pursue their needs even in the face of conflicting pressures. Rather than advocating for better regulation of medical and state practice in order to reduce the potential for abuse, activists argue that any device with potential for abuse is unacceptable. Together, Chapters Two and Three demonstrate that women’s health activists propose one standard of acceptable, safe birth control devices and birth control use, leaving most women to wait for the

ideal social circumstances under which they could choose woman-controlled barrier methods.

Chapter Four

I conclude on a somewhat different note, looking not so much at the debates over Depo-Provera's acceptability as the epistemological foundation of a feminist regulation. Activists and government officials alike call for women's participation in contraceptive regulation and policymaking with the idea that women, as women, will offer truer accounts of all women's needs and the best ways to meet them. I problematize the notion that simply inviting more women to participate in the same regulatory processes necessarily produces more "feminist" decisions, as well as the essentialist belief that one woman can speak for all women on the basis of a shared essential subjugation or experience. I conclude by arguing that an epistemologically and ethically preferable regulation—feminist regulation—privileges an array of situated knowledges rather than the old, disinterested view from above which sees women as data or an essentialized woman's standpoint.

My goal in this examination of women's health opposition to Depo-Provera is not so much to determine whether they were "right" or "wrong" about the drug's medical and ethical dangers, although it will become clear that I often disagree with their analysis. Rather, I hope to demonstrate how their theoretical approach to the regulation of contraception fails to take into account "the best interests" of a diversity of women whose birth control needs are complex and contradictory. I aim to offer a new stream of feminist thought to the ongoing project of feminist regulation.

Chapter One: The Shifting Status of Contraception in the Tumultuous “Marriage of Birth Control and Population Control”

The American birth control movement of the early to mid twentieth century stands as one of the most palpable achievements of modern feminism. Condoms beat Comstock, sexual freedom overwhelmed Victorian prudery, and the pill became the Pill. This movement changed not only the material conditions of people’s lives, but permanently altered the country’s sexual (and gender) ideology. Yet the success of the birth control movement, the expansion of contraceptive services and the development of effective contraceptive devices must be understood in the context of a simultaneously developing doctrine of fertility reduction: population control. To understand the story of Depo-Provera—why it was developed, why some fought so hard for its approval and some fought so hard against it—it is instructive to situate this method in the historical and conceptual moment when birth control and population control had merged to the point of being indistinguishable from one another. Many feminists feared that contraception had become a means of controlling women, rather than expanding women’s reproductive control. As the state, the medical establishment, and pharmaceutical companies became major suppliers of increasingly “high tech” contraception, it appeared that some contraceptive practices could do more harm than good to women’s health and reproductive rights. In short, some feminists found that the connection between birth control devices or practices on the one hand, and feminist birth control politics on the other, is anything but secure.

The goal of this chapter is to explain the context out of which Depo-Provera, and the feminist activism that opposed it, developed. First I trace the overlapping

histories of the feminist birth control movement and the doctrine and institutions of population control, in order to demonstrate why some activists in the 1970s would feel the need to protect women from contraception. Along the same lines, I wish to demonstrate why Depo-Provera—a highly effective, provider-controlled contraceptive—would be understood as a population control device. Next, I briefly discuss the roots of women’s health and consumer activism, out of which feminist involvement in drug regulation grew. I also discuss women’s health activists’ response to “the dangers of sex hormones” and the phenomenon of sterilization abuse. Finally, I offer a summary of the complex regulatory history of Depo-Provera, from its introduction in 1967 until its approval in 1992.

The Tangled Histories of Birth Control and Population Control

The issue of birth control should be distinguished, both conceptually and historically, from that of population control, which is the action of more powerful groups to control the reproduction of others. The movement for birth control was initially part of a radical movement in which women struggled to gain control of their reproductive processes (Michaelson 1981: 14-15)

The history of the birth-control movement in the United States reveals at least two groups with differing motives for their involvement: those who want to make birth-control services available to all who want them as a right and matter of health; and those who are using birth control as a way to further their own institutional and class interests. At present the latter are clearly in control (Sharpe 1977: 72)

The Progressive and Oppressive Roots of Birth Control

The modern birth control movement in the United States was born out of a seemingly contradictory assortment of theories and activism starting in the early 1800s. “Women’s rights” politics had a limited role in changing society’s attitudes about sexuality, and particularly in influencing government and pharmaceutical interest in contraceptive development and distribution. Historians of the movement

such as Linda Gordon and Rosalind Petchesky identifies a number of birth control movement progenitors, including “voluntary motherhood” activism, social purity campaigns, free-love Utopists, neo-Malthusianism, and eugenics. Each of these influences contributed some pieces to the birth control puzzle. For example, voluntary motherhood asserted women’s right to choose when and whether to have children, but was anti-contraception. Free-lovers pioneered the separation of sex from reproduction, but women often felt exploited in free-love experiments. Neo-Malthusianism, the idea that reducing family size can reduce poverty and improve society, and eugenics, the belief that certain “undesirable” human characteristics, such as retardation and dark skin color, can be “bred out” of humanity by controlling the fertility of the undesirable,⁴ piqued the interest of influential Americans—politicians, philanthropists, and scientists—hoping to use birth control in social (engineering) programs. Both doctrines emphasize that fertility reduction among certain populations is of particular state interest. Although it is clearly worth separating the influence of such doctrines from feminist projects of gender equality and sexual freedom through birth control, these interests have often. It is difficult to accept that a movement that had such a positive influence on many women’s lives was founded partly on something as troubling as eugenic dogma, but this realization in fact greatly enlightens our understanding of how contraceptives like Depo-Provera could come to be seen as feminist nemeses.

The feminist birth control movement of the early 20th century, led by radical socialist Margaret Sanger, was a revolutionary one that “wanted to transform the

⁴ The authors of a 1926 book on *Applied Eugenics* identified their project as such: “1) Reducing the racial contribution of the least desirable part of the population. 2) Increasing the racial contribution of the superior part of the population (cited in Tone 1997: 164).

nature of women's rights—indeed, of human rights—to include free sexual expression and reproductive self-determination” (Gordon 2002: 138). At the time, the Comstock Laws prevented women from even receiving information about contraceptive devices, much less the devices themselves. This prohibition, along with bourgeois ideology about woman's sexual submission and maternal destiny, “ma[de] it her exclusive responsibility to say no and ma[de] pregnancy her God-given, exclusive burden if she didn't, while denying her both artificial contraception and the personal and political power to reject male sexual demands” (61). Contraception was demanded by women and for women as a fundamental precondition of their liberty, yet birth control activists were not so naïve as to think access to birth control would assure women's equality without broader social change. Although the movement's leaders were virtually all white and mostly bourgeois, some of them, including Sanger, were working class, and “appealed for support, particularly to women and to working-class and poor people in general, because they believed that lack of control over reproduction helped perpetuate an undemocratic distribution of power” (139). Strongly influenced by socialism, the movement worked not only to overcome sexism but economic and political injustice as well. Still, it is worth noting that “the new ideology of family limitation and responsible motherhood defined the superiority of bourgeois mothers” (Petchesky 1984: 45). Birth control was a raced and classed concept that applied differently, in theory and in reality, to poor or black women. Further, as Sanger sought legitimacy, and therefore financial and political support, for her movement, and as eugenic ideology crept ever deeper into her personal beliefs (“More children from the fit, less from the unfit” is Sanger's infamous declaration),

the movement drifted away from its radical, socialist, women's-rights foundations and deeper into white, male, middle-class respectability (Hartmann 1995: 99). These factors shifted the movement away from ground-up revolution and toward social policy.

Birth Control as Social Policy

The growing birth control establishment facilitated and was reinforced by advocates of population control, which emerged in the 1930s as a direct descendent of the eugenics movement and was backed by prominent eugenicists and philanthropists. Whereas its progenitor was interested in weeding out unfit "genes" from society, "population controllers are more class oriented. They are concerned about 'overpopulation' among the lower classes and poorer nations and its impact on the environment, food supplies, and the nation's political stability" (Shapiro 1985: 13). This political-economic perspective on fertility regulation is clearly related to the theories propounded by Sanger and other socialist feminists, yet ironically it was now advanced by the very "ruling class" which socialists had concluded "kept birth control from the working class in the interest of continued exploitation" (Gordon 2002: 141). Population controllers emphasized the "premise...that population growth and size are primarily causal, rather than primarily symptomatic, of poverty, distress, and inequality;" from this perspective, no greater social change is needed so long as birth control is available (283). Sanger and the socialists sometimes fell into this sort of thinking, but always envisioned radical social change. Population control fits neatly into an imperialist, capitalist world. Like eugenics, population control ideology is permeated with racist and classist biases; its proponents were much more

concerned about the “excessive” fertility of poor people of color in America and the Third World than that of middle-class whites. By the 1950s a host of well-endowed population control institutions such as the Population Council, The International Planned Parenthood Federation and Planned Parenthood–World Population, were organizing programs all over the world (281; also Shapiro 1985, Hartmann 1995). The publication of Paul Ehrlich’s *The Population Bomb* in 1968, and the accompanying panic about “overpopulation” in the Third World, ensured the popularity of these organizations. This work abroad inspired domestic family planning. “The rationale for federal and state funding of birth control clinics was derived from the justification for committing taxpayers’ money to help other countries deal with overpopulation” (Watkins 1998: 68).

The eugenic motivation to reduce “undesirable” fertility rates combined with the feminist wish to expand women’s access to contraception. When Sanger opened the first American birth-control clinic in Brooklyn in 1916, it was a radical, illegal move, and her high-profile trial attracted public interest in the cause. However one clinic would not reach millions of American woman, and Sanger “gradually came to the conclusion that to lead an effective struggle to make contraceptives accessible to all women, she would need more support” (Sharpe 1977: 61). She merged her radical movement with the conservative ladies’ National Birth Control League, doctors interested in asserting their authority over birth control as a “medical” concern, and the eugenics establishment. The result was “professionalization” of the birth control movement starting in the 1920s, which helped to “stabilize, rationalize, and centralize foundation-directed social planning,” and was made possible and advanced by the

belief that “some individuals were more valuable to society than others” (Gordon 2002: 174). Through this process, during which organizations like Planned Parenthood and “family-planning” clinics became the face of the movement, the women’s rights orientation of birth control was shifted in favor of an interest in social control often divorced entirely from feminism. “The loss of a women’s rights emphasis left the birth control movement...without a guiding ideology, open to any justification...” (203).

Professionals [were] eager not just to legalize birth control but also to install it as social policy. Their commitment to individual liberty was tempered by their recognition that some people were wiser than others, that good social policy would not necessarily result from allowing each individual to make private decisions about such matters as birth control (175).

Not only would policymakers provide birth control services, they would take it upon themselves to persuade the “less wise” to use them. Once the professionalized birth control movement established contraception as a matter of social policy, contraception was up for grabs, practically and ideologically. The social provision of birth control is not dangerous in itself, and may in fact be the only way to ensure that all women have access to contraception. However, whereas Sanger and other radical BCM activists envisioned birth control as part of a socialist, anti-sexist revolution, birth control went mainstream in a context of a racist, sexist, and capitalist society that could and would manipulate birth control—the practice, the concept, the movement—for its own ends. “Because state societies are hierarchically organized...[state-organized programs to reduce or increase fertility rates] have a distinct class and frequently ethnic dimension” (Petchesky 1984: 70). By the 1960s, the Office of Economic Opportunity was distributing grants for family planning

services as part of President Johnson's "War on Poverty," suggesting the root of the state's interest in birth control (Littlewood 1977: 45, see also Shapiro 1985).⁵ Birth control, the practice of limiting one's reproduction, is not inextricably tied to birth control, the feminist concept of increasing women's control over their lives, or the feminist birth control movement. All three were ripe for appropriation.

Birth Control v. Population Control: Why the Distinction Matters

There are a number of fundamental conceptual differences between birth control and population control ideologies. Briefly, the former takes as its starting point women's reproductive choices and desires and seeks to facilitate them (control from below), while the latter privileges "society's" interest in limiting or changing women's reproductive choices and desires (control from above). From a population control perspective, increasing women's reproductive self-determination is not considered an end in itself, and is not a priority; when achieving target reductions in fertility is the goal, ensuring that women are *choosing* contraception seems much less important. Population control programs sometimes offer incentives for contraceptive use, a practice considered coercion by some women's rights advocates (Hartmann 1995). Women are often completely abstracted as individuals and are rather referred to as "contraceptive acceptors" or "users."

Further, while feminists understand contraception as one of many elements necessary for women's liberation, population control officials advocate contraception as a cure, a technological fix, for social ills. "Population control is substituted for social justice, and much needed reforms—such as land redistribution, employment

⁵ Public family planning was also funded through the Department of Health, Education and Welfare.

creation, the provision of mass education and health care, and the emancipation of women—are conveniently ignored” (37). These differing priorities orient birth and population controllers toward different types of contraception. While the former, particularly during the women’s health movement, advocated “user-controlled” methods like diaphragms, the latter engender “a lopsided emphasis on the ‘more effective,’ or ‘high-tech,’ methods” which must be provided by a health professional and generally pose more health risks (38). “Professionalization” of birth control also entailed medicalization and pharmaceuticalization, as drugs and devices were taken up as profitable ventures (Petchesky 1984). Highly effective, mass-distributed methods—those desired by population control programs—receive the most research and development.

Most research on contraceptive technology was driven by the assumptions that poor women lacked the intelligence and the motivation to use existing contraceptive devices...and that future development should concentrate on contraceptive methods that were easier to use and that required less user participation. As a result researchers neglected considerations of women’s self-determination (Schoen 2005: 72).

As activist Jill Rakusen wrote in an article on Depo-Provera: “It is evident that the range of contraceptive choices open to women is very much governed by commercial and/or population control interests” (1981: 196).

Population control was not simply another movement related to birth control; their historical and conceptual identities are closely intertwined. However, the former became dominant, and “in the 1960s, just before the rebirth of feminism and a woman-centered birth control movement, population control was the defining element in the politics of reproduction” (Gordon 2002: 286). Population control is often depicted by feminist theorists as the evil twin of birth control, a brutal force that

wrenched women's newfound and tenuous control over their reproduction from them and aimed it like a weapon at the female body. From this viewpoint, birth control was perverted and usurped. Angela Davis, writing in 1981, asserts that the birth control movement "had been robbed of its progressive potential, advocating for people of color not the individual right to *birth control*, but rather the racist strategy of *population control*" (315). While I believe it is useful to distinguish these concepts from one another, the distinction between the enactments of these two agendas is hardly clear. For example, the establishment of family planning clinics in low-income neighborhoods might be seen as increasing poor women's access to birth control, or as government imposition on poor women's fertility. In 1973 four black Congresswomen, Representatives Burke, Collins, Chisholm, and Jordan, wrote a letter to Caspar Weinberger, Secretary of the Department of Health, stressing the need to combat the oppressive potential of these sites while recognizing their value:

The heart of the issue is how do we make family planning information and services available to all of those individuals who want and need them and at the same time insure that no element of coercion creeps into programs which Congress has specifically mandated must be voluntary in nature...There is a difference between providing information and assistance and coercion and it is a difference which must be jealously guarded (reprinted in House 1973: 1563).

Some argue that highly effective hormonal contraceptives simply facilitate state-interested fertility decline to the detriment of women's health, while others laud them for the unprecedented level of control and peace of mind they provide many women. This ambiguity is expressed by Linda Gordon when she refers to the Pill as "the marriage of birth control and population control" (2002: 286). Although "fear of a world population explosion legitimated work on the pill," "the Pill was mainly taken

up by Western women who saw in it a means to free their sexuality from the constraints of reproduction” (Wajcman 1994: 170, 172). Feminists opposed to Depo-Provera tend to frame it as a population control tool and as the product of population control interests; therefore it cannot be a “birth control” method in the feminist, progressive sense of the word. Yet if we recognize that the interests of birth and population control often overlap in complex ways, the potential meaning and use of Depo appears open to negotiation. “It is important not to underestimate women’s capacity to subvert the intended purposes of technology and turn it to their collective advantage” (172). Nevertheless, Depo opponents’ identification of the *structural* dominance of population control, and its influence on everything from contraceptive regulation to distribution, helps explain many of the abuses enacted in the name of birth control, and prompted feminist intervention into these institutions.

Protecting Women from Contraception: The Birth of Feminist Regulation

As noted above, by the 1960s the feminist birth control movement had more or less been overshadowed by family planning and population control. However when Depo-Provera emerged at the end of the decade, a reinvigorated movement, generically referred to as “second-wave feminism,” was there to greet it. Among other things, this movement fought for “reproductive rights”—advocating for women’s right to contraception and for the decriminalization of abortion.⁶ The FDA approval of the Pill in 1960 offered women a new degree of control over reproduction, and

⁶ *Griswold v. Connecticut* (1965) declared state laws prohibiting the sale of contraception to married couples unconstitutional; in 1972 *Eisenstat v. Baird* extended this right to unmarried women. Finally, abortion was legalized by *Roe v. Wade* in 1973.

gave birth control “a new public presence and legitimacy” (Petchesky 1984: 118).⁷⁸

The ideals invoked to defend women’s right to abortion—sexual freedom, self-determination, control over one’s body—helped reconceptualize birth control as a feminist matter. Planned Parenthood and The Population Council were no longer the only visible advocates for contraception. According to Linda Gordon, “the first impact of the women’s liberation movement was to divide feminist from mainstream birth control advocates (2002: 322). Initially the movement for abortion rights was a radical and socialist project; feminist groups “consciously rejected both the medical model of reproductive health and (though not always) populationist goals as the basis of birth control” (Petchesky 1984: 126). Yet the lack of race or class analysis in this mostly white movement prevented activists from addressing the inadequacy of a legal “right to choose” for women who cannot afford abortion or contraception, and for women on whom fertility control is *imposed*. They neither addressed the state’s role in abusing contraception nor the need for the state to protect women from such abuse.

Women’s Health and Consumer Activism

Women’s health activism emerged as a compatriot and foil of the increasingly liberal reproductive rights movement. Whereas liberal feminists emphasized access

⁷ The chicken and egg question of women’s independence—did they use the Pill because they were sexually free or did the Pill make them free?—is not one I can answer. Petchesky argues that “certain conditions and relationships created a pill ‘market’ to begin with and that it was the *conjunction* of an effective new technology with other social conditions...that led to changes in consciousness among women” (1984: 170). Still, she points out that the availability of theoretically “unfailing fertility control as a normal part of life” changed women’s expectations of how “perfect” contraception could be and allowed them to plan their lives differently. Similarly, Linda Gordon rethought her premise that “birth control represented the single most important factor in the material basis of women’s emancipation in the course of the past hundred years,” concluding instead that “birth control has been as much a symptom as a cause of larger social changes in the relations between the sexes” (2002: 2).

⁸ Considering the sexual prudery associated with the 1950s, Pill approval by the FDA, a government agency, in 1960 is rather remarkable, suggesting that sexual mores had already changed a great deal by the time Pincus made his great invention.

and free choice, women's health activists took a more radical and protective stance. They were skeptical that women's access to patriarchal medical care and a "male-supplied" contraceptive cafeteria was an adequate solution to their oppression (Holmes 1980: 18). They put forth some of the earliest critiques of a sexist, patriarchal health-care system inherently harmful to women, and were all too aware that "not all calls for birth control...are calls for women's liberation" (Dreifus 1977: xxiii). They were united by "their distrust of organized medicine, their belief that self-knowledge of anatomy and bodily functions can be liberation, [and] their insistence that women control the means of reproduction—and thus their lives" (xxv, see also Ruzek 1978). "The demand for more consumer knowledge and control over the health-delivery system develops as that system becomes increasingly alienated from the needs of the people whom in theory it exists to serve" (Fee 1977: 289). Women's health activists produced *Our Bodies, Ourselves*, invented "self-help" gynecological clinics where women learned how to examine their own cervixes, and emphasized "user-controlled" barrier contraceptives like diaphragms, all as part of their mission to reduce women's involvement with medical technology and the medical establishment and to increase their physical and intellectual control over health decisions. It was a time for *Seizing Our Bodies*, to borrow the title of Cynthia Dreifus's excellent 1977 anthology on the history and politics of the movement. Depo-Provera—provider controlled and "high-tech"—conflicts with its basic ethics.

It is important to note the raced and classed aspects of this movement. "While women from all races and classes self-help in the United States and Canada, white middle class women predominate. This may be related to their high level of education

and propensity to put their knowledge into practice” (Ruzek, House March 1978: 436) As shall become clear in the ensuing chapters, women’s health activists opposing Depo had a certain conception of acceptable “control”—women comfortable with touching their genitals, using barrier methods, provided with full information from sensitive healthcare providers. While one could argue that this might be “ideal,” in actuality, many poor, undereducated women, or women of color needed accessible, effective birth control.

This movement was tied to consumer activism, which advocated both for the protection of consumers from dangerous products, and educating consumers to give them an informed, proactive role in consumption—including healthcare. “The most common understanding of consumerism is in reference to the widening range of activities of government, business and independent organizations that are designed to protect individuals from practices that infringe upon their rights as consumers” (Aaker and Day 1971: 3). As early as 1962 President Kennedy articulated the consumer’s four rights: to safety, to be informed, to choose, and to be heard (Consumer Advisory Council 1971: 24). Consumer activists called for the government to take responsibility for protecting consumers, and “as of 1963, Federal responsibility for promoting the consumer interest [was] well-grounded in the historically validating, commonly accepted principles reflected in President Kennedy’s Consumer Message” (ibid: 33). The 1962 Kefauver-Harris Drug Amendments “instituted requirements for premarket testing of drugs for efficacy as

well as safety,” expanding and strengthening the FDA’s role (ibid: 33).⁹ Yet as will become clear, government regulation did not always succeed in protecting consumers, requiring the continued involvement of activist groups like Ralph Nader’s Public Citizen’s Health Research Group and later, the National Women’s Health Network.

A strain of paternalism runs through consumer activism, as watchdog groups decide what is “in the best interest” of the consumer. Aaker and Day write:

[There is] a strong justification for the protection of inexperienced, poorly educated, and generally disadvantaged consumers. More controversial by far is the extension of this notion to all consumers, on the grounds that manipulated preferences may be disregarded when the consumer is not acting in his best interest. So far the idea has not been adopted with enthusiasm” (1971: 4).

As shall become clear, women’s health activist go back and forth between working to *ban* Depo or other dangerous methods from the market, determining what should be available for all women, and ensuring better testing and better patient information. In general, consumerists and women’s health activists sought not simply to *protect* consumers by opposing the availability of dangerous drugs and devices, but to inform them about risks and increase regulatory transparency such that an informed public could oversee and check pharmaceutical companies whose products could and did devastate women’s bodies. “Rather in the manner of the Naderites, they seek to inform and organize those who receive health care and thus indirectly bring pressure on the patriarchs of the system” (Fee 1977: 286).

⁹ In the case of prescription drug regulation, the relationship between consumer and product is complicated by the mediation of the prescribing “expert”: a doctor. Consumer advocates emphasized the patient’s right to know the risks and make her own decisions, but the primacy of medical authority in making the final decision was vigorously defended by the medical establishment. As will become clear, Depo proponents defended the physician’s right to weigh risks and benefits for each individual patient, and found the idea of a uniform ban paternalistic. Conversely, the medical position is paternalistic toward patients...(Edwards and Graber 1988).

The Dangers of Sex Hormones

Women's health activists realized that individual women often did not have the power or resources to "seize their bodies." They were particularly concerned about the danger of contraceptive technology produced by pharmaceutical companies and approved by the FDA with little to no input from women. The titles of articles in Dreifus's collection point to this anxiety: "The Dangers of Oral Contraception," "A Case of Corporate Malpractice and the Dalkon Shield," and "The Dangers of Sex Hormones." In fact the women's health movement developed through years of activism in response to the revelation that a number of trusted reproductive technologies posed serious, even deadly, health risks to the millions of women using them. The first and second wave birth control movements demanded access to contraception; as birth control became more effective, and more high-tech, the question of *which* contraception became important. This history informed activists' approach to Depo-Provera.

The first reproductive pharmaceutical to harm women was probably DES, a synthetic sex hormone "given to millions of pregnant women as a preventative for miscarriages" from around 1945 until 1971 (Seaman 1977: 167). Not only was it prescribed for two decades after having been found ineffective in preventing miscarriage, it caused "a kind of hermaphroditism in some infants" and "some of the DES daughters," girls born to women who had taken DES, "were developing rare forms of vaginal and cervical cancer" as early as age eight (167-8). This instance of blatant medical incompetence and disregard for women revealed both how serious drug "side effects" could be and how little some drugs were researched before being

unleashed on the world. In the 1970s an intra-uterine device (IUD) called the Dalkon Shield became quite popular as a non-hormonal, highly effective contraceptive. Thanks to a series of corporate cover-ups and a lack of regulation, women were not informed that the faulty device could and did cause serious, deadly septic infections, also left many women infertile. “The Dalkon Shield was inserted into 3.3 million women in the U.S. and overseas” (Dowie and Johnston 1977: 88).¹⁰ And “as of last January 17 [1977], 17 American women had died” (ibid). Of course, the Dalkon Shield was not used by nearly as many women as the contraceptive Pill. The revelation that this product could be dangerous, and the fight to inform women about it, was central to the formation of a women’s health movement.

Women using the Pill were well aware of its many side effects—loss of libido, weight gain, and headaches to name a few. But “in 1961 came the first reports of Pill-related deaths from pulmonary embolisms (blood clots traveling to the lungs)” (Gordon 2002: 332). Journalists and scientists publicized their concerns throughout the 1960s, but no doctor was required to warn women of these risks. Ironically, many women who did hear of the risks chose the Dalkon Shield as a safer alternative. In 1969, Senator Gaylord Nelson read Barbara Seaman’s book *The Doctors’ Case Against the Pill*, which documented the medical evidence about the pill’s dangers as well as women’s accounts of their experiences with it, and was inspired to organize

¹⁰ When I mentioned to my mother all I was learning about the dangers of contraception way back in the 1970s, she told me nonchalantly that she used the Dalkon Shield for about a year, and suffered from excessive, irregular bleeding. Barbara Seaman once said that those who wish to ban certain contraceptives “have had a death, stroke or other severe side effect in their own family” (House March 1978: 131). Obviously if my mom had been killed or rendered infertile by the Dalkon Shield I would not be around to have an opinion about reproductive technology. Nevertheless, this revelation, and the sense of panic I felt for her twenty-something year-old self, helped me understand why activists were so stridently opposed to drugs and devices that posed what might seem to be infinitesimal risks.

hearings specifically about the “biochemical, physiological, and psychological effects of the pill” (Watkins 1998: 107). Banning oral contraception was never at issue; all parties involved “realized that such a proposal was unrealistic and impractical, and could lead to a black market for the pills” (109). The hearings centered rather on the question of how much information about risks and side effects doctors and pharmaceutical companies are required to give their patients. D.C. Women’s Liberation, a radical feminist collective, crashed the hearings and added a feminist twist to the consumerist debate. “It is not our mission to have all women on the pill discard it...We are opposed to unsafe contraceptives foisted on uninformed women for the profit of the drug and medical industries and for the convenience of men” (cited in Tome: 236). “At that time, the FDA had no organized system for consumer input and women’s health activists, in turn, knew of no direct way to impact the agency’s decision-making process;” The National Women’s Health Network (NWHN), co-founded by Seaman, formed out of Pill packaging activism to fill this void, although it was not officially established until 1976 (Pearson 1995: 133). In the end, the pharmaceutical companies were required to include a bare-bones patient information packet, the first of its kind, in the Pill packaging. This solution did not fully satisfy anyone, but it did institutionalize the idea that the mere availability of contraceptive technologies does not give women “control;” they must be provided with the necessary knowledge to make an informed decision about whether or not to use a given technology. It was also the first instance of “feminist-organized consumer resistance...play[ing] watchdog, making up for what the FDA did not do” (Gordon 2002: 335). By March of 1978 Barbara Seaman could proudly testify to Congress that

“the FDA has very gradually come to share our views on informed consent” (House: 129).

Evidently, the regulatory mechanisms meant to screen out dangerous drugs, and the physicians meant to inform patients of risks, frequently failed to do so. Some feminists believed “high-tech” contraception could be acceptable if properly tested and given with patient information. Yet others, particularly those who would become Depo opponents, concluded that population-control funded, pharmaceutical-produced contraception was inherently anathema to women’s health and birth control practice. “Birth control pills, diethylstilbestrol, prostaglandin abortion, Depo-Provera... are only a partial list of what women have been subjected to as a result [of population control] (Punnett 1980: 67). In any case, the Pill regulatory story reads as a cautionary tale: feminist intervention is needed at the regulatory level to ensure the safety of contraception. As NWHN member Judy Norsigian wrote in 1983, “...many now believe that the Pill was approved much too prematurely...Rather than make the same mistake with Depo, we argue for more caution, for more conclusive data *before* Depo is widely distributed as an FDA-approved method of contraception” (5). As one family-planning journal put it, “For DMPA opponents, the uncertainty of [Depo’s] risks, following closely on the postmarket discovery of problems associated with contraceptives such as the pill and the Dalkon shield...is sufficient to inflate the dangers of DMPA use to unacceptable levels” (Gold & Willson 1980: 159).

Sterilization Abuse: When “sterilization is not ‘birth control’”

As these mostly white activists struggled to give women more informed access to contraception, poor women and women of color fought a different battle

entirely, against widespread sterilization of women in hospitals and publicly funded family planning clinics. This was the most blatant incarnation of population control ideology and American state and medical practice. From middle-class women's point of view, obstacles to sterilization were of greatest concern.¹¹ However by the 1970s many of these legal impediments had been dropped and sterilization was widely encouraged by family planning programs, particularly in poor neighborhoods. In his book *Population Control Politics*, Thomas Shapiro writes that throughout the 1970s "women often were misled about the dangers of surgery; misinformed about its permanence, coerced while under the stress of labor or abortion...and sometimes were uninformed that they had been sterilized" (1985: 89; also Dreifus 1977). Johanna Schoen writes that "a lack of oversight over family planning programs and a social context in which many continued to feel ambivalent about women's ability to make responsible decisions concerning their reproduction contributed" to the appearance of coercive policies (2005: 73).

The practice grabbed national attention with the case of the twelve and fourteen year-old Relf sisters in Alabama, which poignantly illustrates the entanglement of racism, Depo administration, and sterilization. "The surgery had been ordered by the HEW-funded Montgomery Community Action Committee after it was discovered that Depo-Provera, a drug previously administered to the girls as a birth prevention measure, caused cancer in test animals." Their illiterate mother signed the consent form for the surgery because "she assumed...that it authorized the

¹¹ As of 1969, the American College of Obstetricians and Gynecologists still mandated the formula that a woman's age multiplied by the number of children she had must come out to at least 120 in order to be eligible for sterilization. (A thirty-year old would need *four* children). Further, her decision had to be approved by one or more doctors and psychologists.

continued Depo-Provera injections” (Davis 1981: 216).¹² In 1973, Secretary Weinberger instituted a moratorium on “the use of HEW funds to pay for sterilization of minors and other legally incompetent individuals” (Senate 1973: 1601).¹³ Joseph Levin of the Southern Poverty Law Center testified: “Sterilization is not ‘birth control’ when applied to minors and incompetents—it is mayhem, and it should be stopped now (1499). Meanwhile, activists in communities of color raised government *and* feminist awareness of the problem, and women’s health writers reported on abuse in publications like *The Progressive* (Dreifus 1977). By 1975 umbrella groups like the Ad Hoc Advisory Committee on Sterilization Guidelines and the Committee to End Sterilization Abuse (CESA) had formed to organize the various organizations involved in developing sterilization regulations and ensuring that they were enforced. Helen Rodriguez-Trias, one of the leaders of this movement, writes: “It quickly became evident that the issue of sterilization abuse could mobilize much broader segments than could that of abortion rights,” since it addressed reproductive rights not simply as a “woman’s issue,” but a race and class one as well (1984: 118). In its mission statement, CESA stated that “the U.S. ruling class denies us our rights to choose the best available method of birth control”; the group emphasized the

¹² Banning use of the drug “may have led to these sterilizations” but, of course, “the purpose of insisting on adequate informed consent for the use of Depo-Provera...is to protect the rights of the patient. Those rights are not well served by the substitution of sterilization for the use of Depo-Provera without informed consent” (Kennedy, Senate 1973: 1445). For more on sterilization abuse in the U.S., see Shapiro 1985 and Rodriguez-Trias 1984 (the movement for regulation), Petchesky 1981 (its socio-economic conditions), Dreifus 1977 (abuse in L.A. County General Hospital), and Senate 1973, Pt. 4 (the Relf case and HEW regulation).

¹³ In *Buck v. Bell* (1927), Supreme Court Justice Oliver Wendell Holmes concluded that a “deficient” woman “may be sexually sterilized without detriment to her general health; and that her welfare and that of society will be promoted by her sterilization...It is better for all the world if instead of waiting to execute degenerate offspring for crime, or let them starve for their imbecility, society could prevent those who are manifestly unfit from continuing their kind” (cited in House 1973: 1604). According to the ACLU, in 1973, twenty-two states had sterilization laws derived from this decision on the books (ibid).

race/class implications of sterilization abuse, and its inherent connection to population control (Shapiro 1985: 144). The movement forced feminists to recognize that, so long as the state has an interest in limiting the fertility of certain women, protection and regulation is just as vital as choice and access. In order for free choice and reproductive self-determination to become a reality, the *conditions* for such choice must be established. In 1977 the coalition achieved an enormous victory when HEW “issued regulations for all federally funded sterilizations” including informed consent, a waiting period, and an age minimum of twenty-one (142).

As with the Pill, activists did not seek a ban on this form of birth control, despite the “potential for abuse,” and sought instead to ameliorate the conditions under which sterilization would be an option for women, not an imposition on them. They did not claim that sterilization was an inherently harmful practice or one that served only population control interests. “A sharp distinction was made between CESA’s opposition to *programs* of discriminatory population control and its support for all *forms* of birth control” (144, emphasis added). Activists from poor communities of color drew white middle-class women’s health activists’ attention to the fact that withdrawal from the health care system would not improve the (reproductive) health of women already excluded for it. “Ultimately, [the movement’s] greatest weakness was its overall failure to address the need for power within the institutions where most of the abuses were taking place” (Rodriguez-Trias 1984: 124). The separatism inherent to some women’s health activism, advocating for women-run clinics and shunning of high-tech contraception, failed to resonate with

women who wanted access to high-quality healthcare and effective birth control. They refused to throw out the baby with the bathwater.

Rather than total disengagement from state, pharmaceutical, and medical institutions, feminist regulation of birth control appeared as a viable solution to the medical and political problems posed by high-tech contraception and the influence of population control on birth control programs.

As stated by one women's group, '...we find that a portion of our fight has a reactionary as well as a progressive potential. We have been trying to open up laws around birth control and abortion without moving to effectively control its use'...Women have long been consumers of birth-control services. They are now beginning to realize that they must control the policies, direction and administration of these programs (Sharpe 1977: 72).

The status-quo of contraceptive development, regulation, and distribution was clearly biased against women's best interests, particularly those of poor women and women of color. The pernicious influence of population control doctrine on public family planning and haphazard treatment of women's bodies by drug companies and doctors had to be countered by an explicitly woman-interested regulation, one that would improve reproductive choice, and maintain contraception as a feminist birth control practice, by either limiting those choices to "safe" options or demanding better conditions in which those choices would be made. By framing Depo as an inherently dangerous, population-control device, they were led to pursue the former initiative.

The Depo-Provera Debate

The ideal contraceptive has frequently been described as a one-shot contraceptive that is long-lasting, that does not require counting or frequent repetitive action, that is inexpensive, that is convenient, that is safe and that does not require the services of a medical professional (House August 1978: 2).

DMPA, the compound branded as Depo-Provera, was synthesized in 1954 by a company scientist experimenting with progestin, one of the hormones involved in regulating ovulation (Potts and Paxman 1984: 1). In 1960 the FDA approved its use to prevent endometriosis (the painful presence of endometrial, or uterine, tissue elsewhere in the pelvis) and miscarriage (Weisz et al 1984: 11). It was discovered during testing in Brazil that Depo had another (more profitable) use altogether: contraception.¹⁴ By the late 1960s demographers studying contraceptive use (and of course women themselves) noticed how many women encountered “psycho-social” obstacles to effective contraception, mostly “involved in the actual mechanics of contraceptive use—association with coitus, messiness, uncertainty, daily bother, and the like” (Blake 1975: 230). Depo-Provera, 99% effective and lasting three months with a single shot, would eliminate “compliance” and “motivation” problems. Additionally, given the health risks posed by estrogen, especially to smokers and older women, a non-estrogen hormonal contraceptive was sorely needed. Finally, the invisibility of Depo (the shot leaves no trace) would allow women forbidden or discouraged by their male partners to use contraception. As Dr. Fred Sai of the International Planned Parenthood Federation (IPPF) put it, “By its nature too a woman is more free from an uncooperative husband (a not infrequent occurrence [in Africa]) than when she uses other contraceptives clandestinely. It fits in very well in the social pattern” (House August 1978: 7). For these reasons and more, “Depo-

¹⁴ Depo-Provera is also an effective contraceptive in *men* but Upjohn never attempted to market it as such since it also nixes their libido. Thus it has been used to “chemically castrate” sex offenders in exchange for reduced prison sentences. In an instance of staggering irony, Roger A. Gauntlett, heir to the Upjohn Company, was sentenced to Depo-Provera treatment as part of his sentence for raping his teenage stepdaughter. The Michigan Supreme Court threw out this ruling; he was eventually sentenced to 5 to 15 years in jail (*Dallas Mornings News*. “Upjohn heir resentenced in rape case,” sec. A, Sept. 22, 1984.)

Provera is thought by some to come about as close as any drug comes at present to being the perfect contraceptive” (2).

Whereas Depo supporters argued that “compliance” and “motivation” problems could and should be solved by reducing women’s responsibility for contraception and developing provider-controlled devices, women’s health activists feared that women’s rights to reproductive self-determination would be violated and that fertility was being treated (and medicated) as a disease. Depo embodied a dangerous combination of the health risks of sex hormones and the ethical risks of provider-controlled methods like sterilization. Provider-controlled, pharmaceutical-produced, highly effective and efficient to administer: from the discussion of birth control versus population control above, it is not difficult to see why activists identified Depo-Provera as a tool of the latter.

One Step Forward, Two Steps Back: The Depo (Non) Approval Dance

Depo-Provera sounds too good to be true. And, not surprisingly, Depo-Provera turns out to be less than the ideal contraceptive (Levine 1980: 101).

Unfortunately for Upjohn, the drug would need to be approved for this new purpose, and thus commenced what would be a thirty year regulatory nightmare. The following summary is gleaned from a comprehensive timeline in the 1983 report from the Public Board of Inquiry. One year after submitting a new drug application for use of Depo as a contraceptive in 1967, the company initiated two long-term animal studies in beagle dogs and rhesus monkeys (Weisz et al 1984: 12). In 1972 trials involving 4700 (mostly black) women at the Grady Memorial Family Planning Clinic in Atlanta began and continued until 1978; this was the largest sanctioned human use of Depo in the United States (Hartmann 1995: 204, Branan 1984). That same year,

the beagle studies were started over again due to high mortality among the dogs (apparently unrelated to Depo). In the meantime, word spread about this highly effective contraceptive and many American women were prescribed Depo “off-label” by private doctors, through family planning clinics and in mental institutions. The drug also spread widely in Third World nations such as Thailand, Kenya, Sri Lanka, Botswana, Tanzania, Zaire, and Jamaica, as well as developed countries like Sweden, New Zealand, and Belgium (Minkin 1981; Potts 1984).

Contemporary writers about Depo-Provera differ in their characterization of this spread. Consumer activist Steven Minkin, who wrote two important, scathing critiques (1980, 1981) of Depo-Provera as a medical and social danger, states that the IPPF under director Dr. Malcolm Potts “was responsible for the distribution of millions of shots to nations such as Thailand, Kenya [etc]”(1981: 36). Potts himself, a powerful figure in population control circles and a major supporter of Depo-Provera, stated that by the 1980s, Depo “had been approved as a contraceptive by more than 80 developed and developing nations” (1984: 9). It is clear that the former sees these nations as passive recipients of a population control tool, whereas the latter emphasizes the active “approval” of the drug by those nations.¹⁵ As for numbers, Minkin states that by 1980 “an estimated 5 million women have been injected with the drug;” by 1984 Potts figured “Depo-Provera has been used by some 10 million women...currently 1.25 million women around the world are thought to be using the drug as a contraceptive” (1980: 49, 1984: 9). Again, note the passive/active dichotomy emerging; women are “injected” or they are “using” depending on one’s

¹⁵ In Minkin’s account in particular it is interesting that he speaks of nations rather than women, employing a common colonization metaphor with drugs as first world invaders of nations and bodies alike.

perspective. In the same “neutral” event—the injection of a drug into an arm—Minkin sees imposition from above (population control), while Potts describes women choosing for themselves (birth control).

However one interprets its use, Depo-Provera extended its reach far and wide throughout the 1970s before it had been approved by the FDA. Nevertheless, government agencies involved in population control, the most significant of which was the Agency for International Development (AID) could not distribute any drug without federal approval, whereas independent organizations like the IPPF could do so freely (Hartmann 1995: 201). Another motivating factor was many countries’ reluctance to approve a drug not deemed safe for American consumers. From the Upjohn Company’s perspective, FDA approval was worth fighting for not so much to increase domestic use of the drug, but international use, whether by U.S. population agencies or foreign governments. Upjohn never foresaw a large American potential user population. During Congressional hearings in 1978, the president of Upjohn stated, “we estimate that somewhere between 3 and 4 percent of all [U.S.] contraceptive users might choose Depo-Provera if given the opportunity to do so” (27). At the same hearings, Chairman Scheuer noted that the committee had been asked to “examine the FDA decision [not to approve Depo] because of its impact on millions of women in the developing world” (2). One could say, then, that Depo always had more potential as a population control device than as a birth control option, or even that it was intended for the former purpose. Indeed much of the consumer and women’s health activism against Depo-Provera was performed in the name of protecting Third World women from First World technological intrusion. Yet

one must keep in mind that simply because a contraceptive is intended as a population control device does not mean that its use always constitutes coercion, imposition, and lack of choice. Many women in the U.S. and abroad did not have contraceptive choices given their own or their partners' discomfort with available methods.

By 1973, having reviewed the available animal and human data, the FDA announced its plan to approve Depo-Provera for “a limited and well-defined population”; it “was to be given only to women unable or unwilling to use other methods” (Weisz et al 1984: 12; Maine 1978: 343). Just that year, Senator Edward Kennedy had held hearings to discuss “the wide-spread unapproved use of Depo-Provera” in Tennessee. Depo was not simply being prescribed by the occasional private doctor, but shipped by the caseload to family planning clinics and mental institutions (Senate 1973: 4).¹⁶ Kennedy and Representatives Burke, Collins, Chisholm, and Jordan, protested the FDA announcement, stating that approval would “result in widespread use of the drug in institutions for the mentally retarded and in health clinics serving the poor and uneducated” (Kennedy, cited in Maine 1978: 342) and that “the rights of the poor and minorities might be abused” (ibid). Indeed, the category of women “unable or unwilling to use other methods” can easily be interpreted as a code for those who do not *want* to “choose” birth control, i.e. poor and uneducated women who social planners believe should not have children. As Carol Levine put it, “One can feel in these words the frustration of medical professionals and family planners in dealing with women who will not or cannot do what is considered by others to be in their best interests!” (1980: 103).

¹⁶ This unapproved use of Depo will be discussed in Chapter Three.

In spring of 1974, during hearings on the use of advisory committees by the FDA, Representative L.H. Fountain discovered data suggesting that risk of cervical cancer posed by Depo (House 1974). On September 12, 1974, the FDA officially approved Depo-Provera, but this decision was stayed a month later after Representative Fountain sent the agency a letter expressing his concern. It would be four years before the FDA officially delivered the bad news to Upjohn in a March 7, 1978 letter citing five major concerns, including an insufficient potential user group, the risk of birth defects if pregnant women were given the drug and results from the animal trials indicating that “metastatic breast cancers or tumors were produced in the Beagle dog with the use of Depo-Provera,” and that monkeys developed endometrial cancer (House August 1978: 20). Rather than *disapproving* the drug, they refused to approve it, and asked Upjohn to withdraw its petition. According to Upjohn president Hubbard, “in the [FDA] Drug Bulletin of April 1978, admirable candor was shown in stating that ‘the decision to approve Depo-Provera for use as a contraceptive was stayed because of consumer and Congressional objections,’” leading Depo supporters to insist that the decision was political rather than “scientific” (248).¹⁷ However, activists and FDA officials alike insisted that the agency simply did not have the evidence to call the drug “safe.” That same year, the FDA performed an audit of the Grady Clinic studies and terminated them, having found that “the study was poorly designed, patient records were inadequate, and researchers did not follow patients who dropped out of the study or provide long-term follow up to assess potential

¹⁷ Much of the disagreement about Depo’s safety boils down to questions about the applicability of animal data to humans. In particular, supporters argued that beagles are particularly susceptible to breast tumors. Alice Nichols, a lay Depo user who testified in August 1978, memorably commented, “How can you compare a woman to a beagle dog? A woman has two breasts, a beagle dog has eight” (House: 179).

cancer risk” (Sun 1984: 950). The only official study of Depo in US women was not only scientifically deficient but demonstrated a remarkable disregard for the health of the subjects.

In response to the March 1978 non-approval decision, a hearing dubbed “The Depo-Provera Debate” was held before the Select Committee on Population in August 1978. Twenty-one people (eighteen men) testified over the course of three days. Most of them supported approval; most were doctors or researchers involved with population control organizations. Consumer activist Anita Johnson offered the only explicitly anti-Depo testimony, emphasizing the significance of animal and human data indicating Depo’s cancer-causing potential. The American College of Obstetricians and Gynecologists, in a statement prepared by Dr. Kamran Moghissi, proclaimed that “definite need exists for injectable contraceptives in the United States to accommodate a certain patient population which includes *drug addicts, mentally retarded women, and those unable or unwilling to use other contraceptive modalities*” (347, emphasis added). Malcolm Potts noted that “even among the vast population of the United States, you can find subgroups of people who have the same problems as people in the developing world...I think you can find the same type of population...as one finds in the north of Thailand” (19). From Depo opponents’ standpoint, these men were explicitly stating the Depo is a drug for disenfranchised, institutionalized, poor, or dark-skinned women in the U.S. In other words, it was a drug for the objects of population control. Thus they fought Depo on the basis of *both* its medical risks and abusive potential.

Depo advocates are often condescending in their defense of Depo, complaining of obstinate women refusing to control their fertility. Some of them may have genuinely thought they were pushing a feminist cause. In any case, they certainly appropriated feminist language. Dr. Fred Sai of the IPPF opened his testimony:

I would like, right at the beginning, to make a plea to those who think they fight the feminist cause in the United States to realize that some of us who make decision that look awkward to them are as much fighting the feminist cause where we are as they think they are. As I stated last time, I find it impossible to see how a woman can be saddled with fertility every year or every 2 years and still have time to be developed and have human dignity and status (House August 1978: 4).

Whether or not Dr. Sai is sincere in his feminist convictions, it is interesting that officials were sufficiently self-conscious of doubts about the compatibility of their work with feminist goals to go on the defensive, and that invoking feminist language seemed a propitious rhetorical move. A doctor testifying at Kennedy's 1973 hearings on the use of Depo in Tennessee used similar language: "Daily our women are sentenced by inadvertent pregnancy to compulsory motherhood, to loss of self-esteem, to denial of self-actualization and to instant poverty. Where other methods have failed many had had a pregnancy free interval by use of Depo-Provera" (Brooks, House: 78). Like Sai, he describes the real problem of "compulsory motherhood," but does so in a paternalistic voice, and explicitly asserts that unwanted pregnancy causes poverty, a basic population control premise. Yet as troublesome as the Depo defense appears, men like Potts and Brooks had a point: "subgroups" of U.S. women were suffering from unwanted pregnancies and maternal morbidity, and the Pill and condoms were not helping them. One can argue that Depo is "aimed" at vulnerable

women by those who disregard their health, or that Depo filled a gap in women's need for birth control. As will become clear in the next two chapters, feminists often ignore the contexts in which a woman might genuinely need a method like Depo.

By the time of the 1978 hearings, the NWHN was campaigning hard against Depo-Provera, and had achieved enough legitimacy to be invited to testify before the Committee on Population in March 1978 on priorities in contraceptive development, at which Depo was also discussed. Seaman remarked on this achievement: "I wish to thank those people at the FDA and HEW generally, and in Congress, who support the consumer position for women as well as for men" (129). In 1979 the Network "announced the creation of a Depo-Provera registry. Depo-Provera users were urged to complete a questionnaire about their experiences with the drug. During the six years the registry was active, nearly 1,000 women reported their experiences" (Pearson 1995: 134). The Network remained the most visible and active opponent of Depo for the next two decades. In 1983 the Network "file[d] a class action suit against the manufacturer of Depo-Provera, seeking compensation for women who had been injured by the drug;" the suit was eventually withdrawn (ibid). Rosalind Petchesky observed in 1984 that "the seriousness with which the Depo-Provera alignment has had to meet its feminist critics...shows that the concentration of interests controlling the contraceptive market is not all-powerful. It has to accommodate the self-perceived needs and organized demands of women through a subtle process of negotiation and struggle" (177). Depo proponents and journal articles reporting on the ongoing debate always refer to the "consumer" influence, suggesting that they at least sensed a "politicization" of the regulatory process. A

family planning journal writing on the “decades-old controversy” in 1980, sounded exasperated:

These groups, *drawing their own conclusions* from the published scientific evidence, have concentrated on using the popular media to generate opposition to Depo through charges of a double standard of medical care for rich and poor women...They have *extrapolated anecdotal evidence* about problems with Depo use to warn of the possibility of large-scale health risks, and *issued reminders* of the safety problems that occurred with other fertility-related drugs, including the pill and DES, after they were marketed (Gold & Willson 1980: 158, emphasis added).

Although the family planning establishment clearly considered Depo opposition political, sensationalist, and unfounded, it was a force to be reckoned with, and as the next two chapters should demonstrate, few could seriously contest the significance of doubts about Depo’s medical safety and ethical distribution.

Most likely encouraged by the overwhelmingly favorable slant of the 1978 hearings, Upjohn pressed doggedly forward and requested a rare Public Board of Inquiry (PBI) hearing. This three-person panel would review the evidence, particularly concerning the carcinogenicity of Depo in animals and humans, hear testimony from interested parties, and make a recommendation to the FDA commissioner. In 1983, the World Health Organization, IPPF, AID, American College of Obstetricians and Gynecologists testified in favor, while NWHN, the Health Research Group, the Institute for Study of Medical Ethics, and feminists Gena Corea, Carol Korenbrot, Stephen Minkin and Helen Holmes testified against (*Network News* 1983: 10).. Scientists Judith Weisz, Griff Ross, and Paul Stolley finally concluded in 1984: “The facts relating to the long term consequences of the use of the drug are inadequate and insufficient to provide a basis for risk assessment” and therefore it could not be approved (172). “NWHN claims major victory for non-

approval of dangerous contraceptive Depo-Provera,” trumpeted the organization newsletter (1984: 1). Although Depo proponents, surprised by the ruling, continued to decry non-approval as “political,” it seems quite clear from the report that the available evidence pointed to uncertainty, not safety. As Fletcher Campbell of the FDA Bureau of Drugs testified to the PBI, “We believe that to approve Depo-Provera...without good human data would bring about nothing short of a revolution in regulatory policy.”

Although ethical questions abounded about the populations at whom Depo was “aimed,” the regulatory debate was officially framed around scientific safety questions, and thus the resolution would come only with more evidence, not an ethical determination.. “[T]he board carefully avoided implying that the injectable contraceptive is dangerous and stressed instead that the recommendation was based on an inability to conclude that the drug is safe” (*Family Planning Perspectives* 1985: 38). Some experts felt that proof already existed. “Several witnesses at the hearings argued that despite the animal studies, the safety of Depo has been shown in its extensive use by women worldwide” (ibid).

Depo Approval: A Welcome New Choice for Women?

In fact, Third World women were providing evidence of safety day by day. It is ironic that, in the end, the very women whom activists wished to protect from Depo-Provera ended up providing the data leading to its approval. Feminists argued that the use of women as test subjects for a possibly unsafe drug was unethical; Depo proponents responded that the drug’s safety could emerge only through the medium

of millions of women's bodies. This paradox was clear as early as 1978, when FDA Commissioner Donald Kennedy remarked:

[W]e have to balance how much hazard a drug presents with the benefits that we presume derive from it. It is, of course, true that there is some 'Catch-22' built into a drug that is used chronically, as contraceptive agents are, and that, at the same time, one has not had an opportunity to test in humans" (House August: 33).

Following the 1983 board of inquiry, "Upjohn was given the option to submit a new application when further relevant data were available" (Klitsch 1993: 37). While Upjohn waited for data, family planning clinics continued to prescribe Depo; the use of the drug by the Indian Health Service on mentally retarded women prompted a new burst of controversy and Congressional hearings in 1987. "In 1991, several reports of research studies conducted by the WHO on cancer risk and DMPA were published; for the most part, their findings exculpated DMPA as a cancer-causing agent" (Klitsch 1993: 37) This data, gleaned from studies conducted among some of the *11 million* women who had used Depo since 1967, was presented in June 1992 to the FDA Fertility and Maternal Health Drugs Advisory Committee, and after a public hearing, the committee unanimously voted for approval. The FDA took its committee's advice four months later, on October 29, 1992. In the end, it appears that the complex ethical questions were never resolved, simply subsumed under the sheer force of large, longitudinal studies.

Was the approval decision a victory for population control or birth control?

The decision was characterized in the mainstream media as a victory for women. *The New York Times* called it "A welcome new choice for women" in an editorial. At the time a new controversy was raging—over whether or not to approve the abortion pill,

RU-486, in America—and it seems that liberal journalists were extremely frustrated by the “political” obstacles to reducing unwanted pregnancy. “It can hardly be called a courageous breakthrough, but the FDA has finally approved a well-tested drug that prevents pregnancy,” declared the exasperated editors of the *San Francisco Chronicle* under the headline, “Approval at last for Depo-Provera.” The gleeful response of the media provides another example of how easily one can slip between birth control as women’s right and birth control as a social policy tool. The *Chronicle* calls Depo, “a welcome resource in the effort to limit the number of unwanted pregnancies in the United States.” Women are not even mentioned in this sentence; excessive unwanted pregnancy is framed as a social phenomenon literally disembodied from the women in which that pregnancy occurs. Nary a word about women’s liberation is spoken. The early 1990s was the heyday of the “teen pregnancy crisis,” and the old population control premise that this “excessive fertility” was creating poverty circulated in public discourse (Luker 1996). This is not to say that unwanted pregnancy is not of concern to women or feminism, nor to deny that Depo was a good contraceptive option for many women. The *Salt Lake Tribune* noted that approval “gave American women the first birth-control method that is utterly private” (Chui 1992).

Women’s health advocates fought against Depo until the bitter end, maintaining the two-pronged argument about medical danger and “potential for abuse.” Cynthia Pearson, director of the NWHN, is cited in a *Times* piece: “We are very sorry it was approved. We are concerned about bringing a drug linked to cancer into a country where the risk of breast cancer is already so high” (Hilts 1992). The article goes on, “health advocates for low-income and minority women are concerned

about Depo-Provera being pushed on women at clinics because it is an easy means of providing contraception and of assuring compliance.” By this time the NWHN had been joined in Depo opposition by the National Black Women’s Health Project, the National Latina Institute for Reproductive Health, and global reproductive rights coalitions such as Women’s Global Network for Reproductive Rights and Feminist International Network of Resistance to Reproductive and Genetic Engineering. Yet whereas one group of actors argued that Depo would be imposed on the poor, others expressed concern that they would be denied access. Surgeon General Jocelyn Elders declared, “If reproductive choice is to be a reality in our country, reproductive choice must include access to the latest, most effective means of contraception...The fundamental problem remains, the price of Norplant and Depo Provera is too high in this country for a large portion of working poor women to realize contraceptive equality” (Leary 1994).

As I have tried to show throughout this chapter, the line between birth control as a facilitator of “reproductive choice” on one hand and an *imposition* on that choice on the other, is often blurred. Elders’ statement seems to betray an ignorance of the historical use of Depo-Provera among the poor, which, as we will see, has been characterized by everything from carelessness to outright coercion. Nevertheless, women’s health activists’ continued unwillingness to grant that Depo might be an acceptable birth control device even after studies indicated the drug was at least as safe as other hormonal methods suggests that they engaged in the Depo regulatory debate not simply to protect women from drugs whose risks are practically unknown, but to ensure that available contraceptives meet certain “women’s health” standards

of birth control. Given the strength of population control ideology, the social control of women's reproduction in the U.S., and the devastating effects of drugs like DES and the first contraceptive pills, it should be clear that feminists had good reason to intervene in the contraceptive regulatory process, and to argue that adding another method to the contraceptive cafeteria does not necessarily improve women's reproductive health or freedom. Yet I shall argue in the following chapters that the theoretical foundations of this "feminist regulation," and activists' standards for birth control, would leave many if not most women without *any* choices for contraception.

Conclusion

In this chapter I framed the development of contraception and public birth control clinics, feminist consumer activism, and the Depo-Provera debate in terms of the complex interplay between the theory and practice of feminist birth control and population control. I emphasized that "high-tech" contraceptives and their distribution to women might be understood as both expanding women's reproductive choice and as an imposition on that choice and women's health. The development and debate about approval of Depo-Provera, and women's health activists' strident opposition to the drug, must be understood within this context. Given the history of unsafe contraception and sterilization abuse in the United States, it is not difficult to understand why activists perceived Depo-Provera as medically and socially dangerous. This history also explains the development of what I call "feminist regulation," as activists engaged fruitfully in the regulation of drugs (calling for better patient information and more stringent safety standards) and in state-funded medical practice (creating obstacles to the imposition of sterilization on poor women and

women of color). They perceived that those in control of contraceptive development, regulation and distribution either disregarded or willfully imposed on women's reproductive health freedom; feminist intervention was necessary in order to protect contraceptive devices and practices as tools of *birth control*, rather than population or social control. In the next two chapters I will delve into the Depo-Provera debate in order to explore how feminist regulators framed Depo-Provera as an inevitably dangerous drug, not an acceptable birth control device, beginning with the medical problem.

*Chapter Two: Weighing Risks and Benefits on an Individual Scale:
Embodiment, Abstraction, and Women's Values*

The regulatory debate swirling around Depo-Provera for over two decades ultimately hinged on one simple question: Is it safe? As women's health activists entered the realm of drug regulation, they brought along a unique perspective on the meaning of safety and a commitment to ensuring that all contraceptive drugs and devices approved for women's use would meet that standard. In this chapter I argue that they were making a conscious intervention into the status quo of contraceptive regulation, which they perceived as privileging a drug's efficacy over the health of women using it. They attributed this bias to the dominance of population control values over women's health or birth control values, to an analytic standpoint from which women's rights are abstract and the benefits to society of reduced fertility, particularly in certain populations, trumps risks to the individual. While this chapter will show that any response to the safety question is at least in part attributable to the values or interests of the respondent, Depo opponents made those interests explicit, convinced that their feminist regulation, which prioritizes the health of "the individual woman," would best protect women's overall reproductive health and freedom, and ensure that the only contraceptive methods on the market would be those compatible with birth control values.

This chapter begins with a look at the science of determining safety, which, at the FDA, is grounded in risk/benefit analysis. Although these risks and benefits are ostensibly medico-scientific, visible in objective data, Depo opponents and supporters define and weigh risks and benefits differently, producing different ideas about "risk

acceptability.” I will discuss how activists articulated the importance of evaluating risk with birth control values—privileging “the individual woman”—and evaluate one instance of a clash of values between a consumer activist and a Depo-sympathetic Congressman. Depo supporters minimize risk for an abstract population, or valorize the individual’s right to choose risk above all, while opponents consider risk for a vulnerable, embodied woman who deserves protection. In the last section I question women’s health activists’ ability to consider how risk/benefit analysis for “the individual woman” depends on the context in which that woman is found. Their conclusion that Depo’s risks necessarily outweigh the benefits of efficacy and convenience, and their expectation that women can and should use “safe” barrier methods, relies on a particular understanding of contraceptive acceptability and accessibility that simply cannot be generalized for “the community of women.” Using concepts like “women’s values” and “the individual woman” makes their approach sound highly responsive to individual women’s needs but ironically erases the very particular women’s-health-activist values underlying their analysis.

The Uncertain Science of Risk/Benefit Analysis

Deciding what to do about technological risks—‘managing’ them—involves more than simply estimating probabilities and consequences. At some point there must be judgments made about what level of risk is tolerable or acceptable to society, and what constitutes safety (Kraft 1988:189).

Having witnessed the suffering, and even death, of women using approved contraceptive methods like the Pill and the Dalkon Shield, women’s health activists were unwilling to give Depo-Provera, a powerful hormonal drug that remains in women’s bodies for three months after one injection, the benefit of the doubt, and it appears that the FDA wished to err on the side of caution as well. This, of course,

frustrated the Upjohn Company and family planners excited by Depo's potential uses in the U.S. and abroad, who felt that the risks of Depo, particularly its carcinogenicity, were being exaggerated. Already it seems that a contradiction is emerging: is there more than one answer to the safety question?

“The Federal Food, Drug, and Cosmetic Act of 1938 and its 1962 amendments require that drugs be proved safe and effective”; the duty of the Food and Drug Administration (FDA) is to determine whether there is sufficient “proof” to approve a particular drug (Green 1989: 121). Theoretically, a drug is presumed to be unsafe until the petitioning pharmaceutical company can provide sufficient data, often gleaned from animal and human testing, proving the contrary. Thus the Upjohn Company faced an uphill battle in its quest to convince the FDA that Depo-Provera was not only an effective contraceptive, a fact few people contested,¹⁸ but a safe one. As noted in the last chapter, the Kefauver amendments “strengthened the FDA’s regulation of the introduction of drugs into the market by giving the agency greater authority and control over the testing of new drugs,” and drug testing procedures became more regimented and rigorous (Watkins 1998: 144 n73). Unsurprisingly, pharmaceutical companies complained that staunch regulation standards were slowing down the rate of innovation, particularly of contraceptives. As the president of the Upjohn Co., William Hubbard, testified in March 1978, “The regulatory environment has had the very greatest single impact on the decision to invest in research and development” (House: 135)

¹⁸ By “effective” here I mean that Depo consistently prevents pregnancy when used correctly; this is its ideal or theoretical effectiveness. “Use effectiveness of any contraceptive depends on patient motivation and utilization” (Barnes, House March 1978: 216). Women’s health activists argued that highly *ideally* effective contraceptives like Depo or the Pill actually had low *use* effectiveness in practice because women stopped using them due to side effects.

Nevertheless, from a consumer and women's health activist perspective, the FDA's safety standards were seriously lacking, particularly when women's health was primarily at risk. The legacy of approved drugs and devices that turned out to be dangerous, such as the Dalkon Shield and high-dose birth control pills loomed large over the Depo fight and motivated feminist involvement in regulatory affairs. "It also became clear that the FDA approval was no guaranty [sic] of safety or efficacy" (Ruzek 1978: 37). Women's health activists felt that consumers were effectively test subjects when potentially unsafe drugs were approved and marketed. As National Women's Health Network (NWHN) lawyer Sybil Shainwald said at a 1987 hearing, "By its very nature, then as with DES and the Dalkon Shield, this [the use of Depo in the Third World] is human experimentation on a massive scale...we are opposed to the use of a potential carcinogen for birth control. We are opposed to the distribution, sale, or marketing of any unsafe drug for birth control" (House: 10-11). Thus feminists felt they had to enforce the FDA's purported commitment to proven safety. "The principle that a drug may be used indiscriminately on human beings until clinical trials prove it harmful is the opposite of that on which the FDA is supposedly founded: that no drug may be commercially sold until clinical trials have proven it safe" (Petchesky 1984: 177). William Hubbard was no fonder of these "safety watchdogs" than of the "regulatory environment" in general. "There is no area in pharmaceutical research and development in which pressure groups are more vocal or more abusive than in the field of contraception research" (House March 1978: 136).¹⁹

¹⁹ Two articles published in family planning journals—*Whatever Happened to the Contraceptive Revolution?* (1987) and *Still Waiting for the Contraceptive Revolution* (1995)—bemoan the effects of "the consumer rights movement and feminist activism," "cumbersome requirements by regulatory agencies," and the "effects of overregulating the pharmaceutical industry."

In theory, the FDA's determination about the acceptability of Depo would be based on a "purely" scientific evaluation of its medical risks and benefits. As shall become clear, political, social, and moral questions influence its decisions, either subtly or explicitly, but in the realm of regulation "science...stands for the promise that a rational, neutral, and objective assessment of drugs is possible—an assessment that is legally defensible and satisfactory to all parties affected by the regulation of drugs" (Bodewitz et al 1989: 244). Activists became Depo data experts; Stephen Minkin's 1980 article *Depo-Provera: A Critical Analysis* made public for the first time much of the data on Depo's effects on test animals and had a significant enough impact to prompt a certain amount of backlash.²⁰ Gena Corea argues that a comprehensive grasp of the data is a prerequisite for regulatory decisions. "I suspect that all experts on Depo-Provera are not fully conversant with Upjohn's animal studies...it appears that medical experts may be making judgments on Depo-Provera's safety based on mere summaries of the data..." (1980: 113). Similarly, Minkin states that "this report presents documentation showing that doctors, family planning professionals, and patients did not have access to the information necessary for making a scientific assessment of Depo-Provera" (1980: 49). Because the animal cancer data was not publicized, "Upjohn was well placed to manipulate the flow of information regarding the alleged benefits and risks of the drug, thereby increasing sales in the U.S. and abroad" (51-52). Thus on one hand activists like Corea and Minkin argue that, if one has a full grasp of the data, Depo's danger is clearly visible.

²⁰ Benagiano and Fraser published a rebuttal in the journal *Contraception* in 1981. "A widely publicized article has in recent months caused a great deal of concern among individuals interested in responsible promotion of family planning. The article contains a long series of factual errors, distortions and biased quotations" (abstract, accessed through www.pubmed.gov).

Throughout her PBI testimony Corea points out the insufficiencies and biases plaguing the animal studies, but still refers to Depo as an “animal carcinogen” (1991: 174). “[N]o other contraceptive on the market has been linked to cancers in all animals tested as has Depo-Provera,” pointed out Sybill Shainwald of the NWHN (House 1987: 166).

However, as we will see, they also recognized that the same data has different meanings depending on the values of those interpreting it. Of data indicating that Depo caused endometrial cancer in test monkeys, Minkin writes, “while there is little or no room for disagreement about the above-mentioned *facts*, one must recognize that millions of dollars in risk-capital and unrealized profits are tied to these *opinions*,” namely, Upjohn president Hubbard’s conviction that despite said facts, “Depo-Provera...is safe and effective” (1980: 56). They distrusted the male-dominated FDA—and powerful organizations with political access to it—since they had failed to protect women in the past, and thus took it upon themselves to put forth a feminist, scientific risk/benefit analysis of the Depo data.

Unfortunately in the case of Depo-Provera simply identifying the risks was made difficult by the fact that most of the relevant animal trials available in the 1970s and early 1980s had been badly designed, carried out, and documented (Weisz et al 1984). Worse, “large numbers of women in various countries including the U.S.A. were receiving DMPA as a contraceptive while the long term dog and monkey studies were being completed. Yet not until recently...were plans made or acted upon to collect data in any systematic manner from humans” (84-5). Not only does this fact reveal a terrible disregard for all the women using an essentially experimental drug,

but as of 1983, despite the fact that millions of women had used Depo, very few useful conclusions about its effects in women could be drawn.²¹ The PBI defended the FDA's commitment to approving drugs whose risks are known. "The long term risks need to be defined before a decision can be made on the level of safety of a contraceptive intended for use by essentially healthy women, possibly for long periods of time" (166)

Yet even if there had been sufficient or conclusive evidence of Depo's carcinogenicity, no immediate determinations about its fate could have been made. A drug is not necessarily condemned as "unsafe" and therefore unacceptable because it poses risks: "safety does not mean zero risk" (Kraft 1988: 189). As the PBI report states:

[R]esolution [of questions about long-term risk], like the term safety, does not necessarily mean that the drug has been shown to be entirely without major undesirable effects, but that these side effects have been defined and the frequency of their occurrence established within reasonable limits by scientifically acceptable methods (1984: 165).

The concept of risk/benefit analysis dominated the Depo-Provera debates over the decades. As the NWHN newsletter put it, "The basic question is: do the benefits of Depo-Provera outweigh its risks?" (1983: 8). Risk/benefit analysis is central to the FDA's regulatory process. "The FDA makes regulatory decisions that depend heavily upon an assessment of scientific evidence and a determination of what level of risk is acceptable" (Green 1989: 122) Risk analysis is a two-step process: "risk assessment" is the relatively objective process of collecting data about the health effects of a

²¹ Actors on each side of the Depo debate responded differently to this lack of information. In response to one small human study suggesting Depo increased the likelihood of breast cancer, "advocates of the use of DMPA tend to stress the deficiencies of this study and to discount it on scientific grounds. Conversely, those opposed to the use of DMPA point to the weaknesses of the studies in which no association between breast cancer and the drug were identified" (Weisz et al 1984: 92).

particular drug. It is “in part a matter of estimating the probability that certain events will occur...and in part an estimate of how serious the consequences might be if it does occur” (Kraft 1988: 188). “Risk acceptability” is another story. Risks are perceived as more or less acceptable depending on how beneficial the drug will be to the target population, how likely the risks are to materialize, and how serious they are. If benefits outweigh risks, a drug is deemed effectively “safe.” Risk/benefit analysis has a nice computational ring about it, particularly its ideal output: a “risk/benefit ratio,” a mathematical conclusion. This type of analysis also appeals to the image of a scale; risks are placed on one side, benefits on the other, and we watch it tip. This metaphor has the added bonus of placing the determination in the hands of Justice. Our analysis will not simply be correct, but moral. Yet, perhaps in the case of contraceptives more so than for other pharmaceuticals, the weight of risks or benefits, and the definition of what *counts* as a risk or a benefit, cannot be determined by any strictly mechanical means. Further, risks and benefits are not simply “medical”—they can be social as well.

For example, the FDA cited “insufficient patient population” as one of its reasons for non-approval, a demographic consideration. Rep. McCloskey challenged FDA scientists on this point at one hearing: “I mean, aren’t you getting beyond FDA safety questions when you start determining what the potential population is?...That’s a political determination that a Congressman might make. How does a scientist make it? (House August 1978: 69-70). Yet at the same hearing, Rep. Scheuer, chairman of the proceedings, describes the “morass” of FDA Commissioner Kennedy, who, “Is challenged on the one side by a congressional mandate that requires him to look only

at the health implications of drugs in the United States, and on the other he is faced with demands that FDA consider the ramifications of its actions of the developing world” (2). He thus indicates that one must consider the social context in which the drug will be used, and reveals that he *values* and believes the FDA should have an interest in fertility control in the developing world. However moments later he emphasizes “that the FDA decision was not made on the basis of any demonstrated safety problems of the drug for humans,” privileging the (lack of) hard scientific facts (ibid).²²

Risk/Benefit Analysis through the Lens of “Women’s Values”

Although Corea, Minkin, and Rep. Scheuer might all wish that determining Depo’s safety was as simple as checking the numbers, risk/benefit analysis is contingent upon value judgments and considerations of context. Indeed, look back at the PBI’s statement about risk resolution. What are “reasonable limits,” and for whom? Which effects are “undesirable,” and to whom? “Risks may be measured largely by scientific techniques and by scientists, but judgments of the acceptability of those risks are social decisions made by individuals or groups” (Korenbrodt 1980: 47). Neither Depo supporters nor opponents were blind to the “subjective” qualities of risk/benefit analysis, and by extension, regulation in general. Supporters in particular questioned the validity of Depo non-approval, arguing that it was “not made on the basis of any demonstrated safety problems” as Rep. Scheuer said, and was instead attributable to the “consumer and Congressional objections” noted by the FDA and cited by Upjohn president Hubbard (House August 1978: 248).

²² Considering that, as early as 1974, evidence suggested that Depo caused cervical cancer in women, Rep. Scheuer’s statement simply is not true.

Population Control Benefits, Birth Control Risks?

On the flip side, some government officials suspected that the FDA committee that approved Depo in 1973 decided risks outweighed benefits because of its population control interests. At 1974 hearings on FDA advisory committees, after which Representative Fountain intervened in impending Depo approval, officials tried to understand why the drug was approved despite the fact that sixteen cases of cervical cancer—all resulting in hysterectomy—occurred in one human study.²³ “It would appear from the transcript that the cancer-in-situ figures *were not discussed at any time during the committee’s consideration of the safety of Depo-Provera,*” marveled Rep. Fountain (House 1974: 369, emphasis added). One subcommittee staff member, Mr. Goldhammer remarked “it seems to me this committee was composed almost exclusively of population control people” to which Dr. Crout, an FDA director, replied, “OK, this committee is among those we thought needed some breadth...Most of the members of that committee are in the population control business” (436). Dr. Goldberg, a hearing staff member, felt he had gleaned from a transcript of the committee debate that “they were not thinking in medical terms; they were thinking in terms of how to limit population growth” (437).

²³ This hearing, which I discovered late in the research process, deserves a chapter all its own. Fountain’s staff calculated that the rates of cancer in a Depo-using population suggested by the trial figures would be 410 per 100,000, vs. national rates of 36 per 100,000. Dr. Crout, the FDA director being questioned at this hearing, seems utterly flummoxed. “If the data you are suggesting...are correct and we have missed the point, then there is absolutely no question that the benefit risk of this drug changes and—” (374). Staff member Mr. Goldhammer assures him: “this does not mean that the subcommittee or the staff is suggesting that Depo-Provera is a possible cause” (which doesn’t seem entirely sincere). “We are only asking whether or not this should have been discussed by the advisory committee.” “And,” adds Rep. Fountain, “what impact on the decision it might have made” (375). It is impossible to know what caused this high rate of cancer; the WHO data that convinced the FDA Depo was safe in 1992 showed that the drug did not increase cancer rates. Nevertheless, it is nothing short of astonishing that this pattern was not even discussed.

More activist-inclined Depo opponents offered a similar analysis. Rakusen and Petchesky refer to the “politics of birth control,” arguing that the development of Depo and certain groups’ advocacy for its approval are inextricably tied to the material and ideological dominance of population control and its accompanying values (1981, 1984). The spread of Depo despite non-approval, “was facilitated by the enthusiasm of governmental and population control agencies for simple technological solutions to the complex problems of human fertility and population growth in the Third World” (Minkin 1980: 52). Depo opponents argue that most contraceptive regulators implicitly or explicitly evaluate a drug’s *population control* benefits. A number of papers from a workshop on Ethical Issues in Human Reproduction Technology [EIHRT] held at Hampshire College in June, 1979, make this point:

- Currently society approaches the decision of whether to deploy this drug or device with a risk/benefit calculus such as this...overall, the benefit to society from having fewer poor persons is greater than the benefit to society from avoiding morbidity among poor women (Holmes 1980: 4).
- With all its side-effects—minor and major, suspected or known—it is difficult to imagine how such a drug could even be considered as a contraceptive for free citizens. But if we look on Depo-Provera, *not as an aid developed to help women control their reproductive lives, but as a particularly efficient weapon in a war against female fertility*, then much confusing information becomes comprehensible (Corea 1980: 107, emphasis added).

Benefit to society and effectiveness are here coded as “population control values” that weigh less on an alternative risk/benefit scale.²⁴ From a population control

²⁴ The obsession with effectiveness is not necessarily a symptom of malevolent projects of social control. The Pill transformed *women’s* expectations of how effective a method should be. “The persisting and unfilled demand for a ‘perfect’ contraceptive, applicable and acceptable to a large segment of our population that is poor, uneducated, intimidated by authority or disdainful of that authority, has led to use of nonapproved techniques where the appeal of effectiveness takes precedence over insured safety implicit in FDA approval” (Dr. Kase, House 1973: 64, see also Petchesky 1984, ch.5, and Watkins 1998). Oddly enough, in 1981 Depo supporter Malcolm Potts and Robert Wheeler

perspective, the value of a contraceptive device rests entirely on pregnancy prevention as an end in itself; fertility is conceptually detached from the women that produce it. Occasional deaths from cancer, or frequent suffering from menstrual irregularity, headaches, or depression, are outweighed by the overall benefit to society of reduced fertility. If contraceptive developers and regulators privilege safety over efficacy, large-scale social benefit over women's health, Depo-Provera indeed appears to be the "ideal contraceptive." While government officials called for the need for "a balance" of opinion, a return to objectivity on committees making risk/benefit decisions, women's health activists called for a shift in perspective.

"Finally, the debate over Depo-Provera is really a contest over values," testified Gena Corea to the PBI. "Or, to be more accurate, the debate is a result of the imposition of the values of those in power and a choice to be insensitive to all other values" (1991: 179). These "other values" are, in women's health activists' conception, women's values, *birth control* values. Feminist regulators approached risk/benefit analysis from the perspective that for a contraceptive device to facilitate true birth control—reproductive self-determination—its risks had to be considered from an individual, embodied perspective. Since they approached regulation with "women's values," their risk/benefit analysis would be in women's best interests. "Whatever decision the Board of Inquiry reaches on Depo-Provera will...have

wrote an article entitled "The Quest for the Magic Bullet" in which they questioned the wisdom of pursuing one-shot, highly-effective contraceptives given the inverse relationship between safety and efficacy: "the greater the effectiveness...the greater the probability of problems among users" (269). They suggested instead a move—just like women's health activists—toward the barrier method-abortion combination. "Perhaps contraceptive research and development should attempt to introduce modern methods of contraception optimized for good continuation, if necessary at the expense of effectiveness" (270). Nevertheless, given women's discomfort with or inability to use barrier methods, and lack of access or moral opposition to abortion, highly effective hormonal methods remain important options.

embedded in it a certain valuation of women and particularly of poor and minority women” (Corea 1991: 179). Activists hoped to offer alternative, more just, valuation.

Championing Safety for “The Individual Woman”

Helen Holmes, in “Reproductive Technologies: The Birth of a Woman-Centered Analysis,” discusses the “emerging women’s values” informing a feminist anti-Depo stance which are set in opposition to the “existing values” behind contraceptive research and regulation (1980: 10-15). The lists read as follows:

- (1) Respect for the Individual
- (2) The Personal is Political
- (3) The Political is Ethical
- (4) Autonomy and Choice
- (5) Wholeness of the Individual
- (6) Wholeness of the Community of Women/Women-Centeredness
- (7) Wholeness of the Human Community
- (8) Wholeness of the Ecosystem
- (9) Connectedness and Nonhierarchy

Two organizing concepts are particularly relevant here: the individual and wholeness.

From Holmes’ point of view, ethical reproductive health programs or technologies must privilege unique, individual women’s needs as well as the integrity of their bodies. A whole woman, including her “psychological, physical, and emotional aspects,” serves as the unit of a woman’s health analysis; it is not enough to look at the effects of a drug on one organ, or acceptable to ignore less concrete emotional effects (13). Birth control is not meant simply to prevent pregnancy; the idea is that reproductive self-determination is beneficial to women’s health overall.

“Contraceptive drugs and devices are used primarily by young healthy people to prevent an unwanted pregnancy...We are not treating a disease” (Barnes 1980: 118).

A primary concern for *safety* stems from this value. For example, the first priority in selecting a contraceptive is total well-being. Non-invasive

techniques that leave the body intact are preferable. Depo-Provera with its numerous, diverse, and often irreversible side effects—psychological, emotional, as well as system-wide physical effects—clearly is unacceptable under this ethic (ibid).

For women’s health activists, Depo-Provera—“the dangerous contraceptive,” as Holmes calls it—is clearly unacceptable as a feminist birth control device. The feminist approach to regulation asks that we shift our understanding of risk such that “in no way would we as women analysts condone the chance of death or disability in the service of contraception” (4). “Basically I don’t think that safety is of much current concern among researchers and policy makers. In fact, I think it’s of much less concern than efficacy” (Norsigian 1980: 86). “Any significant increase in a fatal disease would be unacceptable for contraception,” because “a primary concern for safety” trumps population controllers’ preoccupation with efficacy (Johnson, House August 1978: 186).

Depo opponents take short-term side effects and long-term cancer risks more seriously than Depo proponents not only because they do not privilege fertility reduction and “benefits to society” in the same way, but because they consider the embodiment of those risks differently. They advocated for regulation informed not only by a commitment to safety, but to privileging the individual woman’s health over “social” benefits. For example, whereas Depo supporters minimize “minor side effects”—or question their existence altogether²⁵—activists take the woman’s perspective, from which weight gain, hair loss, and depression *are* significant.

²⁵ Dr. Mokhtar Topozada, speaking of women’s complaints of headaches accompanying Depo-induced amenorrhea, said, “Even a woman who is not on Depo-Provera, if she gets amenorrhea, she gets headaches, distention, and she comes complaining of all sorts of problems. Is this really a side effect related to amenorrhea or only a psychosomatic symptom?” (House August 1978: 84).

“Depression is a minor side-effect that merely destroys the entire quality of a woman’s life” (Corea 1980: 109).²⁶

In essence, Depo opponents argued that Depo would only be approved by those ignoring its consequences for an individual. “The demonstrated ability of Depo-Provera to control birth, in the face of a worldwide population crisis, has led FDA to the brink of approval in spite of the unfavorable benefit-to-risk ratio to the individual woman. FDA’s approach is morally repulsive... The “FDA must stop human exposure to Depo-Provera, a dangerous contraceptive. (Johnson, House March 1978: 398). As a sociologist writing on the Depo debate explains, “Respect for the individual is the feminist unit of analysis which significantly alters the risk/benefit assessment from that of the proponents because adverse side-effects and carcinogenesis takes on a much more serious meaning” (Hayman 1985: 58). “*Our* ethical question would begin with individual respect: Which approaches are best for the women concerned?” (Holmes 1980: 4). “This is what remains invisible in discussions of Depo-Provera: the unique, discrete, individual woman into whom the drug is injected,” said Gena Corea at the PBI (1991: 178).

Playing Russian Roulette with Women’s Lives

Activists believed they were making an intervention into the regulatory status quo which abstracts risks and turns a blind eye to real, embodied women’s suffering.

The hazard of a contraceptive (or any other drug) is a matter of probability in which every individual user may have an exceedingly small hypothetical risk

²⁶ Depo debaters rarely discuss the influence of the “minor” side-effects on risk/benefit analysis; supporters consider them insignificant, and opponents recognize that FDA approval hinged on “the more worrisome question of Depo-Provera-induced cancer” (Corea 1980: 109). However, as I will discuss in more detail in the conclusion, the unpopularity of Depo in the US, and thus its limited usefulness from a social policy or individual perspective, is, to a great degree, attributable to women’s unwillingness to tolerate weight gain and menstrual disturbance!

of death, but *that risk is immediately translated into 100 per cent certainty for the one who dies*. If a drug carries lethal risk, then use of that drug is a form of Russian roulette...Put another way, *the convenience and benefits of many may be counterbalanced by the suffering and death of a few* (Potts and Paxman 1984: 13, emphasis added).

This perspective on weighing risks and benefits offered by Depo supporter Malcolm Potts and a family planning researcher is precisely what women's health activists were attempting to overcome. In the abstract, risk is "a matter of probability," a projection of the likelihood of a particular effect occurring.²⁷ If risk probability is dispersed throughout a population, referring to everyone and no one at the same time, "the convenience and benefits of many may be counterbalanced by the suffering and death of a few." When regulators consider risk only as "the potential effects occurring in an abstract population," they cannot see risk embodied. Risk becomes abstract, a judgment made in favor of the majority, the society at large. The individual suffering "100%" from a risk fades away.

Women's health activists, speaking *as* women from the perspective of women's lives, argued that this approach to risk/benefit, informed by population control values, was ethically unjustifiable and led to the release of dangerous drugs on the market. Belita Cowan of the NWHN put it this way:

We have come to learn, in a very painful way, that men think of us as statistics, that their risk/benefit ratios often ignore our health needs and our concern for safety as well as efficacy. To the male scientists working on contraceptive development, I say, try explaining your 'ethics' to a 23-year old

²⁷ Potts and Paxman produce their own abstract representation of the relative risk of Depo-Provera in a strange chart depicting how long an individual would live if "he or she were immortal except for the specified risk of death" from certain practices (14, Table 3). "If the cardiovascular risks of oral contraceptives are considered, then a non-smoking user would live 63,000 years. If the protective action against certain cancers is considered, she might be immortal—as, on the available evidence, would a Depo-Provera user(!)" (ibid, exclamation point original). The authors contrast this with the fact that a woman "giving birth every year" would live a mere 6,000 years, demonstrating that the risk presented by Depo-Provera is negligible compared to that of the repeated childbirth to which women are submitted without sufficient contraception.

who has been paralyzed by a pill-related stroke—try talking about the so-called ‘population explosion’ to a middle-aged couple whose only child, a 20-year-old college student, is sterile because of an IUD infection” (1980: 45).

Potts and Paxman are comfortable with “the suffering and death of a few” because they do not take the perspective of those few, the embodied view, the view from below; feminist regulators refuse to turn a blind eye to this quandary.

The Absolute Reality of Infinitesimal Risk

We see these differences play out in the encounter between Anita Johnson of the Environmental Defense Fund and the male members of the Select Committee on Population at the 1978 Congressional Hearings on the Depo-Provera Debate. Of the twenty-one witnesses who testified, Johnson spoke last, the only consumer advocate, the only explicit opponent of Depo-Provera, and one of three women (the others were a lawyer for the IPPF and a pleased Depo user, Ms. Alice Nichols). Ms. Johnson opposes the position that the scientific evidence on the correlation between Depo use and cervical cancer in women is useless. She has prepared data comparing the cervical cancer rate in a population of mostly black Depo users (“the Upjohn patients”) to that in a different population of black women (“the Dunn patients”). “I compared the rates of cervical cancer in the Dunn study to the Upjohn patients and found there also a very large increase between the Dunn patients and the Upjohn patients. It was an increase of about 3.5 excess cases of cervical cancer per thousand people in the Upjohn patients” (184). Note that she provides the “absolute number;” between three and four more Depo-Provera users—actual women—got cancer than non-users.

Ms. Johnson allows that, although comparing cancer rates in two unrelated groups cannot provide proof, “my purpose in bringing out these figures is to say we have highly suggestive evidence that humans have the same effects from Depo-Provera as animals do” (185). The simple fact that Depo seems to be a human carcinogen is cause for concern. Committee chairman Scheuer cuts her off and presses her to “give us some idea of what these rates were” (ibid). Ms. Johnson refers him to a table in her report, then goes on to rephrase her findings as follows: “Black Depo-Provera women are 2.6 times more likely to have cervical cancer than black women in the Dunn study” (ibid). Rep. Scheuer still wants a different expression of the rate. “I am trying to get the order of magnitude of the risk. You have given us percentages, but if it is .00001 as against .00005 you are talking about an infinitesimal increase on an infinitesimal risk.” After some confusion, they arrive at this exchange:

Johnson: The absolute number of extra cervical cancer patients in Upjohn patients was 3.5.

Scheuer: Out of how many users?

Johnson: Out of 1,000. There were 3.5 extra cervical cancer cases in Upjohn users.

Scheuer: So that would be three and a half tenths of 1 percent increase. Would that be a lifetime increase of 0.35—thirty-five one-hundredths of 1 percent—as a result of using Depo-Provera? (ibid)

Rep. Scheuer pushes Ms. Johnson into ever more abstract language; where once we had an understanding that three or four more women out of 1,000 using Depo got cervical cancer than those not using Depo, these instances of cancer have been abstracted into a “three and a half tenths of 1 percent increase.” Rep. Scheuer’s painstaking articulation of this “infinitesimal increase” is of course meant to ridicule and diminish the significance of these findings and imply that Ms. Johnson is being unreasonable to suggest that such an increase would influence the FDA not to

approve the drug. This depiction of risk assessment as a mathematical process in which small numbers hardly factor at all fails to acknowledge the real women to whom those numbers refer. Yet Rep. Scheuer next makes an interesting and clever rhetorical move.

Scheuer: I would think that Ms. Nichols might very well say that she would gladly accept a risk of one-third of 1 percent increase in her prospects of getting cervical cancer.

Johnson: My point in describing—

Scheuer: Ms. Johnson, let me put it this other way: What do you feel is an acceptable rate? (186).

First Rep. Scheuer removes Ms. Johnson's findings from the embodied realm in order to abstract and diminish them, then he invokes Ms. Nichols, the pleased, convivial Depo user whose testimony directly preceded Ms. Johnson's ("I have a lot of friends who are on it and I have had no side effects whatsoever—nothing. I just cannot say enough for Depo-Provera" (177)), in order to prove his point that a reasonable person, nay, a reasonable *woman*, would also scoff at "a risk of one-third of 1 percent increase."²⁸ Rep. Scheuer talks about the risk of cancer in terms of an abstract likelihood of occurrence in an indeterminate population; he makes no acknowledgment of the suffering borne by women in whom risk becomes reality, the "cases of cancer." Yet he *does* recognize individual women insofar as they make

²⁸ If nothing else, a feminist critique must note that he is literally speaking for Ms. Nichols, and therefore Women, although in an enlightening exchange later she is called back in and questioned by Dr. Goldhammer, Rep. Fountain's representative at the hearing, as to what exact percentage of risk she would find acceptable.

Goldhammer: If it were 100 percent—your chances of getting cancer were 100 percent, would you have subscribed to the use of this drug?

Nichols: If they were 100 percent?...I would take that chance.

Goldhammer: You would take that chance?

Nichols: Yes, I would. I take a chance getting into my automobile each day. I do smoke cigarettes (House August 1978: 202). However, when asked if she would recommend it to her daughter under these circumstances, Ms. Nichols decided, "No. I do not want my daughter getting cancer." **Mr.**

Goldhammer: You would not. How about 50 percent chance of getting cancer? **Ms. Nichols:** That is difficult to say (ibid).

choices. Individual women choose to accept risk; an abstracted 0.35% of those women suffer the consequences.

The Individual's Right to Choose Risk

Rep. Scheuer pushes Ms. Johnson to answer questions about women's "right to choose" and consumer freedom. He ceases to engage with her points about Depo's effects since he can simply argue that Ms. Nichols has the right to choose. He concludes that "we disagree on a basic fundamental philosophical point and that is at what point the Government should deny choices to individuals" (196). Depo supporters invoke informed consent as a justification for providing a risky drug. Dr. Donna Cooper, representing a family planning clinic, commented that "if the public can make their informed consent to drink Tab and to smoke Camels, then they should be able to use their informed consent to take birth control pills or Depo-Provera. I think we need a little perspective here" (House March 1978: 50). These officials' unit of analysis is a disembodied choice-maker whose freedom and well-being is based primarily on her ability to indulge "in what Sir Douglas Baird many years ago called the Fifth Freedom: the freedom of individuals to determine their own fertility" (Potts & Paxman 1984: 17).²⁹ This individual is neither in need of protection nor situated in such a way that all available "choices" are harmful.

Their argument against non-approval of Depo is more or less an argument against regulation in general: "I would like to see a world where we put some of the choice back nearer the consumer and further away from the drug regulatory authority" (Potts, House August 1978: 18). Whereas feminists argue that risks must

²⁹ The limits of women's ability to make "free, "informed" choices will be discussed in Chapter Three.

be considered *for* the individual, Depo supporters believe it is up to the individual to weigh the risks! This libertarian conclusion is one logical endpoint of the choice-based reproductive rights politics questioned by women's health activists. "There is a very strong movement that wishes to abolish all regulation and, under the clock of liberalism and individual liberty, is saying, "We will leave everything to the freedom of the individual and freedom of choice..."It's a very 'far left' approach to a very rightist position" (Lashof, Depo-Provera Discussion 1980: 132). Depo opponents recognize that "choice" is not reducible to the availability of many methods of dubious safety. "Are there no limits to the cafeteria?...We need to think about setting limits to the notion of absolute reproductive choice and a completely free cafeteria situation" (Berkman, Depo-Provera Discussion 1980: 131). Ms. Nichols' willingness to accept the risks of Depo does not make the drug safe, or the choice acceptable. At the EIRHT workshop, NWHN founder Judy Norsigian commented, "I was really struck when Laura Punnett said something like 'women wouldn't do things to themselves that are unsafe.' I'm not sure this is always true" (1980: 85). Even Potts recognizes that the FDA must "screen out patently dangerous drugs;" he simply does not think Depo qualifies as such, an opinion women's health activists would attribute to his inability to consider "women's values" (House August 1978: 18).

Who and Where is the Individual Woman?

Yet underlying Depo supporters' troubling, nearly libertarian claims that risk/benefit analysis must be left to the individual is an important recognition about "the individual" utterly obscured by women's health activists. Activists recognize that risk/benefit analysis depends on the perspective of the analyst and the analyst's "unit

of analysis” (individual or society). However they are unable to adequately address the fact that risks and benefits for the individual depend on *context*. Feminists’ intervention into regulatory debates was intended to reorient contraceptive risk/benefit analysis around birth control rather than population control; abstraction from the actual women whose reproductive and total health will be affected by hormonal contraceptives is not tolerated.

Yet there is not one “individual woman,” but millions of individual women differently situated from one another and, importantly, from the activists who aim to protect them. Bruce Schearer of the Population Council testified:

It seems to me that when authorities or health officials, remote from *the conditions of the individual*, attempt to impose their sense of what safety is on an individual, they really are making an effort that is not realistic. The individual himself or herself must assess *in the totality of the experience that that person faces about pregnancy and about the alternatives to pregnancy*, what the safety issues are (House August 1978 169).

Schearer adds another dimension to the seemingly intractable conflict between the desire to protect a vulnerable individual woman and the laissez-faire belief that women can decide for themselves. Those protecting women *must* take into account the context in which “the individual” woman is found, and in which risks and benefits weigh differently. Population controllers *and* women’s health activists abstract from individual women’s particularity in their evaluation of risks and benefits.

Depo supporters frequently argued that the risks of Depo must be weighed against those of pregnancy. In response to the question “could you define subgroups within the USA population where the risk-benefit ratio of contraceptive use differs from the general population,” Malcolm Potts submitted data showing that in 1976, the maternal mortality rate per 100,000 live births for white women was 9; for black

women, 26.5 (House August 1978: 25). Even when the FDA chose not to approve Depo in 1978, it noted that “risk/benefit considerations may be different in other nations where alternative methods of contraception may be less available or less acceptable” and where maternal morbidity is higher (cited in *Family Planning Perspectives* 1978: 163).³⁰ On this matter, the PBI remarked, “Consideration of the specific circumstances of each country and population of subjects can, we think, effect not only the benefit but also the risk side of the equation on which the decision whether or not to use the drug must depend” (164-5).

Women’s health activists were not oblivious the importance of context, “We must weigh when we are willing to allow risks...In that process of looking at the benefits and the risks, one must look at the social, cultural, and economic situation of the area. (Lashof, Depo-Provera Discussion 1980: 135) Yet they rejected the notion that Depo’s risks might be acceptable to “certain subgroups” on the grounds that dangerous contraceptives are not the solution to these women’s vulnerabilities. The feminist response to the “risk of pregnancy” argument is that “the question is not whether Depo-Provera is preferable to child-birth but whether it is preferable to other contraception” (Johnson, House August 1978: 202). Activists make the same point about the pill: “the choice is not to take the Pill or get pregnant” (Seaman, House March 1978: 133). They tend to support non-hormonal, barrier methods. Rosalind Petchesky wrote that “we *have* a 100 percent effective and reasonably safe form of birth control: the diaphragm or condom (and now a new vaginal sponge) backed up by early legal abortion (1984: 189). Anita Johnson cites a study showing that “the

³⁰ Stephen Minkin suggests that this proviso “may have been in response to pressure by Congress and international population control agencies” (1980: 50).

mortality of the oral contraceptive is enormous compared to the safest method, which is a diaphragm used with abortion” (House August 1978: 196). Rather than inventing and distributing effective methods rife with side effects, a just society will improve the conditions of women’s lives such that barrier methods and abortion become accessible to them, and such that pregnancy does not pose such high risks to particularly oppressed populations. Depo is not simply a “band-aid,” a quick technological fix for complex social problems, but represents yet another wound. “The use of high rates of maternal mortality to justify higher contraceptive risk in effect *penalizes the poor for their poverty*” (Hartmann 1995: 185). The PBI also rejected the “risk of pregnancy” factor. They argued that “the risks of unwanted pregnancy and the benefits of DMPA as a contraceptive can not obscure the fact that the factual information available on DMPA fails to provide adequate, scientifically valid information on the major outstanding question of the drug’s long term side effects” (Weisz et al 1984: 166).

I am essentially in agreement with women’s health activists and the PBI that it would have been unfounded and unethical to approve Depo-Provera as safe for contraceptive use based on the available evidence at the time. Further, I have no difficulty understanding activists’ opposition to the notion that risks of cancer are somehow less significant for certain groups of women, especially when there is ample evidence that those making this argument were less interested in respecting women’s needs than controlling certain groups’ fertility. When the FDA’s advisory committee recommended approval in 1973, it was because Depo’s “risks outweighed its benefits” for women unwilling or unable to use other methods, “and those who were

mentally retarded and institutionalized” (Green 1989: 123). Similarly, Dr. Griff T. Ross of the PBI board dissented from his co-authors, who did not recommend Depo for any population:

While I concur with [Weisz and Stolley] that the data submitted are inadequate to show that Depo Provera is safe, these also fail to show that the drug is unsafe...I would recommend that the Commissioner consider approval...for limited use in two populations...1. Oligophrenic (mentally retarded) women and 2. Women using drugs abusively (Weisz et al 1984: 181).

Given that as early as 1973 Depo was administered to mentally retarded women for “hygienic reasons,” at what point is this “conditional” risk benefit analysis a response to women’s needs, and at what point does it reflect a callous disregard for certain women’s health and rights? Does Depo fill a contraceptive gap for certain groups or further abuse them? I cannot answer this question; as I tried to show in Chapter One, the apparent clash of interests between women’s desire for birth control and the social control of fertility is often in reality an uneasy compromise.

Depo opponents believe approval for certain subgroups reflects a hierarchical valuation of women; Depo is too dangerous for white, American women, but fine for black women or poor women abroad. “We are opposed to the use of the drug as a contraceptive for any group,” declared Sybill Shainwald of the NWHN, “because we are opposed to having different standards of safety for poor women and ‘irresponsible women’ and Native women” (House 1987: 170). At the August 1978 hearing Dr. Zanartu from Chile made the astonishing claim that, “particularly in population control, certain people deserve certain drugs or certain methods and others not” (114). One of Holmes’ values I did not discuss, “wholeness of the community of women,” undergirds activists’ commitment to valuing all women’s health and rights. Yet

valuing women as a group demands that one respect the diversity of women's needs. I am inclined to agree with IPPF official Fred Sai when he said, "I happen to believe that differences in health needs do not mean inferiority," although I would rephrase, "do not *always* or *only* mean inferiority" (House August 1978: 46).

What disturbs me is that Depo opponents framed their position in terms of protecting a universalized "individual woman" and on the basis of "women's values" and their assumption that the combination of barrier methods and abortion is the ideal contraceptive method for all "individual women." Women's health activists, mostly white, middle-class women with the particular education, politics, and morals that facilitate barrier-method use, characterized Depo as unacceptable and dangerous within a value system that sees barrier-method use as protection of "wholeness of the individual" and safety, and Depo as a necessary violation of these values. In their view, Depo is a dangerous and unacceptable substitution for the broad social change that would facilitate women's control over their fertility without compromising their health:

The best results in birth control do not depend on family planning programs alone, and certainly not on the availability of one contraceptive, but on a whole range of measures... *Given that range of social and economic measures, women will seek on their own to control fertility, and, thus motivated, will choose methods that are best suited to their medical and other needs.* Under these circumstances, the simplicity and convenience of Depo-Provera will probably not weigh so heavily in the risk/benefit equation" (Levine 1980: 105, emphasis added)

Levine fails to acknowledge the fact that women *already* choose methods "best suited to their medical and other needs;" for many women, "simplicity and convenience," not to mention effectiveness, weigh heavily in the "risk/benefit equation." Even if this tradeoff is the consequence of unjust conditions, the individual woman's risk/benefit

balance deserves consideration and respect. The initiatives so well articulated by Levine above have not been completed, were certainly not completed in the 1970s and 1980s, and women still needed effective contraception. Is asking women to wait for the “range of social and economic measures” more just, more *safe*, than allowing for the use of higher-risk, but more effective, more convenient methods? Given Depo’s effectiveness and many women’s unwillingness, inability, or simple distaste for barrier methods, Depo best ensures their “wholeness” and safety by protecting them from pregnancy!³¹ Activists cannot dismiss the medical risks and material consequences of unwanted pregnancy, and cannot limit the “contraceptive cafeteria” of acceptable birth control to only those methods accessible to privileged women. Feminist regulators cannot substitute valuation of “the individual woman”—her humanity and her body—for recognition of women’s diversity of needs—her particularity.

“We’re faced with a condition and not a theory,” said Rep. Scheuer, citing Grover Cleveland. “We’re trying to measure risks and benefits in the very real life of the rural Third World” (House August 1978: 108). In their defense of “the individual woman” activists slip into a theory of Woman rather than addressing the condition of women. Gena Corea accused Depo supporters of just this erasure of difference during her PBI testimony. “The advocates place women in a category, ‘low socio-economic status and low educational attainment,’ and treat them all alike, ignoring their

³¹ I feel I must acknowledge *my* values; clearly I do not think Depo is as dangerous as women’s health activists did in the 1970s and 1980s. I have the benefit of hindsight, of having met women who use it, and of the data showing that Depo does not cause cancer. Nevertheless, my point is less about whether or not activists were “wrong” in their conclusion that Depo is not safe, but rather their rationale, and the importance that a “feminist regulation” recognize women’s particular needs, not only their individual value and humanity, which, of course, is no small thing.

individual needs and aspirations...In making these generalizations, they are regarding women not as individuals but as a...class” (1991: 70). Ironically, by appealing to “the individual woman” activists constitute women as a class whose needs are all alike. Whether Rep. Scheuer *or* women’s health activists have an adequate grasp of the “very real life,” or needs, of the Third World or disadvantaged U.S. communities is up for debate.

Responding to the discussion of “women’s values” and Depo’s dangers at the EIRHT workshop, where most participants opposed Depo and advocated for barrier methods, sociologist Kristin Luker stated:

I spent the early ‘70s telling people in the US government maybe effectiveness wasn’t everything. I may spend the ‘80s telling people that maybe safety isn’t everything. There is a strong trend—particularly in the Women’s Movement—that safety is the single most important thing; but perhaps our lives are really more diverse than that...I believe it’s perfectly rational—and a responsible choice I can respect—for people to tolerate the higher risk of the pill because they really don’t want to have an abortion. Yet I feel that that’s been invalidated as a legitimate choice at times (1980: 81).

Here Luker challenges both the emphasis on safety and the assumption that abortion is an acceptable alternative to hormonal methods or backup for barrier methods. She contests the belief that the barrier method/abortion combination represents safe and effective birth control because she recognizes and respects the fact that many women “really don’t want to have an abortion”: this method is not practically *accessible or acceptable*. “We have seen that, even when women have been aware of risks to their health and life, they have been willing to take those risks in order to assure their control over pregnancy; *control*, for most women, has historically taken priority over safety” (Petchesky 1984: 171). This is not to say that contraceptive development should therefore disregard safety, but it is important to acknowledge and respect

women's need and desire for contraception and not to demand that every "individual woman" share the same values as those situated to choose safety.

Committee on Population research associate Dr. Goliber asked Ms. Nichols, the pleased Depo user: "Is there any reason these women could not use a diaphragm or foam or gels or did they simply choose Depo-Provera as a matter of convenience...?" She responded, "Well the girls and ladies I do know that are on this—Depo-Provera—have tried the diaphragm and the IUD and the birth control pills. For one reason or another, the Depo-Provera is better for them" (House August 1978: 204). Can feminist regulation take into account this perspective without simply arguing that under the best, most free conditions, a woman would use a diaphragm? That one need never even consider the risks and benefits of Depo either because women do not need it or because that need would be best addressed through social change?

As the authors of another paper from the conference conclude, "It is not useful to cut off the dialog by simply demanding an end to research on methods that may have side effects and promoting a wholesale return to barrier and local methods that may be inappropriate for many individuals and cultures" (Atkinson & Ans 1980: 58). They critique a fellow workshop member, who "divides those interested in contraceptive development into two camps, one interested in high technology methods and population control, and the other in the use of 'safer' methods and control of their bodies. This dichotomy may be artificial" (ibid). Cutting off dialog is precisely what Norma Swenson does in 1987, when she states:

Until we have the studies we cannot say so positively that Depo is not a killer, too, as the Pill is known to be. And I do not want to call for the studies

needed, knowing that some women would surely die in the process. There are, after all, alternative methods of contraception available” (House 1987: 129-130).

The Pill does have rare, lethal side effects; at the time, it appeared that Depo did as well. Yet this does not justify putting an end to hormonal contraceptive testing. The fact that “alternative methods of contraception” are available means little to women without access or desire for such methods. Just as Depo supporters evade the question of risk acceptability by appealing to women’s “right to choose,” opponents avoid it by asserting that any risk is unacceptable since “risk-free” methods are available. As Rep. McCloskey says to Ms. Johnson, “every one of these situations is a balancing of risk. But as I understand it, in your case, if there is any risk, you would ban it” (House August 1978: 196).

Conclusion

To put it simply, women’s health activists opposed FDA approval of Depo-Provera because, given the risk of cancer suggested by animal and human studies, and the availability of safer contraceptive methods, the drug’s risks outweighed its benefits. I have tried to demonstrate in this chapter that their risk/benefit analysis, like that of Depo supporters, is not reducible to an objective analysis of the scientific data, but is contingent upon a certain set of “women’s values”—perhaps more accurately described as “women’s health values” from which an acceptable contraceptive would never pose serious health risks. Although I concur with their conclusions to a point, I suggest that a feminist regulation capable of considering and respecting the needs of a diversity of women is not ensured, and in fact may be precluded by, an oversimplified conception of “the individual woman” and the need to protect her from “the

dangerous contraceptive.” The double meaning of woman, singular, which can refer to particular individuals or to an abstract concept of Woman allows feminist regulators to construct an abstract Individual Woman who is more likely than not to be a victim, unlike the regulators themselves who are by definition in a position of power, yet shares the regulators’ risk/benefit analysis.

Yet I must note that many Depo opponents were willing to accept the drug once truly adequate information about its short and long-term risks was available, *and* if said information was provided to patients as a matter of “informed consent.”

Barbara Seaman emphasizes this point:

Women should not be given drugs that can maim or kill us just for birth control; certainly not without our complete informed consent...My own opinion, and that of most of my colleagues³² in the women’s health and consumer organizations, is not that these products should be banned. Rather, we have always pressed for informed consent...and education on the safer alternatives (House March 1978: 129, 133).

The obstacles to informed consent in the case of Depo-Provera are twofold, as suggested by the phrase itself. On the one hand, informed consent requires *information*. As the PBI pointed out, information about long term effects, “is needed to enable health care professionals and the subjects they treat to arrive at an informed decision concerning the risks vs benefits associated with the use of a drug and to make an informed choice among drugs” (165). The second requirement is *consent*. An unspoken factor in activists’ risk/benefit analysis is their perception that this “dangerous drug” would be imposed on uninformed women. This risk, broadly referred to as “potential for abuse,” has less to do with Depo’s medical properties

³² My research leads me to believe that Depo opponents were quite convinced of its unacceptable medical danger and did not expect more information to exculpate it. However, it is possible that, for rhetorical reasons, they exaggerated their stance on the drug in testimony and newsletters.

than with the conditions under which it was administered and the populations at whom it was “aimed.” It is to this concern, and the questions it raises about the conditions of reproductive freedom and the meaning of choice, that I now turn.

***Chapter Three: The Inevitability of Depo-Provera Abuse and Women who Cannot
Use Birth Control***

I and the Boston Women's Health Collective remain opposed to the approval of Depo-Provera as a contraceptive for U.S. women because of the many unanswered scientific questions, questions which led our own F.D.A. scientists to reject the drug for U.S. women because of unproven safety in 1983...On their evidence alone we oppose approval. But our opposition is also based on our belief, shared by many others, that there is virtually no way that ethical informed consent can be obtained for this drug, and that it lends itself to several different types of abuse more readily than almost any other contraceptive we know of (Norma Swenson, House 1987: 127).

From all the discussion about the risk of cervical cancer and the need for better scientific data, it might seem as though the feminist opposition to Depo-Provera hinged on whether or not it could be proven “safe.” Yet underlying feminists’ arguments about the physiological effects of Depo-Provera were their concerns about its effects on women’s reproductive freedom and the way it could be used to carry out discriminatory population control policies. This “risk” is indeed central to women’s health activists’ analysis of the dangers of reproductive technology. Potential for abuse was implicitly and explicitly considered a major risk by women’s health activists, and their opposition to “the dangerous contraceptive” must be understood in that light. Although the FDA decision—ban or approve—ultimately hinged on the scientific evidence of Depo’s medical risks, other debates on the experimental or unapproved use of the drug focused on broader ethical and political questions. Thus even as debates about Depo’s safety raged for decades, women’s health activists were involved with a separate struggle to expose the unethical testing and prescription of Depo in U.S. and Third World women, and the need to regulate medical and state practice. In 1973 Senator Edward Kennedy held hearings on the ethics of medical experimentation, and devoted the first day to the example of Depo-Provera. Fourteen

years later, Senator Sam Gjedenson held another questioning the use of Depo by the Indian Health Service (IHS). As witnesses before these committees, and in academic and activist writing, feminists made the case for Depo's "potential for abuse" as a technology—a weapon—rather than merely as an unsafe drug, like aspirin. Feminists were just as opposed to the form of Depo-Provera, a provider-administered injection, as to its hormonal content.

I begin this chapter by describing the efforts of women's health activists and politicians to establish higher standards for contraceptive use, namely that providers should always obtain informed consent from their patients. When women are not informed about the risks, especially of an experimental drug like Depo, and when they are pressured or threatened into using the drug, an abuse occurs. Although some policies existed to inform and protect women seeking contraception, they were often violated and the distribution of Depo in the 1970s and 1980s was indeed characterized by "abuse" under these terms. Yet rather than arguing for more stringent regulation of state and medical practice, activists make a case for the inevitable abusiveness of Depo, which I argue relies on their conception of certain groups of women as literally unable to choose, and their belief that when uninformed, disempowered women meet Depo providers, the interests of the latter always prevail, only abuse—population control—occurs, never *birth control*. Further, they argue that Depo, like other reproductive technologies, inevitably "takes" control from women. Although "abuse potential" and the social conditions of choice are important considerations for feminist regulation, I believe it is problematic to set the standards for birth control use such that the contraceptive market is limited to only those

methods accessible to privileged women. When feminists write Depo out of the birth control (as opposed to population control) paradigm entirely they fail to address the unfortunate reality that for many if not most women, the process of making choices and taking control is influenced and constrained by the interests of those with more power. While ultimately this means that reproductive freedom depends more on the establishment of a truly egalitarian society than on the discovery of the perfect contraceptive technology, in the meantime feminist regulators can try to protect women from abuses while allowing that a contraceptive used to abuse might also create new possibilities for women in difficult circumstances.

Setting the Standards for Contraceptive Use

What is Abuse?

In order to locate the origin and logic of feminists' fear of Depo's "potential for abuse" one need look no further than the fight against what became known as "sterilization abuse;" indeed, the report from the Hampshire workshop on reproductive technology contains a section entitled, "Depo-Provera and Sterilization Abuse." Abuse does not necessarily or even usually mean a woman is physically forced to undergo sterilization or accept the shot; rather, women undergo these "treatments" without having given consent or under coercion. This conception of abuse is echoed by a more recent writer: "By 'abuse' I thus mean the *uninformed, misinformed, or coercive provision of birth control technology*" (Richter 1994: 220). In a brief on "Forced Sterilization in North Carolina, the American Civil Liberties Union (ACLU) wrote: "Nial Ruth's mother... under threat of removal from the welfare rolls of her entire family, 'consented' to what she was told was a temporary

tying of her daughter's tubes... 'Consent' in this case was to a temporary procedure—under coercion—which was not explained to, nor understood by, either Nial Ruth Cox or her mother” (Senate 1973: 1585). Through a combination of exerting pressure, with the threat of material destitution, and willful concealment of the true nature of the procedure, a “forced” or coerced sterilization occurred, allowing the state to pursue its interest in limiting the fertility of what the doctor described as “an 18 year old mentally deficient Negro girl.”

Women's health activists envisioned Depo-Provera falling into the hands of authorities with these interests in mind. Such abuse is a direct consequence of population control or eugenic ideology which justifies the social control of (certain) women's fertility. These ideologies—and the ability of some in society to carry them out—limit the degree to which women can make free, informed choices about contraception. Perhaps the key difference between birth control and population control is that, in the former case, women demand contraception as a matter of self-determination, while in the latter it is imposed from above. The fact that contraception is “happening”—that women are getting sterilized or taking Depo-Provera—does not necessarily indicate that this reflects a substantive improvement in women's reproductive freedom. Given the history of women suffering side effects of the Pill or DES about which they were never warned, and of women being sterilized without their consent or even knowledge, women's health and consumer activists, and politicians, demanded higher standards for the ethical provision of drugs.

Informed Consent in Theory and Policy

Faden and Beauchamp argue that “informed consent...is given if a patient or subject with (1) substantial understanding and (2) in substantial absence of control by others (3) intentionally (4) authorized a professional” to administer a treatment” (1989: 395). This definition points to the need for information as well as freedom from pressure, the two conditions feminists argue are lacking in cases of Depo (ab)use. By the 1970s, thanks in part to the efforts of consumer activists, the notion that healthcare consumers have the right to know the risks and benefits of the treatments offered to them was taking hold and influencing regulatory policy. Women’s right to information about the possible risks and expected side effects of contraceptives had already been asserted by feminists, and recognized by the government, during Senator Nelson’s Pill hearings. Activists and politicians also argued for the need to ensure informed consent on the part of participants in clinical trials of investigational new drugs (INDs) or medical studies in general. Recall that prior to approval in 1992, Depo was both administered “off-label” at physicians’ discretion, and as part of the clinical trials mandated by the FDA as part of its IND status. The rules governing informed consent policy vary depending on the circumstances.

As early as 1962 the FDA required that “consent be obtained” from participants in trials of INDs “except when not feasible or when, in the judgment of the investigator, it is contrary to the best interests of the patient...in 1967 FDA clarified and strengthened this statutory provision by regulations requiring written consent in the first two phases of human clinical trials” (Dr. Charles C. Edwards,

Senate 1973: 13). By contrast, when the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research gave its summary of conclusions on the duty of physicians to provide informed consent in 1982, their first point was: “Although the informed consent doctrine has substantial foundations in law, it is essentially an ethical imperative” (1988: 124).³³ Thus Depo providers were only *federally* required to ensure informed consent if they were prescribing it as part of a trial; this was the case at the Grady Clinic in Atlanta. Otherwise, it is up to the individual physician to obtain informed consent, although “rules, policies, and standard practices” may be instituted to ensure that physicians do so (Faden & Beauchamp 1989: 394).

Unfortunately Depo’s blurry status—experimental as a contraceptive, yet approved and on the market for certain uses—makes it very difficult to identify under what circumstances informed consent was required.³⁴ It is unclear to me whether doctors prescribing Depo through a government agency, such as the IHS, were required to obtain informed consent. It appears that they did have consent forms, but in Senator Gejdenson’s opening remarks at the 1987 hearing he was indignant: “nor does the IHS have any written requirements for informed consent,” indicating that the agency was not required, *per se*, to have such regulations, but that they were expected as an ethical matter (House: 5). As far as private hospital policies, footage from Kathy

³³ Also in 1982, the American Medical Association affirmed the requirement of informed consent, but this is simply a “principle of medical ethics,” not a law or official regulation (Edwards and Graber 1988:120).

³⁴ Of course, as of the 1983 PBI and until 1992, the FDA maintained that there was not enough information to give patients in the first place; “It is likely to take many additional years of observation before the full picture can emerge” (Weisz et al 1984: 85). One could argue that informed consent was a moot point without the information. Providers giving the drug in trials or to their patients were expected to inform them that the drug was experimental, not approved by the FDA for use as a contraceptive, and caused cancer in lab animals.

Branan's documentary about Depo use indicates that doctors were required to give patient information and begrudgingly did so: "Now there is another thing I need to tell you...we are obligated to tell you that..." (1984). Nevertheless, testifying about Depo in 1987, Sybill Shainwald of the NWHN said, "Currently informed consent forms are required only for patients in studies registered with the FDA" (House: 167).

Interestingly, since Depo was not approved for use as a contraceptive, it was not distributed with FDA-approved patient information for that purpose! The FDA advisory committee's recommended approval for limited populations in 1973 and 1975 was contingent upon an informed consent provision (Green 1989, House 1974). Regardless of non-approval, Depo was effectively distributed to exactly those populations—those unable to use other methods, institutionalized and mentally retarded women—at physicians' discretion. Rep. Fountain read from the advisory committee minutes: "In face of continued, widespread...use of drugs when that use is not part of the approved indications...the [FDA] has an obligation to address the issue and either approve the indication, with appropriate labeling, or tell doctors why it cannot be approved" (House 1974: 339). Ironically, one opposed to Depo might have supported approval insofar as it obliged healthcare providers to obtain informed consent; or, as Rep. Fountain suggested, one could pursue the third choice, "namely, removal of the drug from the market," which, oddly enough, as far as I can tell activists never suggested (340).³⁵

³⁵ As of 1974, Depo-Provera had been proven ineffective for preventing miscarriage or treating endometriosis; it was "approved only as 'palliative' and 'supportive' for inoperable, recurrent, or metastatic endometrial cancer" (Fountain, House 1974: 340). Thus Rep. Fountain suggested that the risks of keeping Depo on the market, given its unapproved distribution, outweighed its benefits for such an incredibly limited use.

Whatever the legal obligations to ensure that women give informed consent for Depo-Provera or any contraceptive, women's health activists and politicians were adamant that it is ethically repugnant to give women an essentially experimental drug without making them aware of its unapproved status and medical risks. "The use of drugs not approved for the purpose by the FDA...is 'investigational' ...or 'experimental' ...Such use requires far more elaborate processes of Informed Consent," testified Norma Swenson of the Boston Women's Health Collective (House 1987: 132). When this is not done, abuse is said to have occurred. Participants at the Hampshire workshop on reproductive technology frequently invoke the need for informed consent. Dr. Helen Barnes wrote, "As health providers we have to make sure the patient understands" (1980: 118). "Autonomy means that we may choose in an informed context" wrote Helen Holmes, linking information and self-determination (1980: 12). And without informed consent, "we know from research that people will agree to do things that are clearly bad for their health because they are presented by people who, they believe, know better" (Kohn, Contraceptives Discussion 1980: 93). In feminists' conception, informed choice is *meaningful* choice and meaningful birth control; taking a contraceptive drug without the slightest idea of the risks is a loss of control, an abuse.

Informed consent, in theory, ensures that women have a chance to weigh risks and benefits for themselves, and may protect them from being pressured or coerced into using a method. The link between informed consent and coercion, to which I have already alluded, is central to the "potential for abuse" dilemma:

Many dangerous and experimental birth control methods have been widely spread throughout the world in a coercive manner for the purposes of

population control...These methods are promoted to women without giving full explanations of the risks, without giving adequate information about and access to the full range of methods to choose from, and without increasing a woman's knowledge of her own body. For example, many poor and third world women are injected with Depo-Provera or sterilized without their understanding or consent" (Women's Community Health Center 1980: 75).

Depo-Provera's spread is characterized as "in a coercive manner" because women are given the drug without informed consent. This slippage between a woman being uninformed about a drug and being *coerced* into using it is not uncommon in activists' discourse. Of course it is easier to convince, and maybe coerce, a patient into using something she trusts is safe ("I felt like anything Grady is gonna give me is for my better," said one woman given Depo through the Grady Clinic trial), but clearly the distinction is important.

On the flip side, in theory informed consent is only *truly* given by someone free of pressure. In 1973 Senator Jacob Javits presented Bill S. 878 establishing informed consent requirements for medical experimentation.

For the purposes of this section only, the term 'informed consent' shall mean the consent of a person, or his legal representative, so situated as to be able to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, or other form of constraint or coercion" (Senate: 7)

Force, coercion, or simply pressure, precludes "free power of choice," and therefore "informed consent." Thus we see that, in feminist theory or government policy, abusive or unethical distribution of a drug occurs whenever the subject does not give informed consent; further, the only subject capable of giving informed consent is one utterly free of pressure. Women's health activists and concerned politicians admirably advocated for improving the conditions for substantive reproductive choice. Yet when the only *non*-abusive use of a contraceptive is utterly free and fully informed,

regulators can justify the removal of any potentially abusive technology from the market, without considering the needs of unfree, uninformed women for birth control. Although Depo was certainly unethically administered, this does not indicate that the drug is always, inevitably abusive, even within an admittedly oppressive and unregulated social context. Because their regulatory priority is preventing abuse above all, and because they cannot conceive of non-abusive uses of Depo, feminist regulators' only recourse is to ban the drug.

Informed Consent in Practice

Depo-Provera did not simply have “potential for abuse,” if abuse is understood as outlined above; abuse was already occurring.³⁶ Feminists had no difficulty finding examples of women being given Depo-Provera without information about the risks, whether they received it as part of a clinical trial or from a doctor pursuing his or her prerogative to prescribe an approved drug. Marcia Greenberger, a lawyer for the Center for Law and Social Policy, testified about the unapproved use of Depo at the Cumberland County Family Planning Clinic at Senator Edward Kennedy's 1973 hearing. “The informed consent of these women was not obtained before the drug was administered. None of the women were told that FDA has not approved Depo-Provera for use as a contraceptive. In addition, all of the dangers and risks involved with the drug's use were not fully discussed” (Senate: 56). In a 1984

³⁶ One gets the sense that Depo supporters were quite sensitive to speculation about the drug's “potential for abuse.” William Hubbard, the president of Upjohn, noted at one hearing that, “It is our view that the patient, with the physician, is in the best position to judge the suitability of the particular contraceptive to be used. This decision should be fully informed and should also be free of coercion” (House August 1978: 27). Thus he allows that coercion is a possibility, but emphasizes the assertive role of the patient in determining what is best *with* the physician, as though they typically interacted as equals. He goes on to assert that “the patient should not have such a judgment [of contraceptive acceptability] imposed or coerced by a government agency,” not-so-subtly implying that an overly harsh verdict on Depo safety from the FDA would “coerce” patients into not selecting the drug! (31).

documentary, “The Ultimate Test Animal,” Karen Branan interviewed black women who had been given Depo through the Grady Clinic without any informed consent procedure or even being made aware that they were participating in a trial. “I wasn’t told about any side effects at all. The only thing I was told was you take them for a certain amount and it is guaranteed to sterilize you.” Branan testified, “Over and over I have heard women say: If they had told me it was not approved the government. If they told me it caused cancer in animals. If they had told me I would bleed so much...” and concluded, “It is a drug with vast potential for abuse” (House 1987: 207). Of the one-thousand women in the NWHN Depo registry, “90%...received no information regarding the drug’s unapproved status” (Shainwald, House 1987: 166).³⁷ According to Norma Swenson, women were not even told that Depo was a contraceptive: “We have heard hundreds and hundreds of reports of what I will call Primary Abuse, that is, misrepresenting the shot as an antibiotic” (House 1987: 136)

Whereas a failure to ensure informed consent might be chalked up to medical negligence, a passive disregard for women’s health, it appears that some women were actively coerced into “using” Depo-Provera. At the 1973 human experimentation hearing, Ms. Anna Burgess, a woman on welfare receiving family planning services from the Cumberland County Clinic mentioned above, gave the following testimony:

Senator Kennedy: Do you feel the social workers were pressuring you to take the drug?

Ms. Burgess: If it had not been for them, I would not have took it...

³⁷ Even if women were given informed consent forms, those forms may not have accurately represented the risks of the drug. In the report from the 1987 hearings on the use of Depo-Provera by the IHS there is a fascinating series of letters between an IHS doctor and Department of Justice officials concerning the content of patient information forms. “I have reviewed the ‘revised’ consent form you provided me and recommend several changes. Generally, the consent minimizes or dismisses the potential dangers of depo-provera usage” (House 1987: 114).

Ms. Burgess: From the impression I got, if I did not take birth control, they would take the check.

Senator Kennedy: If you did not take the Depo-provera they were perhaps going to threaten your assistance program?

Ms. Burgess: In a way, because they said they would rather pay one child as two (Senate: 58-59)

Ms. Greenberger, the lawyer representing Ms. Burgess, says “there were hints of coercion in a second case as well. This woman was visiting repeatedly by nurses...until she agreed to follow their advice and use Depo-Provera” (57). This is the only specific example I have found of women being threatened/pressured into using Depo in the US, although I have little doubt similar practices occurred. Norma Swenson of the Boston Women’s Health Book Collective testified: “we do have documented accounts in our own files of ordinary poor women in various parts of the US being threatened with loss of their welfare benefits if they did not submit to a particular drug” (House 1987: 136). Johanna Schoen identifies a number of conditions for coercion in family planning in the U.S.: (1) state interest (desire to reduce welfare rolls), (2) ideological justification (population control/eugenic ideology), (3) state power (over women dependent on it for material survival), and (4) constriction of women’s choice (2005: 236-237). Depo was certainly distributed under these conditions. However, Schoen reminds us that “even when all of these factors were present, coercion was not a given, only one of several possibilities” a point that, as I will show, seems lost on Depo opponents (238).

The Conditions of Abusive Use

Reading about the use of Depo in the U.S. in the 1970s and 1980s, one is overwhelmed by a sense of chaos, the need for more than confusing informed consent policies to regulate individuals’ and institutions’ behavior. The Grady Clinic, the site

of the largest U.S. clinical test of Depo, simply did not send the FDA required annual reports for eleven years; it took the FDA eleven years to conduct an audit (Weisz et al 1984). The president of Upjohn admitted that the company shipped boxes of Depo to the Arlington Hospital in Tennessee, an institution for mentally retarded women, despite the fact that, “we, so far as I can determine, had no knowledge of the intent for which this drug would be used” (Senate 1973: 105). The fact that Depo was being prescribed so rampantly for an unapproved use points to the relative freedom afforded individual physicians and family planning clinics. The FDA “has no regulatory control whatsoever over the prescribing behavior of physicians,” pointed out FDA commissioner Kennedy, “and most physicians are very glad of that” (House August 1978: 35). Senator Gejdenson raged, “Just because some in private practice have chosen to ignore the FDA does not mean that the IHS, a sister agency within the public health service, should also ignore the FDA. Why then does the IHS prescribe Depo-Provera?” (House 1987: 3)

Even in cases where informed consent procedures were mandated, it appears that they were frequently ignored, and women’s health activists had good reason to doubt physicians’ interest in or ability to fully explain risks to patients. The old cliché is true—“when dealing with physicians... knowledge is power” (Fee 1977: 286). The consumer’s official “right to be informed” as articulated by President Kennedy in 1962 only becomes substantive in practice if an explicit effort is made to truly communicate with people of color, the poor, or women.³⁸ “You find yourself trying to

³⁸ Kennedy says specifically that the consumer, has “the right to be informed...and to be given the facts *he* needs to make an informed choice” (CAC Report 1971: 24, emphasis added). Excusing the liberal assumption of a free male consumer, this right is interesting in that it demands (government)

interpret those data in terms of that lady you see in front of you...Most poor people will understand things if you take the time to explain it to them,” explained Dr. Helen Barnes (1980: 118). “I don’t think most physicians practice medicine the way you do” Judy Norsigian responded to Dr. Barnes, “The incidence of women taking Depo-Provera without any information is very high” (Depo-Provera Discussion 1980: 137).

Depo does not fall into women’s hands, but is literally mediated through the medical and state authorities who are responsible for prescribing, explaining, and administering it. Dr. Donna Cooper, cited in the last chapter saying that if women can choose Camels, they can choose Depo, says later in the same testimony that “as long as Depo-Provera is on the market and *I am convinced* that the benefits outweigh the risks for an individual patient I will continue to prescribe it after obtaining the patient’s informed consent” (March 1978: 22, emphasis added). Women buying a pack of smokes at the gas station are neither advised nor pressured by an authority figure. “I also think that the impact of physicians in deciding ultimately what patients do, you know, needs to be taken into consideration” (Richwald, House 1987: 210). Doctors are the gatekeepers for nearly all contraception, as well as sterilization. This arrangement was a natural consequence of the mainstreaming and medicalization of birth control: “the relinquishing of control over the administration and conditions of fertility control to medical professionals and planners” (Petchesky 1984: 92).

Of course every drug—the Pill, penicillin—has this “potential for abuse” insofar as individual healthcare providers are relatively free to establish their own policy on informed consent. Activists did not characterize the Pill or DES as having “potential

intervention; one does not simply have the right to know, but “to be protected...to be given the facts” (ibid).

for abuse,” although they were widely distributed with little to no acknowledgment of risks for decades. Depo itself is implicated as an “abusive” party in these debates, rather than the social conditions in which misuse occurs, because of the added level of *enforceable* pressure—a different type of abuse. Depo must simply be administered every three months and “compliance” is ensured. “[New reproductive] technologies are accompanied by and enable increasingly effective methods of social surveillance and regulation of reproductive practices” (Ginsburg and Rapp 1991: 315). With the introduction of Depo, women no longer have an “excuse” not to control their fertility, and the state entities on whom many of them depend are in a position to survey and enforce compliance. Activists argued that given the often unregulated conditions under which Depo would be prescribed, and given the state and family planning authorities’ interest in limiting fertility and disregard for women’s health or right to know what she is “choosing,” lack of informed consent, pressure, and even coercion—abuse—would be the norm. Releasing a contraceptive whose use would not occur under the conditions for free, informed choice as understood by women’s health activists would do nothing to advance the cause of *birth control* in a substantive sense.

It is much easier to approve or ban a drug than to regulate people’s use of it, particularly state or medical figures accustomed to a great deal of professional autonomy. Given the chaotic conditions under which Depo was administered, feminists, then, asked how Depo could ethically be released under such circumstances when women would be the victims of this disorganization. Activists argue for the inevitability of abuse. “Depo is on the market for a few other uses...and thus can be

used by physicians at their own discretion...Official government approval inevitably would subject more women to such abuses,” wrote Judy Norsigian of the NWHN (1983: 4). She goes so far as to say, “Offering sterilization and/or hazardous contraceptives to women who don’t understand the risks and consequences involved is unethical, I think. (Depo-Provera Discussion 1980: 137). Women’s *access* to birth control is contingent upon their achieving the level of knowledge of, say, a women’s health activist. Yet the unacceptability of Depo is not simply related to the social context in which informed consent is often not obtained. “The National Women’s Health Network does not believe that further distribution of Depo-Provera for contraception is warranted even with a consent form” because Depo is only meant for women activists believe *cannot* give consent. (Shainwald, House 1987: 167). Depo opponents are unable to conceive of how, within an often oppressive social context, disempowered women’s interactions with Depo-Provera are not always and only abusive, that it is not necessarily less unjust to leave women without any contraception at all, and that Depo does not simply “take” control from women and worsen the conditions of reproductive choice, but may open new possibilities or at least a modicum of flexibility. They write disempowered women, and Depo-Provera, out of the feminist birth control paradigm altogether.

Women who cannot Choose and the Drugs that Choose Them

The unwitting, unknowing, unconsenting recipients of drugs

Note that each of the above stories of abuse involves women disempowered by more than just their sex–racism, poverty, and lack of education are just a few of the conditions that widen the power gap between Depo providers and “acceptors,” as women are sometimes called in family planning literature. At the IHS hearing Dr. Richwald, a physician and public health professor, commented that, “We are not talking about an egalitarian relationship. We are talking about a provider and a patient, and usually there is some distance in class, income, race, and other between the two” (House 1987: 210). If one accepts the proposition that, “abuse per se happens and is occurring whenever choices are arbitrarily limited by those with power, whether the limiting factor be social, political, or economic,” which apparently was a prevailing definition at the Hampshire workshop on reproductive technology, it seems to follow that every interaction between a disempowered woman and a Depo provider would be abusive (Cassidy 1980: 98).³⁹

What made Depo-Provera inexcusably dangerous in the eyes of feminist activists is that *every* instance of Depo abuse would involve such particularly vulnerable women, and therefore that free, informed use of the drug is virtually impossible. At the 1987 hearing activist Norma Swenson provided “a long list of categories of women for whom Depo-Provera was recommended” by Depo supporters, which includes “unmotivated women,” “unreliable or irresponsible women,” “stupid women,” “problem women with problem families” and “illiterate

³⁹ Of course, one might have to accept that virtually all people’s choices are, to some degree, “arbitrarily limited,” which is why I find a feminist regulation grounded in such a proposition highly problematic.

women” (133-134).⁴⁰ The Arlington Hospital and School in Tennessee administered Depo-Provera to mentally retarded women for the purpose “of reducing time in taking care of the personal hygiene of females here who are having menstrual periods,” as did the Indian Health Service (House 1973: 96; see also House 1987, Smith 2005). In short, Depo was intended for and administered to the very women in the worst position to make informed, uncoerced choices. “I do not believe that adequate informed consent has yet been obtained for this drug anywhere in the world, and I am not sure that it can be” (Swenson, House 1987: 136). Anita Johnson makes a similar point. Recipients of Depo are “likely to be poor women who lack adequate contraceptive information...and the same women who are least likely to understand the risks...and least likely to withstand the enthusiasm of a zealous population-control doctor...Informed consent for this drug is thus impossible” (House March 1978: 398). In terms of its medical risk, Depo was not an acceptable “choice” because it conflicted with women’s right to health. When the issue of abuse is considered, it appears that Depo is not something women can “choose” at all.

From many activists’ perspective, women cannot “use” Depo-Provera: they receive it and take it; it is administered and injected. For example, in August 1978 Anita Johnson remarked, “Let us be supercareful before we start using the taxpayers’ money here to inject people in India and Burma” (House: 160). Stephen Minkin connects “women” and “use” in the context of a paragraph depicting the assembly-line administration of Depo in Chiang Mai: “On command, the Thai women, who are

⁴⁰ Those concerned about the potential for abuse rightfully questioned the designation of some women as “unwilling” and how one would make them “willing” contraceptive users. “I am very concerned about the use of the term ‘unwilling,’ because...what does ‘unwilling’ mean? I know what ‘unable’ means, where you are medically unable to use something. But ‘unwilling’ you can basically drive a truck through” (Dr. Richwald, House 1987: 210).

regular users of Depo-Provera, roll up their sleeves and tighten their expressions (1981: 35). “On command” seems to cancel out any positive sense of “use.” To use a contraceptive for the purpose of (reproductive) self-determination requires agency and information. The true Depo users, then, are the medical and population policy professionals who administer it for their own purposes, which may coincide but often conflict with the interests of those at the other end of the needle. Norma Swenson makes just this point. “It is clear that these users of Depo-Provera for social control and institutional control represent an abuse of the human rights of these groups of women” (House 1987: 136). At the moment of Depo injection the poor woman, the brown woman, and the uneducated woman are abused because they are situated as powerless. The injector has interests (convenience, fertility reduction) and the means to realize them; the injected merely offers her arm.

In order to justify their opposition to the addition of Depo-Provera to the contraceptive cafeteria, feminist regulators had to navigate the meaning of women’s “right to choose.” As seen in the last chapter, activists promoted respect for the individual’s right to health while Depo supporters invoked the individual’s right to choose. The two sides were unable to reconcile the two and thus essentially spoke past one another. Here, as feminists argue that it is abusive for women to use/receive contraception without free, informed consent, they reintroduce the freely choosing individual as the ideal contraceptive consumer. They argue convincingly that the very women for whom Depo is intended (and, one must remember, the very women for whom other methods are somehow inadequate) are, to varying degrees, unable to be the savvy consumer, the self-helping patient promoted, protected, and educated by

consumer and women's health movements. If birth control in the feminist sense is a practice only of such subjects, then uneducated, poor, or Third-World women (that is, the vast majority of women) do not fit in the picture. Such women either do not use contraception at all, or they receive it under abusive circumstances. Women either use birth control, or participate in the social control of their bodies. Feminists opposed Depo-Provera on the grounds that it is a drug that would only be "chosen" by women unable to choose. In this way they actually evade the choice question entirely. A woman who chooses Depo is coerced or uninformed, since:

- "Any woman with the resources *to truly comprehend the unknowns involved* would have access to alternative methods of birth control..." (Swenson, House 1987: 136, emphasis added).
- "Because of their age, intellectual capabilities, or environmental circumstances the capacity of these special populations to consent is diminished...If these patients were capable of asking all the right questions about risk, understanding the answers, *and making competent decisions for themselves*, they would most certainly be able to use other contraceptive methods" (Levine 1980: 103, emphasis added).

Choosing Depo is *in and of itself* a sign of a woman's powerlessness. Only desperate, uninformed, or coerced women would use such a drug. "Women's situation cannot be truly known for what it is, in the feminist sense, without knowing that it can be other than it is" (MacKinnon 1989: 101). Feminists appeal to a liberal, Rawlsian standard of "rational choice," a choice "accessible to that person through a process of rational deliberation in which the conditions for rational deliberation are idealized" (Babbitt 1993: 247). Nevertheless, positing women's conditional choices under ideal circumstances does little to address women's *actual* choices (in the double-sense of options and actions) under *less than-ideal* circumstances.

It is difficult here to avoid simply arguing that they “deny women agency,” a frequent criticism leveled at activists who point out that individuals are oppressed, that their choices are constrained or unduly influenced by material or ideological forces. As Janice Raymond writes, “To expose the victimization of women is to be blamed for creating women as victims” (1993: x). Nevertheless, it is significant that there are no subjects at the other end of a Depo injection. Women are not victimized simply at the moment of injection, by the act itself. They enter the story as victims: “Men aim the Depo-Provera weapon at the powerless” (Corea 1980: 108). Katsi Cook, a Native American midwife and activist, expresses a similar construction more generally: “Technology is used against poor people” (1980: 129). One is reminded of Catharine MacKinnon’s infamous formulation, “Man fucks woman. Subject verb object” (1989: 124). There is not room for two subjects in these sentences. “Black women in the South and Native American women have been special targets,” testified Sybill Shainwald. “Mentally retarded women, incarcerated women and addicts are also victims” (House 1987: 168). The NWHN established a “Depo-Provera registry to assist Depo-Provera victims” (Cowan 1980: 44).

The undeniable fact that women are targeted as the objects of population control interest does not establish that they are always, only targets, that the victimization is always successful. Further, the same activists who criticize family planners for considering certain women too irresponsible or stupid to be taught to use barrier methods ascribe to them this same incompetence.⁴¹ “The Network is

⁴¹ Indeed, family planners did not have the greatest faith in women’s abilities. In August 1978, Bruce Scheurer remarked, “A daily regime is a difficult regime for many users in developing countries.” “The process of counting and taking repetitive action?” clarified Rep. Scheuer. “That is correct.” (House 1978: 163-164). Depo opponents objected to those who used this reasoning to highlight Depo’s

extremely concerned over the use of Depo-Provera particularly when it is aimed at the most vulnerable in our population. We do not want them to be the unwitting, unknowing, unconsenting recipients of drugs which are not approved by the FDA for the purpose indicated” (Shainwald, House 1987: 167-8). Certainly some women are more “unknowing” than others—there is a difference between a poor or black woman and a mentally retarded one. Some are more “unconsenting” than others—not all uninformed women are pressured as Anna Burgess was. And all of these women have some degree of “wits” about them, some degree of *need* that Depo very well may meet.

In one radical feminist analysis, women are not free agents controlled by those in power; their very consciousness has been ideologically colonized. Gena Corea presents this position in her PBI testimony: “I believe that control of consciousness is one of the tools the patriarchy uses in taking this freedom from women; that it argues that...women freely *choose* Depo-Provera, an animal carcinogen” (1991: 174). Women are not simply denied access to the resources necessary to make choices; on a deeper level they do not know what is best for them. Such an analysis of consciousness clearly justifies the regulation/limitation of the contraceptive cafeteria to only those options which could never be “dangerous.” Yet in the next breath, Corea accuses those who wish to motivate the unmotivated of disrespecting women’s authentic will and desires. “[F]eminists, valuing a woman’s individuality and her control over her own person, would assume that a woman who is unmotivated to use contraception has her reasons. *Perhaps she wants many children...* We see her as a

relative convenience, arguing that if women could not use the Pill or a diaphragm, it was family planning clinics’ duty to teach them, not to give them a “dangerous drug.”

subject living her own unique life, not an object to be controlled” (176, emphasis added). Why does this same woman instantly become an object in relation to Depo?

Feminist regulators did not abandon the notion of free, informed choice, but rather argued that it is unjust to make potentially abusive drugs like Depo available to, or target them at, women who simply cannot make these choices. It is worth looking again at Senator Jim Javits’ conditions for informed consent:

For the purposes of this section only, the term ‘informed consent’ shall mean the consent of a person, or *his* legal representative, *so situated as to be able to exercise free power of choice* without the intervention of any element of force, fraud, deceit, duress, or other form of constraint or coercion” (Senate 1973: 7, emphasis added).

If this person is the only possible “informed consentor,” Depo opponents are absolutely correct; the ideal Depo candidate literally does not fit the definition. If one accepts the feminist premise that “women’s situation” is characterized by more or less unfreedom informed consent bills do nothing to protect them. Thus one could *not* say that regulators, in seeking to ban Depo, were violating the free, informed choice they simultaneously vaunted as an ideal, since potential Depo users do not “have” that choice in the first place.

Yet it does not necessarily follow from the insight that (most, if not all) women’s choices are somehow constrained/uninformed/coerced that each of their encounters with authority and technology is defined by abuse. In these feminist discourses control, use, and choice are all-or-nothing. The analysis of the power relationships involved in the injection encounter becomes a formula; if the input includes two agents, one of whom is disempowered relative to the other, the output will always represent the interests of the latter to the detriment of the former. Women

do not freely choose Depo-Provera. They also do not freely choose to wear skirts, get married, or have children.⁴² Of course there are varying degrees of freedom—there is an important difference between arranged marriage and generalized compulsory heterosexuality. But if (poor, dark skinned, uneducated) women are not described by the definition of the provider of informed consent, why is free, informed choice maintained as the ideal, even compulsory condition for birth control? This argument could be interpreted cynically; since women’s choices are never free, we might as well let them do what they want, regardless of the harm. This is not what I believe. Improving the conditions for (relatively) free and informed choice is and should be one of the most important goals of feminist activism, especially in the realm of reproductive rights. Women’s health activists, in constructing sophisticated arguments about the structural constraints on women’s reproductive freedom, and therefore the potential for abuse within those structures, demonstrate the need for explicitly feminist regulation and policy. Yet in the meantime, women act. Perhaps we can call what they do “choice” only if the term is kept in scare quotes, but they are *doing* something. Perhaps we need a new word for what happens when a Thai women who is sick of being pregnant rolls up her sleeve and tightens her expression.

Mr. Tieng Pardthaisong, a professor conducting a “study on the return of fertility following discontinuation of Depo-Provera” among women in Chiang Mai,

⁴² The anti-Depo argument has interesting parallels to some radical feminists’ anti-penetration stance. (cf. MacKinnon 1989) Given women’s disempowerment vis-à-vis men, and therefore their husbands and sexual partners, instances of penetration/injection(?) could and have been interpreted as abuse. Women do not give their free, informed consent to sex (and the attendant risk of pregnancy). Feminists opposed to Depo virtually never acknowledge the unfreedom in which pregnancy occurs. They only compare the two when arguing that it is unfair to compare the *health* risks of Depo with those of pregnancy, since “fortunately, there are other options, such as contraception by condom, diaphragm, IUD, or surgical sterilization,” an argument I contest in Chapter 2. (Johnson, House August 1978: 202).

the same population described in Stephen Minkin's article, testified at the August 1978 hearings (99):

In our family planning program we give Depo-Provera only to those women who have had at least one previous pregnancy. But when we did follow-ups, asking for birth certifications and other documents, we found that 39 patients had never been pregnant, before their use of Depo-Provera. They admitted that they told a lie, because they would like to have Depo-Provera so much (102).

This description, which portrays women's agency vis-à-vis Depo and those conducting the study quite differently from Minkin's, of course does not necessarily reflect the "reality" in Thailand. Mr. Pardthaisong suggests the insufficiency of their experimental protocols by admitting that they do *not* in fact only give Depo to women who have previously been pregnant.⁴³ Nevertheless, the fact that women would lie to receive an experimental drug suggests their need for more effective or more private contraceptive methods. One can easily argue that choices made in desperation are not choices at all, yet it can just as logically be said that an absence of choices in desperation is hardly preferable. When activists write that, "many poor and third world women are injected with Depo-Provera or sterilized without their understanding or consent" they do not account for the consciousness of women offering their arms (Women's Community Health Center 1980: 75).

In characteristically blunt style, Malcolm Potts once commented, "I don't think women are things you shoot things at. I think they are sensible people who make choices" (House August 1978: 40). Feminist regulators are unable to theorize how Depo functions if women are both at once. Janice Raymond criticizes "liberal

⁴³ Many feared that Depo would cause a serious delay in the return of women's fertility following discontinuation, or that it would leave them infertile.

feminists,” such as Michelle Stanworth, who “encourag[e] women to recognize how these technologies not only abuse women but also how they can be used in women’s own interest...abuse is fused with use” (1993: 90). She is unimpressed by their “nuanced” position, but her phrase, “abuse is fused with use” is a good approximation of the actual relationship between woman and Depo, woman and provider. The fact that women are so desperate for birth control that they will accept the injection of synthetic hormones without information is neither acceptable nor an excuse for inventing more “magic bullets” rife with side effects. Yet it demands that feminist regulators take their desire for control seriously, and consider that Depo, or those who provide it, do not simply “take reproductive control” from those who have virtually none when diaphragms or pills do not suffice. Feminist regulation should indeed be grounded in an analysis of the social relations in which contraceptive choices are anything but free. Yet Depo opponents extend this analysis such that women’s every interaction with “high tech” contraception entails abuse or loss of control and is therefore unacceptable, leaving many women without any contraceptive choices until they “have” control. “If it takes years and years of education before we get to the point where people are making informed decisions, then I think we have to take those years and years” (Norsigian, Depo-Provera Discussion 1980: 137).

In her classic analysis of sterilization patterns in the United States, Rosalind Petchesky argues that women’s selection of this method is defined by “a number of material and political constraints” and condemns “the blatant abuses that limit the choices of poor and minority women” (1981: 50, 80). Yet she does not therefore

conclude that sterilization is an abusive practice or that poor and minority women's relative powerlessness precludes their rational use of contraception:

“Voluntary” and “involuntary” sterilization, “choice” and “coercion” in women's reproductivity, are two poles of a continuum, with most instances of sterilization falling somewhere in the complex area in between. In most cases it is not individual choices themselves that are irrational or unfree, in the sense of unknowing or forced, but rather the very narrow social constraints in which those choices are made (80-81).

Women would not be better off without sterilization, “the surest available birth control solution” *given* their structurally-determined lack of alternatives (63). They would be better off with “the extension of childrearing and birth control responsibilities to men as well as woman” or “the complete socialization of medical care,” to name just two of the socialist-feminist projects Petchesky believes are essential to the achievement of reproductive freedom (81). Frequent unwanted pregnancy is not necessarily “better” than women's use of Depo under pressure from a doctor or without full information. These conditions are two sides of the same coin, characteristic of a world in which women do not make free reproductive choices or “have” reproductive control.

The Inevitable Abusiveness of Reproductive Technology

In the same moment as Depo opponents construct an image of female powerlessness, they ascribe Depo the ability to take control from women and shift the conditions of reproductive choice further toward population control. As noted earlier, feminists were strongly opposed to the *form* of Depo, a provider-controlled injection. The drug is not simply used against women; by its very nature it contributes to women's loss of contraceptive control. “Precisely because Depo-Provera is an injectable contraceptive, *it* eliminates individual control over the contraceptive

method, which I believe is crucial to an ideal method. As an injectable, it is subject to widespread abuse, as we have already seen.” (*Network News* 1983: 10, emphasis added). Recall from the last chapter that women’s health activists advocated barrier methods for their medical safety; here the benefit of “user-control” is crucial. “To the women’s health movement, user control is valued because the women herself is administering the agent that affects her body. It represents her decision, her involvement, and her taking charge of herself” (Korenbrod 1980: 49). There are no doubts about women’s agency in her use of a diaphragm since she must choose to insert it before every act of intercourse; she has mental and physical control over the act of contracepting. Use of a diaphragm is inevitably birth control, not population control, not social control. High-tech contraceptives “take” and “eliminate” control from women; their existence shifts the conditions of reproductive choice in favor of providers. Their development and distribution are the result of and contribute to a population control paradigm.

Opposition to Depo is just one expression of feminists’ ambivalence toward (or outright opposition to) the new reproductive technologies that appeared throughout the 1970s and 1980s.⁴⁴ These included contraceptives to prevent pregnancy, procedures and gadgets to monitor pregnancy (such as fetal heart monitors

⁴⁴ A few helpful anthologies of feminist writing on reproductive technology include Holmes, Hoskins and Gross 1980, Stanworth 1987, Hynes 1991, and Holmes 1992. Gena Corea’s *The Mother Machine* (1985) is a classic single-author text. Contributions to the first three texts represent a range of stances toward reproductive technology, while the latter two are more in the “anti-technology” camp. See also the websites of FINRRAGE (Feminist International Network of Resistance to Reproductive and Genetic Engineering), www.finrrage.org, and WGNRR (Women’s Global Network for Reproductive Rights), www.wgnrr.nl, two feminist coalitions that have done work opposing reproductive technology, including Depo.

and amniocentesis), and infertility treatments to promote pregnancy.⁴⁵ Essentially, women's health activists feared that these developments would "remove" control from women rather than expand their choices. "In Europe, Australia and North America feminists are currently engaged in heated debate over whether new reproductive technologies present a threat or an opportunity for women....do they give women more control?" (Petchesky 1987: 77-78). One sociologist of technology⁴⁶, entitled a piece on different feminist perspectives on reproductive technology, "Delivered Into Men's Hands?," acknowledging the strain of radical thought which argues that technologies are "intrinsically patriarchal," developed by and for men (Wajcman 1994: 157). Senator Edward Kennedy was more accurate than he realized when he remarked that "the technology of biomedical research is the technology of man" (Senate 1973: 1). Depo-Provera represented a step precisely in the wrong direction; its potential for abuse and women's loss of control go hand in hand in feminist discourse.

In a sense, Depo opponents offer their own brand of technological determinism, in which technologies developed for "abusive" reasons and released into a social context of inequality will inevitably be used to abuse. As I noted in the last chapter, some feminists asserted highly effective hormonal methods were designed with population control values in mind, with health secondary to

⁴⁵ The phrase "reproductive technology," and anthologies on this topic, tend to refer to technologies used to monitor existing pregnancies or treat infertility, although contraception is included under the umbrella. It might be more accurate, and more helpful for researchers, to separate the two.

⁴⁶ "Sociology of technology" as a specific sociological discipline emerged in the 1980s. Whereas "social scientists have tended to concentrate on the 'effects' of technology," sociologists of technology ask, "What has shaped the technology that is having 'effect'? What has caused and is causing the technological changes whose 'impact' we are experiencing?" (MacKenzie and Wajcman 1985: 2); see also Bijker, Hughes and Pinch 1987, Kraft and Vig 1988, and Bijker and Law 1992.

effectiveness. Similarly, they point out how well Depo's design fits with a social control model of contraception. "[H]igh technology contraception like the Pill, the IUD, injectables and implants actually represents a trend away from individual women's control, emphasizing the woman's passivity and her dependence, putting greater control in the hands of manufacturers, population planners and medical professionals" (Swenson, House 1987: 139). Their notion that Depo has an inherent abusive potential is not without merit. In a classic article, "Do Artifacts Have Politics?" Langdon Winner writes that those who argue that "what matters is not technology itself, but the social or economic system in which it is embedded" fail to "stop to inquire whether a given device might have been designed and built in such a way that it produces a set of consequences logically and temporally *prior to any of its professed uses*" (1988: 34-35, 39). The intent behind and logical uses of a technology do matter.

It is important to remember that questions about Depo's potential for abuse must be understood in terms of social relations. Depo does not *do* anything on its own; *it* is not abusive. At times in the debate this distinction is lost, and it seems that the enemy is this injection, "the dangerous contraception," rather than the profit or population control motivations behind its development and the power imbalances that would facilitate its abusive use. In the introduction to her anthology on reproductive technology, Michelle Stanworth writes:

An overemphasis upon technology risks distracting attention from the politics and organization of health care in general, from the legal system... and from the impact of the varied material and cultural circumstances in which people create their personal lives. Fundamental social alternatives are not shaped by technologies alone, and technological determinism—whether of the variety that claims that scientific-technical progress provides the key to all social

problems, or of the kind that seems to target technology as *the* obstacle to autonomy or freedom—will not do (1987: 4).

MacKenzie and Wajcman note that “a new device merely opens a door; it does not compel one to enter.”⁴⁷ They go on to say that, “Even more damaging to a simple technological determinism is the fact that *the same technology can have very different ‘effects’ in different situations*” (ibid). The meaning and “effect” of a technology depends on the context in which it is used. Ellen Frankfort, in a 1972 article critiquing feminist self-help ideology, argued “machines per se are not bad...if those currently in charge of the machines and hospitals don’t respond to people’s needs, let’s replace *them*, not the machines” (1977: 270).

Not only does the abusiveness of Depo depend on context, the more important point here is that even in “abusive” contexts, Depo’s use can signify birth control. Depo-Provera opens a door—both to women without access to any other methods, and to those interested in limiting some women’s fertility. The fact that the “women” in each case are often the same leads Depo opponents to cast Depo as a population control device in a population control world, rather than consider the dialectical relationship between a contraceptive technology and the social context in which it is used. It is true that “the development of contraceptives outside women’s control provided the necessary precondition for coercive family planning programs,” but abuse is not inevitable (Schoen 2005: 236). Leaving women without any accessible birth control options does little to improve the conditions of their reproductive choice.

Positing that technologies “take control” from women presumes that all women “have” control in the sense imagined by women’s health activists.

⁴⁷ They are citing Lynn White (1978)

“Technology threatens to replace women’s knowledge and control with drugs and devices designed, controlled, and supervised by experts and commercial interests” (Shapiro 1985: 194). This may be true to some extent, but women socially or morally proscribed from negotiating barrier method use do not *have* knowledge and control as conceived of and somewhat romanticized by women’s health activists. “I think we have to be a little careful about easy assumptions that somehow women had control over fertility and reproduction” (Luker 1980: 82).

Depo opponents ask women to wait for the ideal conditions of ideal contraceptive use, without considering whether the use of less-ideal methods under less-ideal conditions might, in itself, constitute a move in the right direction. Premising a feminist regulation on a concept of (certain) women’s powerlessness vis-à-vis inevitably abusive contraceptives (and those who wield them) demonstrates a disregard for disempowered women’s consciousness and needs and the complex ways that the interests of the powerless and the relatively powerless meet in sometimes transformative ways.

In a sociological study of the use of Depo-Provera in Zimbabwe in the 1970s and 1980s, Amy Kaler was told by informants that “coercion of women to accept Depo did occur quite commonly on white-run commercial farms,” and population control interests clearly motivated many of the family planning programs in the country (1998: 353). *And yet*, even as the black nationalist government banned the drug on the grounds that it was a dangerous tool of population control wielded by whites, the method was extremely popular among women, most of whose partners objected to their use of contraception, “because you can just have it private, like I

did,” as one woman put it, “the injection is for me and that’s all” (369). In 1970, in response to Black Panthers’ call for black women to refuse birth control, “to not cooperate with an enemy all too determined to solve his problem with the bomb, the gun, the pill,” Toni Cade Bambara wrote “The Pill: Genocide or Liberation” (383). “So what about the pill? Does it liberate us or not? Will it help us forge new relationships or not? Does it make us accomplices in the genocidal plot engineered by the man or not?” (384). She has no illusions about the state’s interest in providing birth control: “I know it’s not for nothing, certainly not for love, that b.c. clinics have been mushrooming in our communities” (386). *And yet*, she knows just as well that neither men nor the state will provide for black women’s children, that to be without birth control is to be without control. “I would never agree that the pill really liberates women. It only helps... But the pill gives her choice, gives her control over at least some of the major events in her life” (385). These two texts offer a glimpse at the ambivalent role hormonal contraception plays in the lives of women who are simultaneously the objects of social control and the subjects of their own negotiations for achieving some modicum of reproductive control under oppressive circumstances.

Conclusions

Women’s health activists and politicians made important strides in establishing the standards for informed, free choice. They are probably correct that in reality and “potentially,” the use of Depo would fail to meet those standards. Yet to argue that the solution is, therefore, to ban Depo, and any “provider-controlled” method with abusive potential, rather than making a concerted, society-wide effort to combat the inequalities that facilitate abuse, and a *regulatory* effort to enforce the

ethical distribution of any drug, particularly to extremely vulnerable populations (like institutionalized women), is to abdicate a feminist commitment to offering disempowered women access to birth control. Emily Culpepper pointed out in a workshop discussion on contraception:

I'm really fascinated by natural birth control methods and observing the vaginal mucus as one form of birth control. But relying on that can be discussed in a way that sounds like women who are not going to inspect their vaginal mucus every day are somehow leading less responsible lives, or that, in an ideal world, all women should be responsible in that way...I'm interested in birth control technologies that will work *now* for women in a diversity of situations (1980: 90-91).

The dangerous premise that some (most?) women cannot choose, that abuse always trumps use, and that some technologies are inevitably harmful writes most women with the potential to contracept and some contraceptives with birth control potential out of the realm of possibility, leaving women *now, in a diversity of situations*, to wait for the ideal circumstances of fully informed, perfectly free choice of barrier methods.

Ruth Macklin, a bioethicist specializing in the ethics of reproductive technology research, sketches out the "potential for abuse" in much the same way that Depo opponents do, only she reaches a different conclusion. "Abuse of the right to voluntary, informed choice" includes failure to give information, ensure that information is understood, offer other options, and the use of pressure (1994: 110). Yet she emphasizes that the potential for abuse lies in the context in which contraceptive research and use takes place, that the ethical burden lies with those able to enforce the conditions of informed, voluntary choice:

The fact that some service delivery settings are deficient in quality and ethical procedures is not a sufficient reason to halt research that could provide

benefits to many women. The remedy for poor service delivery is to seek to improve the conditions...Those who would restrict women's options by limiting the range of contraceptive methods are being paternalistic in their attempt to curtail the freedom to choose... the ethically sound approach is not to deny those benefits but rather, to combat the potential for abuse" (Macklin 1994: 112-113).

It is not enough for feminist regulators to argue that a method has and will be used abusively on vulnerable women. Those women remain vulnerable, and without reproductive choice, whether or not Depo is on the market. They have a responsibility to "combat the potential for abuse," rather than the technology with abuse potential. In critiquing women's health activist group FINRRAGE's "blanket conflation of technology with patriarchy, of use with abuse," Naila Kabeer, an expert on gender and international development, makes much the same point. "Policies which promote reproductive technology as an element of reproductive choice can be compatible with, and indeed crucial to, a broader feminist goal of equitable development" (1994: 202).

I have suggested in this chapter and the preceding one that women's health activists tend to gloss over the important distinctions between the needs and experiences of differently situated women even as they advocate for their protection. By either universalizing "the individual woman" or casting oppressed women as entirely powerless in the face of technology (not to mention conflating structural oppressions with one another, considering poor women, women of color, and institutionalized women as a single constituency), they establish that Depo-Provera can never be birth control. They implicitly regulate in terms of how birth control works for privileged women in privileged conditions, rather than in terms of the imperfect realities faced by most women. This raises complicated questions about the ability of feminist regulators to speak for or represent women in all their diversity. In

the final substantive chapter of this thesis, I will consider the limits of feminist regulation premised on the ability of women's health activists to comprehend and speak for all women's needs.

Chapter Four: Toward a Situated Regulation

“Thanks very much to all of you who fought to bring a few women to these hearings,” said well-known women’s health writer Barbara Seaman to the Select Committee on Population at a hearing on “Contraceptive Technology and Development” (House March 1978: 128). Indeed, “a few women”—women’s health activists, no less—were invited to a number of forums at which the risks and benefits, uses and abuses, of Depo-Provera was discussed, adding new voices to proceedings otherwise dominated mostly by men and family planning officials. But, as I have tried to show in the preceding chapters, there is more to a *feminist* regulation than the words of “a few women.” Women’s health activists opposed Depo from a reoriented regulatory perspective. They demanded that the drug’s risks be considered from the perspective of the individual, embodied woman, rather than the abstract consumer or the family planning official. They posited women’s right to health as an important counterbalance to the consumer/patient’s right to choose. Yet they simultaneously defended “choice” as a defining requirement for reproductive freedom, while pointing out that potential Depo users were in the worst position to make choices. Throughout the Depo debates activists insisted that government and pharmaceutical officials consider women’s perspective. They were asked to conceive of women’s position—in their bodies, in the bedroom, in society at large—and consider the consequences of reproductive technologies from that standpoint. In essence, women’s health activists constructed a feminist regulatory epistemology which privileges women’s knowledge, needs, and experiences over population control agendas, profit considerations, or scientific “objectivity.” They spoke *as women, for women.*

I want to expand upon the possibilities and pitfalls of such a regulatory stance, the limits of which I have already hinted at in the preceding chapters. Women's health activists establish universal standards for women's reproductive health and contraceptive needs, while simultaneously arguing that certain groups of women are essentially powerless in the face of reproductive technologies and those who wield them. If one were to extend their regulatory premises for an evaluation of existing and potential items in the contraceptive cafeteria, one would be left with only those options that women's health activists themselves can choose and desire to choose. Birth control becomes the use of "ideal" methods under "ideal conditions," rather than the negotiation of women with reproductive technology or family planning providers at the intersection of self-determination and social control. Women's health activists—and those who "fought" to bring them to hearings—tread on dangerous ground when they imply that a given woman can represent or speak for women, and that the presence of women in a regulatory forum will ensure that decisions are made with a diversity of women's best interests in mind. By conflating women's health activists' perspective with "users," the difference in position, and needs, between groups of women is obscured. In this chapter I will consider the limits of essentialist aspects of feminist regulation of Depo-Provera while pointing to the radical potential of activists' criticism and subversion of standards of disinterested regulation generated by the "view from above." Using feminist theories of scientific epistemology, I will suggest that feminist regulation grounded in the "situated knowledges" of a diversity of women—and men—within which actors speak from an interested perspective, from a particular body in a particular context rather than a

totalizing “woman’s standpoint” or an objectifying view from above, might offer more complex analyses of contraceptive technology.

Representatives of “The Female Community”

“We keep talking about getting women into the questioning process”

At the March and August 1978 hearings before the Select Committee on Population, Congressman Paul McCloskey makes frequent reference to the need to involve women. “We must make sure that the decisionmaking process meets the test of any lay observers from the female community” (House March 1978: 107). At a later hearing he says, “Let me defer to Dr. Rhonda Einhorn. We keep talking about getting women into the questioning process” (House August 1978: 44). It is perhaps a testament to the power of the women’s movement that, by the late 1970s, one could accept that it is logical, moral, and politically imperative to include “the female community” in decisions that primarily affect their bodies, and more broadly, their reproductive freedom. On the other hand, it is worth considering Dorothy Smith’s observation that collecting data from women or any objects of social-scientific interest is often a mechanism of the “relations of ruling.” Such data “transpos[es] the actualities of people’s lives and experience into the conceptual currency with which they can be governed” (1990: 15). Were women’s perspectives sought so as to address their reproductive health, broadly defined, or so as to develop more effective weapons against fertility (know thine enemy)?

Regardless of intent, the effects of these ideas are clear: women were invited—*as women*—to hearings and the PBI concerning Depo-Provera and contraception. How can men purport to speak for women’s needs? Let “the women” speak for themselves.

The structure and underlying assumptions of the regulatory system are left intact, but perhaps its decisions will be more responsive to women's needs. Congressman

McCloskey makes this point at the "Depo-Provera Debate" hearing in August 1978:

It seems to me absolutely imperative that we never again have panels of men battling back and forth this question without the full participation of women...It seems to me that in this area it would be well...that we solicit the advice and the opinion and the judgments of the leading women's organizations nationally and internationally, so that we are not faced with the situation where these decisions have been made entirely by men at either NIH, or FDA, or HEW (House: 137).

McCloskey makes two propositions here. First, he suggests that "the full participation of women" is an adequate intervention into male-dominated policymaking in reproductive technology; the biases and inadequacies of research and regulation are reduced to a matter of gender representation. Second, he assumes that the "advice and the opinion and the judgments of the leading women's organizations" reflect and represent Women, in particular "the user" of family planning services and contraceptive devices. (I will discuss this latter assumption later.) Congressman Scheuer responds, "I very much concur...I wish to underscore [his] remarks on the urgency of female participation" (138). Females—any female?—participate in the process, adding to the chorus of advice and opinions and judgments, and the result will be policy that truly addresses women's—all women's?—needs. Women's presence in these proceedings is taken as an indication that women are involved and that their opinions influence decision-making.

At Senator Kennedy's 1973 hearings, Dr. Leonard Brooks, the director of a family planning clinic, testified to "the measure of healing solace" Depo-Provera offers women (Senate: 78). Sensing that sympathies were not in his, or Depo's, favor,

he offered bombastic and defensive testimony. He immediately remarked “that this is a group almost exclusively of middle aged males,” a group of which one can only presume he is a member, “dictating to women how they are going to control their reproductive lives” and makes the point again later:

Brooks: You as a male are faced with birth but as a middle-aged male you have not been victimized in your productive life. It is not an issue to you any more, and you are not a woman. [Laughter.] Did you see the four or five men sitting here? No woman represented, and no birth control representative here...

Kennedy: What about Marcia [Greenberger] and Anna [Burgess]? I thought they were qualified representatives.

Brooks: One swallow does not make a summer either [Laughter.] (80)

Thus Dr. Brooks attempts to delegitimize this hearing, which highlights the unregulated distribution of Depo to women without any informed consent procedures, by making the case that male panelists and congressmen are “speaking for” women and ignoring their needs. Rather than challenging this cynical invocation of women’s “rights,” Senator Kennedy defends the hearing by pointing to two “qualified representatives” of “the female community.” This exchange between two powerful men about the adequacy of female participation is a poignant example of how easily feminist demands for representation are appropriated and how easily a potentially rich notion of representation is reduced to female presence. However, it points us to an important question: what do women representatives bring to the contraceptive regulatory table?

Why Women Know Best

Although the call for female representatives at times sounds superficial or even tokenizing, simply by “stating the obvious”—that women would have a different perspective on contraceptive priorities and health considerations—officials state the

unspeakable—that experience and situatedness matters in science and knowledge-building, as does the affinity between subjects and objects of decision-making.

Although Congressmen may simply have wanted women’s input, women’s health activists envisioned the transformation of birth control decision-making. One of the most crucial tenets of women’s health activism was that women know best what they need and how to provide quality health services to one another. Activists sought to minimize, even eliminate, the gap between medical authority and patient, decision-maker and object-of-decision making, or simply between subject and object by arguing that women should occupy both positions simultaneously (Fee 1977).

It is our position that *women should be creating policy on behalf of women*, at the very least, and that all users of contraceptives should have a significant voice in determining what kind of research is funded. To the extent that birth control is still primarily the responsibility of women...women should have a major voice in determining which contraceptive research priorities will best meet their needs (Norsigian, House March 1978: 379, emphasis added).

This is not simply a call for “a few women” representatives, but for a transformation in the structure of contraceptive development and regulation, and the knowledge-seeking processes on which such decisions are supposed to be based. This is what I mean by the call for a feminist regulatory *epistemology*. Regulatory decisions about contraception are, ostensibly, made in the best interests of women. Scientists and policymakers collect data about women’s contraceptive practices, or data on the effects of a drug in women’s bodies, and weigh risks and benefits accordingly: women are *data*, the *objects* of research and decision-making. Perhaps they call in “a few women” to offer insight.

Women’s health activists argue that this structure in itself objectifies women and fails to truly address their needs since it cannot gather the necessary knowledge.

“Although policymakers may claim that decisions are made ‘in the best interests’ of women, they do not *know* what is best; therefore they cannot be excused for failing to attempt to involve in their decision-making the input of the women at risk” (Holmes 1980: 5). In order to “*know* what is best,” contraceptive decision-making must be grounded in the perspective of women at risk, of the objects of this decision-making. If contraceptive regulatory decisions are to be based on what is best for women, one must first know what is best for women. Feminist regulators do not argue that there are an infinite number of good answers to this question. There is an answer, and it is best accessed not by men (or women) playing by the old rules of disinterestedness and objectifying detachment from the “subject” of policymaking, but by women (or men) speaking from an interested (women- or birth control-centered) position.

Helen Holmes contrasted the value of objective knowledge seeking and decision making with her “women’s values.” “The professed value is ‘objectivity, ‘an attitude uninfluenced by personal prejudices and based on observable phenomena.’ But what is actually found it, ‘an attitude that turns persons into objects, that depersonalizes; this is **objectification**” (1980: 8). Objective regulation not only objectifies women, but, as I discussed in Chapter Two, women’s health activists argued that most people involved in Depo development and research were not *objective*, as in disinterested, at all. They analyzed risks and benefits in terms of population control interests, regulating from the perspective of the family planning official, rather than starting from the needs and experiences of an embodied woman. Critiquing the value of efficacy over safety in contraceptive research and evaluation, Laura Punnett argued, “professional medicine and medical ethics are *not* objective;

they are inadequate and ineffective in addressing women's concerns and health needs, which are either ignored or used as a means to increase control over our lives" (1980:

62). In contrast:

[W]omen have developed our own empirical knowledge base...The women's self-help health movement translates the demand for self-determination into specifics: control over medical information and technology, active participation in health care, and research programs *developed and controlled by those most directly affected*, with priorities reflecting *the real, experiential needs of women* (ibid, emphasis added).

Women's health activists argue that contraceptive policymaking must be grounded in the knowledge of those whom it will effect, with their "real, experiential needs" and interests prioritized at every stage. They call for "women-controlled" research in women's health centers, and conduct women's regulation of Depo-Provera.

Women's health activists conceive of women as a class, united against oppression. "In general, controversies over the ethics of reproductive control...are political struggles between women who assert the right to control our lives and values, and institutions such as male domination of women, corporate profit, medical professional dominance [etc]" (Punnett 1980: 69). There are "women" on one hand, and "institutions" on the other. Until women occupy or transform those institutions, contraceptive development and regulation will work against women's interests. In her PBI testimony, Corea frames the treatment of women receiving Depo as an assault on a collective "we" of women. "In other words, women would look not just at the physiological effects of Depo-Provera but also at what it does to our spirit to be treated in this way... We would look at how such treatment would contribute to our self-image and to our lack of a sense of our own power" (Corea 1991: 175). Finally,

Holmes suggested that Depo and other reproductive technologies could be analyzed under a universal set of “women’s values.”

Thus the epistemological superiority of women’s health activists’ regulation is premised 1) on women’s shared subjugation vis-à-vis institutions who render them governable objects of study and therefore 2) on women’s ability to represent the subjugated knowledge of women, making women as regulatory objects into women as regulatory subjects. As I mentioned in the introduction, women’s health opposition to Depo-Provera coincides with a cultural feminist moment, as women attempted to articulate the distinctive substance of women’s experience beyond a shared oppression. Out of this moment came feminist theorists’ valorization of a woman’s or feminist standpoint. Drawing from Marxist theory about the “correct vision of class society” available to the proletariat, theorists like Hilary Rose and Nancy Hartsock argued that knowledge grounded in women’s material experience could offer better accounts of the world (Hartsock 1988: 106). On the other hand, “the ruling group’s vision may be *both* perverse *and* made real by means of that group’s power to define the terms for the community as a whole” (110). Whereas “the knowledge produced by science is so abstract and depersonalized,” wrote Hilary Rose in 1983, feminist epistemology involves the “creation of a practice of feeling, thinking, and writing that opposes the abstraction of male and bourgeois scientific thought” and “seeks to bring together subjective and objective ways of knowing the world” (84, 87). Sandra Harding derives from Rose’s work that “[the women’s movement’s] project is to provide the knowledge women need to understand and manage our own bodies: subject and object of inquiry are one” (1986: 144).

Women's health activists identified the objectifying, even "perverse" qualities of the knowledge-building and policymaking of "the ruling group," that is, mostly men in positions of power in government or population control agencies. They articulated how this ruling group has the power to enforce its vision of the world, in which women's fertility requires technological intervention and improved social control. Activists demanded that the institutions of contraceptive regulation recognize the "politics of knowledge" as Gena Corea put it in her PBI testimony. That is to say not only that scientific knowledge is gathered and interpreted with certain values and certain political objectives, but that those who pursue this knowledge tend to use it to govern and dominate others. They thus demand not only that these institutions confront, and ideally, overcome their population control politics, their biases toward social control rather than *women's* control, but suggest that knowledge relating to contraceptive "users" (or more broadly, women) might be put to less dominating ends if gathered and interpreted by those whom it will most directly affect.

Is that goal [of preventing pregnancy] so crucial to the lives of those patients for whom Depo-Provera might be recommended that the risks ought to be discounted? This is an arguable point; however those who are arguing that contraception is paramount are not the women themselves, but those who claim to speak for them—family planners, medical professionals, and program administrators" (Levine 1980: 102).

When policymakers "speak for" women, contraceptive technology is biased toward effectiveness rather than safety, its risks and benefits evaluated with those values in mind. "The women themselves" may have different priorities, and contraceptive technology should respond accordingly.

Which Women Know Best: If all users are women, are all women users?

Yet to what extent were the “subjects and objects” of regulation the same in the Depo debate? Depo opponents emphasize over and over again the need for the *user’s* input in contraceptive policymaking. “Determining an acceptable contraceptive, for example, is so complex an issue that it *requires* input from consumers. Judgment of the acceptability of risks is a social decision that can be made validly *only* by the consumer” (Holmes 1980: 13). Certainly activists are “users of contraceptives,” but there is obvious disjuncture between women opposing Depo and the women who might *need* Depo (or the women at whom Depo was aimed, in Depo opponents’ view). “Most proponents are not arguing that Depo-Provera ought to be added to the list of contraceptive methods that are offered to the average middle-class woman visiting a private physician” (Levine 1980: 102). Depo opponents are not “those most directly affected” by the Depo decision. Conflating “the advocate” with “the user” under the umbrella of shared womanness and presuming that the needs of the latter are adequately represented by the former leaves subjugated women as “spoken for” as ever.

Currently, NWHN is conducting a nation-wide survey of over 100 women’s health centers and women’s health education groups to establish what women’s health organizations see as their contraceptive research priorities. When complete, this study will be a first-of-its kind, revealing what kind of research women want and expect the government to fund” (Norsigian, House March 1978: 379).

“What women’s health organizations see” becomes, seamlessly, “what kind of research women want.” Rep. McCloskey made the same elision above when he argued that “the full participation of women” would be achieved by making an effort to “solicit the advice and the opinion and the judgments of the leading women’s

organizations.” The fact remains that women’s health advocates or activists are not Women. They are a specific subset of women, situated in particular contexts and with at least enough power to treat and educate women situated differently. It is crucial to recognize that the Depo debate hinged on the idea that Depo was intended for/aimed at certain groups of women oppressed not only by sex, but by poverty or racism or lack of education or some combination. How can the feminist regulatory epistemology be grounded in women’s shared view-from-subjugation, a view-from-objectification, when women’s experience (which includes, but is not *defined* by, subjugation and objectification) is intersected by other material and ideological oppressions? “Can there be a feminist standpoint if women’s (or feminists’) social experience is divided by race, class, and culture?” (Harding 1986: 26).

Women’s health activists were not (always) oblivious to this distinction. While many participants at the Hampshire workshop argued that, “the women’s health movement is asserting that what is needed is greater involvement on the part of users in deciding what type of contraceptives should be researched and developed,” others asked to what extent the conference itself exemplified this approach (Korenbrodt 1980: 53):

- How can we talk about contraceptive research when *the very subjects practiced on are absent*? I, for one, would love it if this group could hear what it’s like to be a poor woman...I don’t feel any link between the discussion here and what we in direct services say that is meaningful to those people back home” (Byllye Avery, Contraceptives Discussion 1980: 94, emphasis added).
- *Those women most vulnerable to Depo-Provera attacks...are not here today.* At some point during this workshop, we must discuss why they are not here. But this we must acknowledge: They are the experts on their own lives. We are not. We never can be. We should not pretend to be” (Corea 1980: 116, emphasis added).

The conference aimed to develop an “analysis by women” of reproductive technology, but the very women most directly affected by these technologies were not represented. Even in speaking on women’s behalf they recognize the limits of being “experts” in other’s lives. As government officials and women’s health activists implicitly and explicitly call for women’s participation on the grounds that a woman, qua woman, can transmit some essential need or experience of all women, they reinscribe the regulatory structure of “panels battling back and forth” in the name of some nebulous community of women. The regulatory epistemology—a view from above—is not fundamentally altered. “Yesterday there was a great deal of discussion about safety, but it was all in terms of what researchers or providers thought was a risk worth taking. Ultimately, what’s really important is the user” (Norsigian, House March 1978: 73). Women’s health activists are not “the user,” but nonetheless posit that, as women, they are better equipped to decide what “was a risk worth taking”: Depo clearly was not.

Representative Scheuer rather pithily posed the question of whether or not women’s health activists can represent women to Barbara Seaman:

It has been charged that recommendations such as you make are really based on the perceptions and orientations of an elite group of college educated, middle class, white women who really don’t have an accurate perception of the day-to-day needs of poorly educated, lower class, minority women who absolutely feel they must have access to doctors, that they see no reason why the latest in technology should not be available to them (House March 1978: 133).

Seaman responded simply, “In my view ‘elitism’ lies in assuming that poor or uneducated women (or young ones...) are not sufficiently intelligent, or motivated, to manage the safer methods when they are carefully instructed” (ibid). This is, of

course, true, but it should be clear from the last chapter that women's health activists frequently depicted the women at whom Depo was aimed as "unwitting, unknowing, and unconsenting." At the same time, who concluded that "lower class, minority women...absolutely feel that they must have access to...the latest in technology"?

Is feminist contraceptive regulation to be nothing more than a contest over whose "perceptions and orientations" best represent "the day-to-day needs" of women oppressed by more than just sex, the term by which *women's* health activists identify with them? "One of the biggest problems that we're constantly coming up against is the question of who's making that decision about risk/benefit ratios," pointed out Judy Norsigian. (Depo-Provera Discussion 1980: 136). One can only take an epistemological standpoint so far on "the question of who." On essentialist grounds of women speaking as women, for women, activists either universalize women's situation (The Individual Woman, with a vulnerable body but no choices) or construct subjugated women as a consciousnessless, powerless unit (the unwitting, unconsenting). Donna Haraway, offering a postmodernist critique of standpoint epistemologies, points out:

There is no way to 'be' simultaneously in all, or wholly in any, of the privileged (subjugated) positions structured by gender, race, nation, and class...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 (1988: 586).

Haraway is referencing Chandra Mohanty here, who theorizes the distinction between Woman (a discursive construct) and women (material subjects). "In any given piece of feminist analysis, women are characterized as a singular group on the basis of a shared oppression...It is at this point that an elision takes place between 'women' as a

discursively constructed group and ‘women’ as material subjects of their own history” (2003: 23). Specifically, Mohanty’s claim is that Western women construct an “average Third World woman” who “leads an essentially truncated life...in contrast to the (implicit) self-representation of Western women as educated, as modern, as having control over their own bodies and sexualities and the freedom to make their own decisions” (22).

Mohanty captures here a phenomenon I see at work in Depo opponents’ defense of women of color, poor women, institutionalized, and Third World women, as they ground their knowledge and politics in the unity of all women based on a “sociological ‘unity’” of oppression while simultaneously representing themselves as women who “have” control where Depo users have none, and in fact lose ever more control with each injection (40). First of all, the differences in the degree and nature of the oppressions they face are glossed over—a lack of education has different consequences than being in a mental hospital. Then women subsumed in this net of potential Depo users are constructed as powerless victims who, ideally, would have access to women’s health activists’ resources and methods of birth control. In the meantime, subjugated women “have ‘needs’ and ‘problems’ but few if any have ‘choices’ or the freedom to act” (30). Anita Hardon identifies this division in the “women’s solidarity” on which women’s health activism around contraceptive technologies is founded: “women as free agents able to control their lives, vis-à-vis women as victims of state-led, medical-establishment-enabled oppression” (2006: 616). As I showed in the last chapter, women’s health activists portray power relations in the world such that (certain) women’s interests are always subsumed by

the interests of social control. “This mode of defining women primarily in terms of their object status (the way in which they are affected or not affected by certain institutions and systems) is what characterizes this particular form of the use of ‘women’ as a category of analysis” (23). Even when women’s health activists *do* recognize that race, class, sex, and education operate in different ways depending on the potential Depo user, and even recognize that the institutions facing these distinct groups function in substantively different ways, they nevertheless conclude that this unit of women cannot choose, cannot consent, cannot use Depo and under no circumstances could “take control” or realize a conscious need through these interactions. This is no way to ground feminist knowledge-building or the regulatory policies that might follow from such knowledge.

If “essentialism emerges perhaps most strongly within the very discourse of feminism, a discourse which presumes upon the unity of its object of inquiry (women) *even* when it is at pains to demonstrate the differences within this admittedly generalizing and imprecise category,” is this odd combination of essentialized women’s unity *and* difference, women in a position of privilege speaking as women for women in such a way that totalizes subjugated women’s experiences, abstracts from particularity, and denies them consciousness, an unavoidable pitfall of feminist activism (Fuss 1989: 2)? Can a science grounded in women’s *identities as gendered* be a sound grounding for a *feminist* science” (Harding 1986: 140). I think the value of women’s health activists’ regulatory epistemology lies not so much in “the question of who,” and the notion that women as

women simply “know” better, but rather in the question of *how* one knows, which types of knowledge are privileged, and why.

Moving from the Woman Question in Regulation to the Regulatory Question in Feminism⁴⁸

Like science in general, regulation involves gathering knowledge about the world, determining what is true, what the problems are, and how best to solve them. The question for feminists is how to develop a regulatory epistemology which does not reproduce the objectifying and dominating qualities of science or regulation as usual. I have tried to show that activists’ claims of “knowing” as women what is best for all women results in a totalization and objectification of diverse women’s needs and experiences not unlike the regulatory system they critique, one that observes women from a population-control perspective, a view from above which aims to govern women’s bodies rather than facilitate their self-determination. Of course regulators must make decisions based on some generalization if they are to accomplish anything at all. I do not wish to argue that no woman’s health activist, no scientist, no one can say anything about anyone—as Mohanty writes, “these arguments are not against generalization as much as they are for careful, historically specific generalizations responsive to complex realities” (2003: 37).

Feminist epistemology as articulated by women’s health activists and feminist theorists points beyond the project of inviting “a few women” to speak on panels, and even beyond claims for an essentially, inherently preferable woman’s standpoint.

⁴⁸ In *The Science Question in Feminism* (1986), Sandra Harding argues that feminist critiques of science go beyond the need to place more women in science, as the “scientific world view, its underlying epistemology, [and] the practices these legitimate” must themselves be fundamentally altered (29).

They call for a shift toward an interested, situated regulation. They helped make transparent the oppressive values and abstraction underlying the risk/benefit analysis of Depo-Provera, demanding that the institutions of contraceptive regulation recognize the politics of their own knowledge. But rather than calling for neutrality, they argue that a more ethical policymaking structure, better able to gather and respond to the “reality” of women’s contraceptive needs, will come from experiential, situated knowledge, bringing together “subjective and objective ways of knowing.”

They do not argue that “biases” or subjectivity represent epistemological weaknesses, but that in fact knowing the position from which someone speaks increases the value of the knowledge and increases the chances that one can formulate a comprehensive and ethical response to the needs expressed. Helen Holmes put this quite well at the Hampshire workshop:

Every individual comes from a particular background, the influence of which she brings into every situation. This background stems from her personal experiences in life that modify the important effects of membership in a particular race, sex, and economic class. *Therefore, for her policy proposals to be meaningful and valid, the listener must know from where she comes. This may not make the stance more true, but it increases its informational value*” (1980: 11, emphasis added).

Women’s (users’) perspectives are privileged not because they represent the essential experience of women but because they throw off the cloak of objectivity and all-encompassing knowledge and offer a view from below, from a *position* in a world whose oppressive qualities and disregard for women’s welfare (some more than others’) are all too often obscured in rhetoric about “free choice” and infinitesimal risk statistics. For “it is not the experiences or the speech that provides the grounds for feminist claims; it is rather the subsequently articulated observations of and theory

about the rest of nature and social relations—observations and theory that start out from, that look at the world from the perspective of, women’s lives” (Harding 1991: 124).

The testimony of Anna Burgess (pressured into using Depo) and Alice Nichols (who loved it so much she was willing to accept the risks of cancer) becomes more generalizable (and theorizable), rather than simply one example of why Depo is essentially beneficial or essentially abusive, when one connects their very different “personal experiences” to their very different social position.⁴⁹ One received Depo from a private doctor, the other could never afford a private doctor, and was dependent upon a welfare system with an enforceable interest in limiting her fertility. Their experiences tell feminist regulators something about how the effects and *meaning* of Depo depend on context, and suggest the types of regulations that would be needed in each.

Regulatory processes would not automatically become more just and responsive to “reality” if representatives of every group of women could appear on a panel before the Subcommittee on Population. However they might be better if a diversity of women were invited to speak, *not* as authoritative representatives of

⁴⁹ The tokenization of testimony in political forums is another dilemma entirely, but I want to point to an interesting intervention into this approach at Senator Kennedy’s 1973 hearing about the sterilization of the Relf sisters. Representatives Yvonne Burke, Cardiss Collins, Shirley Chisholm, and Barbara Jordan wrote him a letter expressing their concern that the young girls would be asked to testify. “We fear that their appearance will encourage sensationalism rather than careful discussion of the complex problems involved...If you proceed along the course presently outlined it will not only be harmful to the children, but unnecessarily threatens the future of all family planning programs and the vital services they provide” (reprinted in House 1973: 1560). Their words were heeded, and the girls gave their statements in private chambers, never appearing before the committee. This intervention is remarkable not just because of these women’s concern about the exploitation of witnesses, but their desire that the problem of sterilization abuse not be blown up such that public family planning was implicated as an inherently harmful institution that should be dismantled. They simultaneously recognized the dangers of family planning services and poor women’s need for them.

“women’s experience” but as situated knowers able to offer information about the world, and able to reveal or contest values accepted as universal or neutral. “As long as representatives of alternative points of view are not included in the community, shared values will not be identified as shaping observation or reasoning” (Longino 1991: 112). Scientific analyses or testimony at Congressional hearings represent more than one subjective opinion or experience, while still less than an absolute, all-knowing perspective on the truth, when one understands the particular context and values grounding their experience and opinions. Women’s health activists pointed out that certain regulators’ evaluation of risks and benefits ceases to be objectively “true” when one understands their grounding in population control values of efficacy or efficiency. And in turn, women’s health activists’ evaluation of Depo becomes more transparent when one understands that their analysis is implicitly and explicitly grounded in a particular set of “women’s (health) values,” and that their conceptualization of ideal, safe, birth control use is connected to a belief that their own experience represents an ideal standard. No actor—neither Malcolm Potts, nor Anna Burgess, nor Norma Swenson—can offer the “truth” about Depo-Provera, but piecing together the world from their partial perspectives moves us toward a more comprehensive understanding of the structural obstacles facing women and the content of “women’s particularity and contradictory interests” (Haraway 1991: 160). “It is only by understanding the contradictions inherent in women’s location within various structures that effective political action and challenges can be devised” (Mohanty 2003: 33).

Women's health activists at their weakest when they imply that as women they can tap into the truth of the female community, but I think at their best when they demand that regulators recognize their own politics and the relevance of any individual's situatedness to his or her interpretation of Depo-Provera. "Feminist objectivity is about limited location and situated knowledge, not about transcendence and splitting of subject and object" (Haraway 1988: 583). Getting more women into the process is an important step toward a feminist regulation insofar as it introduces the notion of the epistemological superiority of speaking from somewhere, but it must be accompanied by a recognition on the part of Congressmen, FDA officials, and women's health activists themselves that there is not a transcendent or totalizing answer to questions of contraceptive need and that a respect for complexity and particularity above all is essential to generating the most ethical contraceptive policies.

In an article describing various groups' constructions of the risks and benefits of the abortion pill—family planning organizations, women's health activists, pharmaceutical companies—Clarke and Montini argue: "by attempting empirically to view the world in the actors' own terms, multiple visions and means of achieving them are highlighted" (1993: 45). Each interest group offers situated knowledge about this contraceptive device which could help construct a fuller understanding of what is at stake for regulators trying to decide whether or not to approve it. "Analyses that represent the full array of situated knowledges" are preferable (ibid). Perhaps if regulatory processes were guided by such a commitment to seeking a variety of partial perspectives, decisions would be more responsive to a complicated social

world rather than women's health activists' or population controllers' construction of that world and women's needs within it. "This notion of knowledge through interactive intersubjectivity idealizes the view from everywhere (perhaps better thought of as *views from many wheres*)" (Longino 1991: 113). Indeed, Cindy Pearson wrote in 1995, "by the late 1980s, the Network's Board was more diverse racially and culturally. Some Board members were from communities where women had either had good experiences with Depo Provera or were generally positive towards injections" (134). This led the organization to reconsider its stance against Depo, and suggests that a diversity of perspectives within "women's" or feminist activism requires activists to shift their politics in recognition of women's experiences which contradict them.

Conclusion

Is this to say that all views and all values are equally valid? As a feminist I am committed to the belief that women's health activists' value of starting from women's lives and needs is preferable to values of social control. Without a passionate political commitment to protecting women's reproductive rights, activists would not have been able to "see" the medical and ethical risks ignored by the FDA advisory committee and many Depo supporters. I also think there is something to be said for the notion that "the user" should have a particularly privileged position in contraceptive policymaking: indeed, evaluating family planning services from "the user perspective," a method championed by Judith Bruce, has become widely accepted (Hardon & Hayes 1997, Bruce 1980). "The experiences and lives of marginalized peoples, as they understand them, provide particularly significant *problems to be*

explained or research agendas” (Harding 1991: 54). Women’s health activists point out that pursuing contraceptive development in the interest of answering the question, “How do we lower fertility rates?” will produce contraceptive “answers” that do not address the structural conditions of unintended pregnancy and may be hazardous both to women’s health and reproductive self-determination. Transforming the “problem to be explained” into women’s terms forces policymakers who conceive of the world (and subjugated groups within it) as objects to be governed to consider needs and experiences expressed “from below.”

I have questioned throughout this work the ability of women’s health activists’ to translate their theoretical and political commitment to defending women’s needs into practice. Perhaps they would be better able to “start from women’s lives” if they overcome the split in solidarity between themselves and the women they protect, if they see themselves not as representatives or protectors of subjugated women, but in solidarity with them. “Epistemologies and politics grounded in solidarities could replace the problematic ones that appeal to essentialized identities, which are, perhaps, spurious” (Harding 1986: 18). As Anita Hardon points out, some activist groups “see users as victims of a state-led medical establishment” who will inevitably be abused, while others “take as a point of departure that women’s interests and needs differ from one setting to another, and that they are best met by making available to women a range of contraceptive options” (2006: 624, 625). Women’s health activism could still be a politically effective movement even as it recognized the limits of its own knowledge and sought solidarity with women they have the political or material means to represent in policymaking.

“The permanent partiality of feminist points of view has consequences for our expectations of forms of political organization and participation. *We do not need a totality in order to work well*” (Haraway 1991: 173, emphasis added).

Conclusion

On the surface, the Depo regulatory debate hinged on a relatively simple question: ban or approve? Yet when one examines the terms on which women's health activists opposed the drug it becomes clear that a great deal more was at stake. Activists did not simply oppose one contraceptive drug, but an entire system of contraceptive technology development and family planning programs in pursuit of the most efficient, effective tool to limit the fertility of women in the U.S. and abroad. Feminists who advocated for birth control as an element of women's self-determination and overall reproductive health felt that the "progressive potential" of contraception was being usurped by the interests of social control, that dangerous drugs and devices were being used to abuse women and reinforce the social inequalities that prevented women from controlling their fertility with safer methods.

Women's health activists demanded a shift in regulatory perspective, urging policymakers to privilege women's health and self-determination over efficacy and ease of distribution in weighing risks and benefits, combating population control values with feminist birth control values. They fiercely contested the notion that some women are less deserving of protection from cancer than others, particularly when those women are least likely to have access to good health care in the first place. They pointed out that one had to consider more than Depo-Provera's "medical" risks, as the provider-controlled injection could and had been given to women without informed consent and even through coercion. When added to the contraceptive cafeteria new drugs can shift power relations, creating previously unconsidered potential for abuse (and use). And finally, women's health activists insisted that the

participation of women (users) be increased at every level of contraceptive research, development, regulation, and distribution such that contraception would respond less to the interests of those in power and more to women who had so long been considered objects, never subjects, of the decisions dictating their contraceptive options.

In essence, they argued that society had a responsibility to create the conditions for women's substantive reproductive choice, not simply invent and market new contraceptive options. Deconstructing medical and state authorities' dominance over (female) patients and encouraging women to learn about and touch their bodies rather than be ashamed and ignorant of them would enhance women's ability to use birth control methods without side effects and reduce the chance that they would be given drugs without any sensitive explanation of the risks. On a broader level, feminists argued that creating economic opportunities for women, and combating poverty, racism and sexism would allow women to pursue their reproductive interests without any "motivation" from family planning programs or drugs like Depo-Provera which require little "motivation" at all. The message is this: Depo-Provera is not the solution to women's lack of control over their reproduction. It represents in itself a whole new problem.

What I have tried to point out in the preceding pages is not that women's health activists were wrong about the oppressive structural biases in contraceptive development or the need for broad social change. Further, I do not want to diminish the significance of their success in delaying the approval of the drug until reasonably good data indicated that the drug did not, in fact, cause breast or cervical cancer. In

this particular case, in the 1970s and 1980s, their opposition to Depo-Provera was an important intervention into a regulatory agency that was prepared to approve a drug without even *addressing* the incidence of cervical cancer in human subjects.

Rather, I have called into question the assumptions about acceptable birth control devices and practice underlying their opposition to Depo, and the limited ability of feminist regulation so grounded to address or even consider how contraceptive technology might meet the needs of a diversity of women even in the face of powerful social structures identified by feminists. Asserting that Depo has only oppressive potential, and that such methods are unnecessary because, ideally, women would use barrier methods with backup abortion, sets a particular privileged standard of birth control use as the only birth control possibility. Women's health activists cannot conceive of how, within a context of constraint, women's use of a drug like Depo—even if it poses some risk, even if their choice is not fully informed or perfectly free (one must of course ask whose choices *are* fully informed and perfectly free)—can be understood as an “acceptable” choice and an act of taking control.

Identifying the structural obstacles to women's substantive choice and control should not preclude the availability of any contraceptive that “fits the social pattern.” Choice is contingent upon more than the expansion of the contraceptive cafeteria, but if available options are inaccessible or ineffective for many women they are left with *no* choice. Regulating in terms of an ideal women's health world cannot address the material needs of women in an imperfect world. Danger and safety, use and abuse: these must be considered not only with a sense of context, but of the contradictory and complex play of interests within that context. On average, the use of a given

contraceptive does not represent either women's fully autonomous pursuit (and achievement) of reproductive control or the malicious social control of vulnerable bodies. Birth control in the U.S. has always occurred at the intersection of social control and reproductive self determination, and feminists should consider women's reproductive needs in terms of this contradictory setting.

Activists approached the Depo regulatory question as though ban or approve were the only options; women's health activists argued even if the drug did not cause cancer, its approval would inevitably lead to abuse. I question why they could not consider approval *with* further regulations on family planning services for better enforcement of patient information practices and checks on coercive practices, improving the conditions for safer and more informed use of *all* contraception. Activists responded to the dangers of sex hormones and sterilization abuse with such measures, rather than calling for a ban on the Pill or an end to publicly funded sterilizations. When activists fought for sterilization regulations, "the question [was] not whether or not specific laws or regulations are in the best interest of women, but, rather, in *which* women's interests and *under what specific circumstances*" (Shapiro, referencing Ruzek, 1977: 152, emphasis added). With an eye to how Depo might have met some women's interests in some circumstances, women's health activists might have turned their regulatory energy toward exposing and combating the oppressive structural biases that produced Depo's potential for abuse in the first place.

Feminist regulation of contraception must be grounded in more than a commitment to "women's best interests" and ensuring that new technologies are truly

birth control, not population control, tools. The pursuit of a diversity of women's best interests requires a willingness to address contradiction, and a great deal of caution when claiming to know, as women, what all women need. Population controllers, government officials, and feminists are all guilty at times of regulating from the "view from above," which pins subjugated groups of women as powerless objects who either need protection or "motivation." Maintaining an awareness of women's consciousness and agency, and seeking to comprehend and respect their interests—which could include forgoing contraception altogether, as *all* women have a right to do, or selecting a method that poses some health risks, which also seems, to me, compatible with "acceptable" birth control practice—will hopefully guide birth control-related decision-making to more progressive ends.

It is worth noting that women's health activists' insistence that family planning center on protecting women's autonomy and overall reproductive health has been taken up globally. Population control is no longer the dominant paradigm (at least not on paper). The UN International Conference on Population and Development in Cairo adopted a commitment to "reproductive health...a state of complete physical, mental and social well-being...in all matters relating to the reproductive system and to its function and processes." Points 7.2 and 7.3 of the Programme of Action are excerpted in Sen & Batliwala 2000:

7.2. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice.

7.3. Reproductive rights...includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (16-17).

The broad conception of reproductive health and choice in which Depo opponents grounded their concerns about Depo's medical risks set the terms for family planning programs worldwide.

Depo-Provera after Approval, the Limits of Contraceptive Technology, and Reproductive Justice

Of course, the question remains: which reproductive technologies should a feminist regulation support, and which should it oppose? Has Depo proven a boon, a scourge, or simply a bust for U.S. (poor) women (of color)? Few actors involved in the Depo-Provera debate foresaw a large American user population, and indeed the methods of the 1970s remain by far the most popular. The most recent data from the Division of Vital Statistics on national contraceptive use indicates that 5.3% of contracepting women use Depo (although nearly 17% have *ever* used it), compared to 30.6% using the pill and 26% female sterilization (the diaphragm, favored by earlier women's health activists, is used by a paltry .2%) (2004). Yet when one looks at the data by age, race, and income, it becomes clear that Depo (called the 3-month injectable below) has a disproportionate influence on certain populations:

- Women in their teens and 20s are more likely to rely on the 3-month injectable than are older women.
- Compared with non-Hispanic white women, Hispanic and black women are less likely to rely on their partner's vasectomy or the pill, and more likely to rely on the 3-month injectable or no method.
- Poor and low-income women are more than twice as likely as higher income women to use the 3-month injectable. (*Guttmacher Fact Sheet*: 2005)
- 24% of black and Hispanic women have *ever* used Depo-Provera, versus 14% of white women; 7.3% of Hispanic women, 9.8% of black women, and 4.3%

of white women who use contraception currently use it (Data from Mosher et al: 2004)

Women's health activists and Upjohn spokesmen alike knew in the 1970s that young, poor, women of color would be the "target population;" the former interpreted this as evidence of a desire to control certain women's fertility, coercively if necessary, while the latter argued that Depo filled a "gap" in the contraceptive cafeteria. It appears that neither the fears of one group nor the hope of another have been fully realized, although both have been borne out to some degree. It is imperative to note that *sterilization* is the leading contraceptive method among black and Hispanic women, which one could argue says just as much about the inequalities of U.S. family planning services as Depo use.

The Major Impact of "Minor" Side Effects on Women's Use of Depo

Although the use of Depo is raced and classed, it is important to note that Depo has been valorized as an important option for *teens*, a demographic really not discussed among the "subgroups" for whom Depo might be appropriate. A 2002 article from the Guttmacher Institute reported that, "by 1995, more than one in eight teen contraceptive users was using a long-acting method [Depo or Norplant, a contraceptive implant], and *primarily because of this shift*, sexually active teens became increasingly successful at avoiding pregnancy" (Boonstra 2002, emphasis added). The titles of two recent family planning articles are illustrative: "A village would be nice but...It takes a long-acting contraceptive to prevent repeat adolescent pregnancies" conclude Stevens-Simon et al (2001), while Kaunitz (2007) declares, "Long-acting hormonal contraceptives-indispensable in preventing teen pregnancy."

Nevertheless, Depo's appeal has its limits. In 1996, a study of Depo continuation rates among 5,178 Planned Parenthood clients in Colorado found that "fifty-seven percent of users returned for their second injection, and only 23% of those eligible for a full year of contraceptive protection (four injections) obtained all four" (Westfall et al: 275). The "minor side effects" dismissed by Depo proponents and pushed aside by opponents in favor of highlighting the "more serious" matter of carcinogenicity are simply unacceptable to most women. A study in New York City found a continuation rate of 42% after twelve months; women discontinuing cited menstrual irregularities (30%) and weight gain (24%) as the most significant reasons (Polaneczky et al 1996: 174). Recall that while 14% of white and 24% of black and Hispanic women have *ever* used Depo (indicating its theoretical appeal), only 3.3% currently use it (indicating its practical problems).

By the year 2000 researchers were moved to ask, "Why Are U.S. Women Not Using Long-Acting Contraceptives?" They concluded that women tend not to choose the long-acting methods, Depo and Norplant, because they: are satisfied with other methods, relying heavily on sterilization and the pill; have never heard of them or have "misconceptions" about them; "are fearful of the side effects of these methods;" and "find the two methods uncomfortable, inconvenient and expensive to use" (Tanfer et al: 191). The authors suggest that women could be "disabused" of their misconceptions and fear of side effects, but they accept that the outlook for widespread use of these methods in the U.S. is not good.

Whereas Depo opponents envisioned powerless women being coerced into receiving injections, it appears that women who do not like the drug simply do not

come back for more. It appears that, so long as severity of side effects and effectiveness are directly related, the contraceptive market will continue to fail women. In a sense, contraceptive developers and regulators do have women's input, as transmitted through data like that cited above. Women's health activists insisted throughout the Depo debate that high-tech contraception will never truly address women's reproductive health or birth control needs. Current trends indicate that innovative education and support is necessary to ensure safe and consistent contraceptive use, whether the device in question is a "messy" diaphragm or seemingly foolproof Depo-Provera. Women are more apt to tolerate side effects when healthcare providers take the time to explain them, although with patient, attentive healthcare women might be better able to use other methods. Naila Kabeer writes of the dilemma on a global scale:

The insensitivity to women's health concerns that characterizes many family-planning programmes probably accounts for persistent reports of unpleasant side effects associated with many contraceptives and which lead to high drop rates...Sporadic use and early discontinuation of contraception does not serve either the narrower objective of fertility reduction or the broader one of reproductive choice (1994: 209-210).

Neither the interests of population control nor birth control advocates are served by the type of reproductive technology that has received the most financial and scientific attention in the last few decades. Thus it is possible to make an argument against the dominance of such methods from a feminist perspective *without* asserting that women are universally powerless in the face of such technologies or even that the health risks and "minor" side effects are necessarily unacceptable.⁵⁰

⁵⁰ Recent studies have suggested a relationship between Depo use and contraction of sexually transmitted infections (STIs), which could be extended to higher susceptibility to HIV. One study in

Women's health activism, international or U.S., has not swayed from its commitment to shifting contraceptive priorities. "A major reorientation of research priorities and process is needed to pursue critical technological gaps: woman-controlled methods that will protect against infection, with or without protection against pregnancy; abortifacients; and male methods" (Germain et al 1994: 36). A large international women's health movement, pushing for many of the same changes in birth control policy as Depo opponents, has done a great deal of work to emphasize women's reproductive health and empowerment in family planning programs. "Their common goal became empowering women to control their own fertility and sexuality with maximal choice and minimal health problems. The movement strongly criticized population programmes' emphasis on the delivery of modern contraceptives...as a means to reduce fertility and the targets used to achieve those aims" (Hardon 1997: 4).

In 1994, in preparation for the impending UN International Conference on Population and Development, a coalition of women's health activists produced a document demanding that the global community: "Develop and provide the widest possible range of appropriate contraceptives to meet women's multiple needs throughout their lives: give priority to the development of women-controlled methods that protect against sexually transmitted infections, as well as pregnancy, in order to redress the current imbalances in contraceptive technology research, development, and delivery" (Women's Voices '94: 640).

Baltimore in 2004 showed that women using Depo-Provera had a threefold increase in chlamydia and gonorrhea infection as compared to women using an oral contraceptive or condom (*Reproductive Health Technologies Project*). As of June 2006, Ibis Reproductive Health and the Reproductive Health Technologies Project concluded that the cause/effect relationship remains unclear and does not justify discontinuing Depo use.

With rising HIV prevalence, particularly among African American women in the US, the need for more and more effective woman-controlled barrier methods has never been more clear. Virtually the *only* method that meets this description introduced since women's health activists started fighting for a reproductive priority shift toward barrier methods is the female condom. Interestingly, there is evidence that cervical caps prevent STI transmission, but most excitement has been generated around microbicides, chemical foams or gels which, unlike spermicides, could kill viruses and bacteria. This invisible method, potentially more convenient than cervical caps or diaphragms, has a great deal of potential to protect women whose partners do not want to use condoms, and who are not protected by hormonal methods. The NWHN cites one of its major initiatives as "advocating for microbicide research and development to give women the tools they need to protect themselves from HIV/AIDS and other STIs."

Long-Acting Contraception and Social Control

In terms of the implication of Depo-Provera in programs of social control, a recent article is illuminating:

SANTA FE -- A measure to mandate contraception [long-acting methods like Depo] for women who give birth to two drug- or alcohol-addicted babies failed to pass the [New Mexico] Senate on Friday... Sen. Rod Adair, R-Roswell, called the bill "too modest." Adair is carrying a bill that calls for mandatory sterilization of a woman following the birth of a second drug- or alcohol addicted baby (Guzman 2007).

This news item from March 2007 echoes attempts made throughout the 1990s not simply to push long-acting contraception on certain women, but *legally mandate* fertility control for welfare mothers or women convicted of drug abuse. While available on the market from 1991 to 2000, Norplant was usually the method of

choice for such initiatives. A mere two days after Norplant approval *The Philadelphia Inquirer* wrote an editorial entitled, "Poverty and Norplant--Can Contraception Reduce the Underclass?," suggesting that women on welfare be given incentives to receive the implant. Also in 1991, a California judge "imposed implantation with Norplant in lieu of a lengthy prison sentence" for a woman convicted of child abuse (Moskowitz & Jennings: vii). While the effects of Depo last only three months, Norplant remains effective for five years and can only be removed by a nurse or doctor with local anesthesia. Thus the contraceptive has even greater appeal for those interested in near-perfect long term effectiveness, and an even greater potential for abuse in that women must be able to find someone willing to remove the drug *and* be able to afford the removal.⁵¹ "Within two years [of approval] thirteen state legislatures had proposed some twenty measures to implant poor women with Norplant," writes Dorothy Roberts, a black feminist legal scholar who has written extensively on this topic. "A number of these bills would pressure women on welfare to use the device either by offering them a financial bonus or by requiring implantation as a condition of receiving benefits" (1997: 109).

Fortunately none of these bills ever passed. Norplant was actually removed from the market in 2000 after a series of lawsuits over its side effects, as well as concerns that women had difficulty finding healthcare providers willing to remove the implants. Yet initiatives like CRACK (Children Requiring a Caring Kommunity) continue to offer financial incentives to drug-addicted women. "Last year, Patricia McBride, a 41-year-old mother of seven who lost custody of her children because of

⁵¹ Like Depo, Norplant is much more widely used abroad, and there is a great deal of international feminist literature documenting its unethical distribution and troubling side effects.

her drug and alcohol addiction, applied to CRACK to receive Depo-Provera, a bimonthly [sic] contraceptive shot. As long as she continues to take it, she'll receive \$200 a year" (Costello 2003). The idea that certain women do not have the right to reproduce remains as potent today as it did in the 1970s, although it may not be as pervasive in domestic and international family planning programs as it once was. Feminists must continue to combat beliefs that the regulation of women's reproductive capabilities is the key to ending poverty or reducing crime. As Depo opponents pointed out, there is not a direct cause-effect relationship between reducing fertility and the improvement of women's economic and social status; the correlation works just as often in the reverse.

Some feminist academics and activists take the ugly history of Depo to argue that all uses of the drug indicate abuse, point to the demographics of Depo use as direct evidence of discrimination, and conflate *subsidizing* the cost of methods like Depo for poor women with *pushing* Depo on poor women and even *forcing* Depo on poor women. The Committee on Women, Population and the Environment, a multi-racial feminist alliance based in Atlanta currently conducting a "Depo Diaries" project to collect women's (negative) experiences with the drug, have this to say on their website:

The gender, race, and class inequalities of society are implicit in ways the distribution of contraceptives target specific populations. For example, Depo-Provera... has been tested and used on predominantly women of color and poor women. A study [from 1994] of Depo-Provera users in the United States found 84 percent were black women and 74 percent were low income. Some of the side effects of Depo Provera include, but are not limited to severe depression, breast cancer, cervical cancer, higher HIV/AIDS susceptibility, excessive bleeding, weight change, and osteoporosis. Depo is mass marketed to clinics and doctors as efficient in cost, without measuring the risks to women.

The CWPE is quite right to point out the racial and class politics of birth control in the U.S.; there is little doubt that public family planning policy has pushed long-acting methods in neighborhoods with people of color or the poor—Depo “mushrooming” like the b.c. clinics in Toni Cade’s words. But the one to one relationship between “targeting” and abuse leaves questions about the contraceptive needs of poor women of color. A qualitative study of three communities of “the South within the North’: women of colour, poor, migrants, and immigrants women of all races, indigenous women, or women trapped in pockets of time in places such as Appalachia or the Deep South” found that these women disproportionately chose sterilization and long-acting contraception (Forte & Judd 1998:256). The authors conclude that although “this reflects the attitudes and biases of medical providers in poor communities...it also reflects the women’s decision to be free of the burdens of pregnancy and childrearing, one which they find profoundly liberating” (290).

However groups pursuing what Native American activist Andrea Smith calls “a woman of color reproductive justice agenda” question the use of methods like Depo and Norplant as part of a larger critique of the old idea that fighting fertility, through women’s bodies, is best for society. Activists continue to argue that a just society will be just as committed to improving the overall health and material conditions of women of color as it is to providing effective birth control rife with side effects (2005: 103). Disproportionate use of methods like Depo and sterilization among certain groups in the U.S.reflects the continuing inequalities in access to health care and abortion, good sex education, and women’s control over their bodies, which, as women’s health activists said in the 1970s and continue to argue, will never

be (fully) resolved by any contraceptive technology. Such social policies will allow women to control their own reproduction on their own terms. “The potential of modern birth-control technology will only be realized if sexual equality, social justice, and reproductive freedom become integral parts of a sweeping movement for social change so that people, especially women, are not manipulated by those who control the technology, but guide their own destiny” (Shapiro 1985: 195). My only addendum is that the use of technology like Depo-Provera can be part of that “sweeping movement” insofar as, in the words of Toni Cade, “gives her choice, gives her control over at least some of the major events in her life.”

Epilogue: Of Science, Ideology, and a Black Box

Following the FDA approval of Depo-Provera in 1992, the drug was embraced by family planning clinics all over the United States. In some states, Depo was subsidized to make it more affordable or even free to low-income women and teens. Though fears about the drug's carcinogenicity had been more or less put to rest, leading the FDA to declare the drug safe not simply for "certain populations," but for all women, scientists continued to quietly analyze four decades of data on the drug's long-term effects in millions of women worldwide.

Then, on November 14, 2002, the FDA announced that it would be adding a "black box" warning to the drug's labeling. "Black box warnings are designed to highlight special problems, particularly those that are serious, and to give health care professionals a clear understanding of a potential medical complication associated with a drug" (*FDA Talk Paper*). Pfizer, which acquired Upjohn in the 1990s, cooperated in this initiative and agreed to the label change. This is the most stringent warning a drug can carry without being taken off the market. The decision was made in response to scientific studies confirming a health risk that hardly registered⁵² in the debates about health risks of the preceding decades: "prolonged use of the drug may result in significant loss of bone density, and...the loss is greater the longer the drug is administered" (*ibid*). The Pfizer warning label explains the implications of this risk in crystal clear words:

⁵² The Public Board of Inquiry briefly addressed "the question of the influence of MPA on bone and on plasma lipoproteins," although this issue was "not specifically addressed in the questions, by the Commissioner" (Weisz et al 1984: 7). They found that Depo use "could result in diminished bone mass and an increased predisposition to osteoporosis in susceptible individuals...The data available is, however, insufficient to provide the definitive evidence needed to resolve this issue" (153).

Use of Depo-Provera...may cause you to lose calcium stored in your bones. The longer you use Depo-Provera...the more calcium you are likely to lose. The calcium may not return completely once you stop using Depo...Loss of calcium may cause weak, porous bones (osteoporosis) that could increase the risk that your bones might break...You should use Depo-Provera...long term (for example, more than two years) only if other methods of birth control are not right for you (Pfizer).

Once again, Depo became a method of last-resort, although rather than women being “unwilling or unable” to use other methods, now the methods that are “not right for her.” Given women’s susceptibility to osteoporosis, this side effect is significant. It is not clear how dramatic an effect the warning, which is communicated both to healthcare practitioners and directly to patients through the patient information sheet, has had on Depo use.⁵³

The severity of the warning could be interpreted as an indication of the FDA’s commitment to privileging women’s health over contraceptive efficacy. Thus the comment on the website of the NWHN, probably the most influential organization opposing Depo in the debates discussed in this thesis, comes as somewhat of a surprise, and is worth citing at length:

We are also pleased that there is finally an FDA requirement that women get information about the negative effect of Depo-Provera on BMD [bone mineral density]. But even while affirming the importance of communicating this information to women, the NWHN shares the concerns of other reproductive rights advocates about the FDA’s motivation for taking this action. Unfortunately, the FDA’s recent track record of manipulating and suppressing scientific data for political ends and the Bush administration’s track record of attacks on family planning cannot help but raise questions about what is behind this label change. In particular, reproductive health advocates have questioned the decision to use a black box warning – FDA’s most severe label

⁵³ As of March 2007, over one hundred Depo users were filing a class action lawsuit against Pfizer. “Some plaintiffs claim that their bones have shattered while undertaking activities as routine as stepping off a curb. What’s more, plaintiffs claim the manufacturer has long known about the problem...The plaintiffs seek compensatory damages for present and future physical, emotional and economic injuries, punitive damages, related fees and costs and, in some cases, medical monitoring” (Toutant 2007) Women’s health activists do not seem to be involved in the case.

warning – which is commonly although not exclusively, used for life threatening conditions. Is it a genuine effort to protect women's health by sharing new scientific evidence? Or is it a politically motivated attack on contraception, using science as a smokescreen for an anti-choice agenda?

This is the same organization that maintained a registry for Depo “victims,” and attempted to organize a class-action lawsuit against Upjohn in their name. The assertion that the warning was “politically motivated” rather than scientifically founded is particularly jarring when one recalls the testimony of Sybill Shainwald on behalf of the NWHN in 1987. “While the manufacturer has always contended that the failure to approve Depo was political, one cannot ignore the testimony of twenty-two independent scientists that the drug was unsafe and that the development of cancer in test animals could not be dismissed as irrelevant to women” (House: 162).

This response may in part reflect women’s health advocates’ tempered opposition to Depo, as a decade of approved use has demonstrated that the drug does not have only negative effects on women’s reproductive rights. However, it seems more likely that it is tied to fears that under the conservative Bush administration, birth control advocates no longer face population control interests as the most pernicious influence in contraceptive regulation, but those who wish to limit the use of *any* contraception. This new battle, which raises interesting questions about how best to advocate for women’s best interests in a new political climate, reached its zenith in the conflict over approving Plan B for over-the-counter use.

When Ideology Trumps Science: the Taboo against Interested Regulation

Like Depo-Provera, Plan B, (the brand name for the morning-after pill), is progesterone based. Taken up to five days after unprotected sex (preferably within seventy-two hours), the two pills may prevent ovulation, fertilization or implantation

of a fertilized egg in the uterus. Plan B has been available by prescription for some time, but this cuts off women without access to healthcare or teenagers afraid or unable to seek such services on their own. Thus three years ago Barr Pharmaceuticals began lobbying for the drug's approval for over-the-counter (OTC) status, asserting that the drug is safe enough not to require a physician's consultation, which prompted a maelstrom of controversy and political division along party lines. Reproductive rights groups and Democrats argued that the drug would help reduce unwanted pregnancy, *and* abortion. Religious conservative groups and Republicans argued that it would encourage promiscuity and, in cases where Plan B prevented implantation of a fertilized egg, was itself a form of abortion.

Caught in the middle, the FDA repeatedly delayed making a decision, despite the conviction of its advisory committees that the drug was perfectly safe, prompting Democrats to put a legislative hold on the appointment of a new FDA commissioner. Senators Clinton and Murray "refused to let Dr. von Eschenbach's nomination as commissioner advance without a Plan B decision" (Harris 2006). Finally, in August 2006 the FDA approved OTC status for women over eighteen, which fully pleased no one but allowed the new commissioner to take his place and the FDA off the hot seat. "I cannot recall any other issue in my 45 years of watching F.D.A. that has garnered this much attention at all levels of government," said one former agency official (quoted in Harris 2006).

What I find most interesting about this debate is the way in which supporters of approval framed the FDA's waffling as a matter of "ideology trumping science." They pointed out that no scientific evidence indicated the drug's danger as an OTC

and that therefore an agency committed to making decision based on science had no choice but to approve it. “We all know what’s going on here. It is the disregard of science for ideological concerns,” stated Senator Tom Harkin (Pierce 2006). The *Minneapolis Star Tribune* editorialized, “From a medical standpoint there is no reason to keep Plan B from any young woman...so why limit this safe and efficacious drug at all? What’s left is moral meddling” (2006). Susan B. Wood, a commissioner for women’s health at the FDA, and now a board member of the NWHN, resigned in 2005 because “I can no longer serve as staff when scientific and clinical evidence, fully evaluated and recommended for approval by the professional staff here, has been overruled” (cited by NWHN). “The scientific and medical evidence was ignored...Also, the decision was clearly not in the best interest of women and families” (Business Wire 2006).

The similarities between the accusations leveled at the FDA by Plan B and Depo supporters are startling. In both instances the FDA chose not to accept the advice of its expert advisory committee; in the case of Depo this was due to “Congressional and consumerist concerns,” (and, one hopes, the evidence that Depo caused cervical cancer) and in the more recent case officials cited concerns about young girls’ ability to use the drug properly and the difficulty of regulating an age limit.⁵⁴ In both instances drug supporters lambasted the agency for ignoring experts in favor of political concerns and interest groups, maintaining a strong rhetorical distinction between Science (good) and Ideology/Politics (bad). The difference is that in the 1970s the meddling “interest groups” were feminist and consumerist; today

⁵⁴ Although Plan B packaging instructs the user to take one pill, then the next twelve hours later, many clinics simply tell patients to take them together; it works just as well and eliminates the chance of forgetting. One imagines that a thirteen year-old could handle this regimen.

they are religious conservatives. How is it that delayed approval of Depo in the 1970s was a triumph of women's health activism, while the assignment of a "black box" warning to the drug in response to a significant health risk reflects "the FDA's recent track record of manipulating and suppressing scientific data for political ends," a record for which the Plan B controversy has become almost metonymic (NWHN)? Did Susan Wood resign because political ideology in the FDA overruled science, or "the best interest of women and families"? Is science sans ideology in the best interest of women?

Throughout this thesis, though I took a critical stance toward some of the theoretical foundations of activists' opposition to Depo, I tried to indicate, particularly in the last chapter, that an interested, situated regulation is a worthwhile and necessary feminist project. Is the idea of an utterly objective, disinterested regulation even appealing? Susan Wood's commitment to the idea that FDA decisions should be in the best interest of women is itself political. She, like feminist regulators before her, recognizes that a "default" regulation will either disregard or make decisions counter to women's interests. I would like to think that, when women's health or reproductive rights activists insist on science over ideology, it is not because they advocate for or believe in the epistemological and ethical superiority of a regulatory view from nowhere, but because they recognize the power of a science whose questions, methodologies, and analyses begin and end with respect for a diversity of women and their needs. In theory, a commitment to these principles would produce the best risk/benefit analysis for any contraceptive.

I do not believe that Depo opponents' analysis was flawed for being too political any more than I believe the FDA advisory committee' determination of Plan B's safety was correct for being perfectly scientific.⁵⁵ Insofar as a commitment to women's rights, including the right to reproductive self-determination and health, is a value guiding the evaluation of reproductive technologies, I believe that regulatory science will be better. In this thesis I have suggested that women's health activists' expression of that commitment in working toward a Depo ban was problematic and would perhaps be more so if applied in other contexts, but I believe closer attention to particularity and complexity would ameliorate the project. Attributing Plan B approval to the triumph of science, and Depo's black-box warning to the manipulation and suppression of science leaves women's health advocates vulnerable to precisely the same accusations leveled at them in the 1970s and 1980s and risks reinscribing the divisions between feminist value and contraceptive development and regulation that led to Dalkon Shield deaths. Even if the science/ideology dualism is merely rhetorical, the fact that in 2007 as in 1974 activists and public figures tear one another apart on the grounds that their politics obscure truth reflects the tenacious hold of the ideal of disinterested science on our society. Given the continuing pervasiveness of sexism, racism, and hostility to the poor, particularly in the realm of fertility regulation, intervention in the name of multiply disempowered women will be a greater corrective than neutrality.

⁵⁵ The influence of pharmaceutical money on "scientific expertise" raises serious questions about the interests underlying advisory committee decisions. In an encouraging recent development, on March 21, 2007, the FDA announced that, "Expert advisers to the government who receive money from a drug or device maker would be barred for the first time from voting on whether to approve that company's products" (Harris).

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