

**DEPO-PROVERA AND THE REGULATION OF
INDIGENOUS WOMEN'S REPRODUCTION**

by

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ABSTRACT

This thesis examines the role of socioeconomic, political and historical factors that contribute to the regulation of young Indigenous women's reproduction through the prescribing of Depo-Provera. This study utilizes critical perspectives and qualitative analysis to focus on the intersection of neoliberalism and risk discourse at the site of contraceptive prescription. Based on a critical discursive analysis of several texts, this research illustrates how dominant discourses reflect colonial relations and neoliberal ideals in framing the characteristics of Depo-Provera users. I show that texts aimed at Third World women and/or "sexually at risk" women living in "confounding life situations" seek to control their reproduction with (health) provider-controlled contraceptives such as Depo-Provera. The analysis reveals the ways in which international and Canadian texts construct the identity of young Indigenous women as a risk population in need of reproductive regulation.

Keywords: Indigenous women; reproductive regulation; depo-provera; colonial knowledge; risk

Subject Terms: Birth control -- Political aspects; Reproductive technology; Population policy

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Chapter One: Introduction

Introduction to the study

This thesis is an exploratory study of discourses and practices focused on the regulation of Indigenous women's reproduction through the prescribing of depo-provera in Canada. Although discourses about reproduction do not determine how Indigenous women respond to and regulate their reproduction (through contraceptive choice), they do provide morally-laden meanings that constrain Indigenous women's possibilities. Additionally, discourses influence practices and policies that address assumed and actual problems of reproduction, and they suggest norms through which Indigenous women can judge themselves and be perceived by others.

Since 1967, millions of women in more than 90 countries around the world have used depo-provera or DMPA as a form of birth control (Bunkle, 1993).¹ As a type of contraceptive that is injected once every three months, depo-provera has a reputation of being highly effective, with a low failure rate of less than 0.3% per year (Littlecrow-Russell, 2000). It consists of regular shots of progestin that inhibit the creation of estrogen, regulate menstruation and block ovulation for up to 12 weeks. Some groups, however, have called into question the research and marketing of depo-provera and, in particular, the way discourses have defined marginalized women as primary target groups for its use. Very little research, nonetheless, has examined the process by which discourses and practices target Indigenous women.

This thesis contributes to literature on the discursive shaping of Indigenous women and reproductive regulation, and draws on Indigenous feminist/decolonizing theoretical perspectives

¹ The Upjohn Company developed depo-provera in the later 1950s as a treatment for endometriosis and for threatened or habitual miscarriage. While unsuccessful for the later purpose, women given the drug experienced a delayed return of menstruation and fertility. Almost inadvertently, the Company had produced a new type of contraceptive with an effectiveness equal to the pill (Kaufert, 1990: 124).

to examine the influence of the intersections of science, medical and health discourse and the constructions of Indigenous peoples as an ‘at risk’ group. By examining documents that are relevant to depo-provera use, this thesis explores racialized discourses that separate colonial processes and the marginalization of Indigenous women from mainstream healthcare through the construction of the discredited subject and that intersect with neoliberal rationalities to powerfully frame the characteristics of depo-provera users.

Borrowing from Phillips and Hardy (2002) and van Dijk’s (2001) definition of critical discourse analysis (CDA) as an approach to social analysis that is grounded in the researcher’s intention of unveiling power structures and revealing social inequalities, I show how Indigenous feminist and decolonizing theoretical perspectives can inform discursive examinations of the construction of Indigenous women as depo-provera users. Fairclough defines “[d]iscourses, as a form of social action enacted primarily through texts and narratives [that] provide parameters for what can be known, said and thought in specific places and historical contexts” (as cited in Rudman, 2006: 184). I use CDA to move away from a focus on Indigenous women’s experiences with Depo-Provera as the principal unit of analysis and consider Indigenous women within broader social historical contexts that construct women as sexually ‘at risk’ and maintain practices of reproductive regulation.

This thesis presents the results of a critical discourse analysis of 5 texts. The texts represent differing genres and are produced by the Alan Guttmacher Institute (AGI), Society of Obstetricians and Gynaecologists of Canada (SOGC), Pfizer, Vancouver/Richmond Health Board, and Health Canada. These texts were chosen because they provide an authoritative framework through which women ‘at risk’ are constructed. Together these texts illustrate how dominant discourses reflect colonial relations and neoliberal ideals in framing the characteristics of Depo-Provera users. I show that texts aimed at Third World women and/or “sexually at risk” women living in “confounding life situations” seek to control their reproduction with (health)

provider-controlled contraceptives such as Depo-Provera. The analysis reveals the ways in which international and Canadian texts construct the identity of young Indigenous women as a risk population in need of reproductive regulation.

Research questions

To explore discourses focused on the regulation of Indigenous women's reproduction through the prescribing of depo-provera, I ask the following questions in this thesis: (i) How do contemporary medical documents construct Indigenous women as depo-provera users and why? and (ii) How does this construction correspond with the socio-political and ideological framework of regulating Indigenous women's reproduction?

Limitations

There are several limitations in this thesis. Although this thesis is limited to the study of uncovering governing discourses and practices that impact the everyday reproductive experiences of Indigenous women, I do not argue that the power to define reproduction is one directional. To portray Indigenous women as passive victims of dominant ideologies would perpetuate long-standing portrayals of Indigenous women as silent and lacking in agency. I do not examine, for example, the ways that Indigenous women actively incorporate, resist or revise reproductive technologies in their lives.

Secondly, while my interest is in examining depo-provera use with Indigenous (including status, non status, Metis, and Inuit) women generally, the data available limits this study to an exploratory discussion of status Indigenous women on reserve and Inuit women². Thirdly, the limitations of documentary analysis include, but are not limited to, the absence of the voices of both health care providers and Indigenous women. These documents do not provide an indication

² I rely, for example, on studies of status women on reserve (Fiske & Browne, 2006; Browne & Fiske, 2001; Browne & Smye, 2002; Jasen, 1997; Health Canada, 2005) as well as Inuit women (Jasen, 1997; Kaufert & O'Neil, 1990).

of how many providers utilize the specified guidelines. Also, because the documents refer to guidelines they leave out the practice of implementing Depo. The experience of clinical practice is not considered. These documents are transmitting knowledge. It is important to look at them but they do not provide the whole picture.

Outline of chapters

In Chapter two I begin this study with an overview of the historical development of depo-provera both internationally and within Canada. I then review medical literature and examine its narrow individualistic focus. I then turn to feminist literature on depo-provera that challenges the micro level of medical analysis and advocates an analysis of depo-provera inclusive of the social and political context. Feminist concerns with depo-provera focus on: socially constrained and (state) mediated contraceptive choices for socially disadvantaged groups; the application of depo-provera in family planning programs where poverty is perceived as an outcome of rapid population growth (also referred to as the ‘population problem’); and depo-provera as a provider-controlled contraceptive that decreases reproductive autonomy and reinforces power imbalances between health care providers and women

In Chapter three I discuss theoretical perspectives that inform my study. I begin by discussing literature focussed on decolonizing science, medical, and health discourse. I then focus on literature that considers how decontextualized practices and discourses construct Indigenous women as discredited medical subjects. Lastly, I discuss theoretical issues in Indigenous women’s reproduction. The work of researchers presented here make important connections between historical colonization and present-day practices of surveillance and regulation of Indigenous women’s reproduction.

Chapter four discusses the methodological considerations that frame this study. I discuss why I use critical discourse analysis in my study to examine how discourse constrains what can

be known, said and thought and how these influence the construction of subjectivities. I also indicate how I use this method to analyze the documents in this study.

In Chapter five, I apply Linda Tuhiwai Smith's (1999) concept of decolonization to medical and health discourses and illustrate how the presence of racialized, discrediting, and decontextualized discourses in 5 texts. In my analysis I show that texts aimed at Third World women and/or "sexually at risk" women living in "confounding life situations" seek to control their reproduction with (health) provider-controlled contraceptives such as depo-provera. I argue that these 5 texts draw on colonial assumptions and neoliberal rationalities in framing the characteristics of depo-provera use.

Lastly, in Chapter six I provide a concluding discussion of my analysis.

Chapter Two: Historical Context of Depo-Provera

Introduction

In this chapter, I provide an overview of the historical development of the approval and distribution of the contraceptive depo-provera, which has targeted particularly young women in the third world and in marginalized communities in the first world. In discussing the medical literature that followed the approval of depo-provera in the United States and Canada, I show how it focuses primarily on the individual problems associated with women's use of depo-provera. I contrast this literature with feminist research that argues for understanding women's reproductive health within a social, political, economic and cultural context.

Historical context of depo-provera

The history of the contraceptive depo-provera and its diffusion throughout the world is characterized by conflict and controversy. Introduced by the American pharmaceutical company Upjohn during the early 1960s, depo-provera was subject to a series of safety trials before the American Food and Drug Administration (FDA) considered it for approval. When the trials resulted in breast cancer and breast nodules in test animals, the FDA denied or "heavily restricted" Upjohn's application to market Depo as a contraceptive within the U.S. (Bunkle, 1993; Smith, 2002). According to Bunkle (1993), Upjohn's struggle with the FDA initiated a divide between who was acceptable and who was not acceptable for use of this contraceptive. FDA's rejection of Depo clearly revealed that American women, and therefore first world women, were not an acceptable market. As a result, Upjohn Corporation turned to the contraceptive markets in the Third World (Mexico, Sri Lanka, Jamaica, Thailand) and began targeting marginalized women within the first world as possible users of depo-provera. Bunkle notes that populations of

women – in the first world but reflecting third world stereotypes - used depo-provera. These included Aboriginal women in Australia, Maori women in New Zealand, and West Indian and Asian women in Britain (Bunkle). Further, in the U.S. before FDA approval of depo-provera in 1992, agencies routinely provided Native women with depo-provera as a form of birth control (Ralstin-Lewis, 2005; Smith, 2002; Smith, 2003). These examples support claims that policies and practices targeted third world women and marginalized women in the first world to use depo-provera.

In Canada, before the Department of Health and Welfare approved general use of depo-provera in 1997, health care workers provided depo-provera to Indigenous women, under very restricted guidelines. Studies suggest that doctors during this time prescribed depo-provera routinely to “Aboriginal women, women with disabilities, teenagers, women of colour, women living in poverty, and substance abuse users” (Canadian Woman Studies, 1995: 161). In addition, Sarkadi (1995) found that in the early 1990s, health workers commonly prescribed depo-provera to Inuit women in the North West Territories as the “first-choice option for contraception” (23).

In North America in the 1990s, depo-provera policy shifted from “heavily restricted” use and from agency provision that disproportionately made it available to marginalized women to general approval. Several factors contributed to US and Canadian approval of depo-provera use as a contraceptive. First, in 1987, the American FDA modified its regulations and began to require cancer testing in rats and mice instead of dogs and monkeys. These new studies found that depo-provera did not cause cancer in rats and mice (Smith, 2002). Second, in 1991, the World Health Organization declared depo-provera safe as a contraceptive; this decision emerged from studies conducted in three countries where they concluded that, after nine years of use, depo-provera did not result in increased risk of breast cancer (Smith, 2002). And finally, and perhaps most importantly, the Upjohn Corporation funded most research on depo-provera. As a result the Upjohn Corporation simultaneously constructed and controlled knowledge of this

contraceptive (Bunkle, 1993; Smith, 2002). Following these shifts, the American FDA approved depo-provera in 1992 and Health Canada approved its use in 1997. Interestingly, despite the American and Canadian approval of depo-provera for the general contraceptive market, research suggests that racialized and/or Indigenous women continued disproportionately to use depo-provera (Littlecrow-Russell, 2000; Hawaleshika, 2005; Smith, 2002; Smith, 2003; Ralstin-Lewis, 2005).

Most Canadian research fails to reveal the racialized characteristics of depo-provera users. Studies indicate that 2% of Canadian women prescribed birth control use depo-provera (Black, O'Grady & Pymar, 2004), which makes it the 5th most popular contraceptive in Canada and that between 1997 and 2003 women's use of depo-provera doubled; in 2003 alone 625 000 prescriptions were filled (Wershler, 2004; Hawaleshika, 2005). Studies indicate that most depo-provera users in Canada are young women in their teens and 20s (Wershler, 2004; Hampton & Mc Watters, 2003; Hampton, Jeffrey, McWatters, 2000) with one study reporting an average age of 19 years at first injection (Hampton et al.). Research suggests that many young women who use depo-provera have had a previous history of pregnancies/and or abortions (Boroditsky, 1999; Hampton et al), are "involved in high risk sexual behaviour and are at significant risk of compromising their sexual and reproductive health"; as well, they consume cigarettes, alcohol, and marijuana (Boroditsky, 1999: 96). Most of this Canadian research has focused on the use of depo-provera by young women. It has not taken into consideration issues of race and class. These Canadian studies contrast with previous research on the use of depo-provera before it gained approval for use as well as literature outside of Canada that recognizes the disproportionate use of depo-provera among marginalized, poor, and racialized women.

On the surface, these Canadian studies seem to contradict research in the U.S., which identifies women of colour as disproportionately prescribed depo-provera. Littlecrow-Russell's (2000) work in the U.S., for example, indicates that eight years after depo-provera's introduction

into the American general contraceptive market most women who utilize depo-provera continue to be poor, working-class, and women of colour who receive health care from federally funded clinics where depo-provera is distributed on a 'two for one' basis. While Canadian literature on depo-provera discusses the demographics of users free of racialized considerations, such analysis does not mean that disparities along racialized lines do not exist among those who use this contraceptive. Absent from this research is an analysis of depo-provera use that considers the intersections of race, class and gender. For instance, this Canadian literature has failed to examine the use of depo-provera in Indigenous communities (Hawaleshika, 2005). The lack of research and insufficient monitoring of Canadian provision of depo-provera to Indigenous women has led to the difficulty in knowing the exact numbers who use depo-provera. Suggested estimates of Indigenous women on depo-provera range from 10 to 20 percent of those utilizing contraception (Hawaleshika, 2005). Only a few studies have mentioned the use of depo-provera as a popular contraceptive method in Indigenous communities but where the use of depo-provera has been mentioned it has been peripheral to the research. For example, Archibald (2004) and Anderson (2002) conducted studies with small sample sizes within specific urban communities and did not aim to generalize to the larger Indigenous population in Canada. Nonetheless, these studies do provide some interesting information that is important to note where the use of depo-provera is concerned and especially in its positioning with other contraceptive choices. In Archibald's study on Inuit youth she reports that among contraceptive choice, condoms rank first, followed by the pill then depo-provera. Similarly, In Anderson's study, she found that of youth who used birth control, 57% identified condoms as their first contraceptive of choice, followed by the pill (27%), followed by depo-provera (7%).

Continuing this trend of depo-provera uptake by Indigenous women as peripheral to research is Hampton and McWatters' (2003) work on the process of depo-provera use in Regina. In their study they conducted interviews with 11 Caucasian and 3 First Nations women who have

used depo-provera. Although their study does not specifically focus on the differential experiences Caucasian women and First Nations women have had with depo-provera and health care providers their work does provide some important insights into this dynamic. Hampton and McWatters note that where Caucasian women were interested in using depo-provera to delay pregnancy and pursue higher education the First Nations women (2 of the 3 interviewed were teen mothers), in comparison, were coerced or pressured into receiving their first injection in the hospital, with no informed consent. One young First Nations woman states:

Oh yeah, they shot me with [depo-provera] before I left the hospital because I have four kids, so everyone was like, "I'll give you some of this." After they gave me this shot, I looked at the side effects and said, "Oh no!" Because it had a lot of side effects. (Hampton and McWatters, 2003: 200)

While Canadian research has not systematically indicated the extent to which agencies or health workers provide depo-provera prescriptions to racialized and/or Indigenous women, studies suggest that, as in the past before the Department of Health and Welfare's approval of depo-provera, such women are likely to be significant users of depo-provera. The absence of research on the extent to which marginalized women use depo-provera suggests that the health care community may be overlooking the ways in which they may be targeting Indigenous young women and the reasons why.

Medical literature on depo-provera

In Canada, medical literature focusing on depo-provera does not address the disproportionate prescribing of depo-provera to vulnerable and marginalized young women. Instead, this literature attends to 'individual patient care issues' (Kaufert, 1990: 122), which include a preoccupation with the high rates of discontinuation in young women's use of depo-provera (Hampton, Jeffrey & McWatters, 2000).

Hampton and McWatters (2003) found that young women chose depo-provera as a contraceptive because of its convenience and effectiveness and their dissatisfaction with other

contraceptives and effectiveness. Despite the fact that proponents of depo-provera highlight its convenience as an attractive feature for adolescents, discontinuation rates are high. The manufacturer's website stresses the convenience of depo-provera as an important marketing feature with slogans like "Concentrate on your life. Not your birth control," and "Depo-Provera. Freedom from the everyday" (Pfizer). However, when discontinuation rates are taken into consideration it becomes apparent that depo-provera is not as carefree as these claims suggests. Studies report variable rates of women discontinuing depo-provera use from 23% to 75% by the end of the first year (Hampton, O'Grady & McWatters, 2000; Hampton, & McWatters, 2003; Oliver & Dukhanova, 2005; Boroditsky, 1999). Young women generally cite depo-provera's multiple side effects as the main reasons for discontinuing use; primary among these side effects are menstrual cycle disturbance and weight gain (Black, Francoeur & Pymar, 2004). Medical studies indicate that "Almost all women using DMPA will experience spotting and irregular or prolonged bleeding particularly during the first few months of use. Most teens consider this unacceptable" (Boroditsky, 1999: 97). Irregular spotting and prolonged bleeding are replaced with amenorrhea in 50% of women using depo-provera after the first year of use (Boroditsky; Black et al.). Studies have indicated that 56% of women have gained weight on depo-provera at an average of 4 to 5 pounds per year (Black et al., 2004). According to Boroditsky (1999), due to weight gain or increased appetite, up to 50% of young women using depo-provera discontinue this method.

In addressing the high rate of discontinuity, health care providers advocate 'structured' counselling to women to sustain their use of depo-provera (Hampton et al, 2000; Boroditsky, 1999; Littlecrow-Russell, 2000; Black, O'Grady & Pymar, 2004). Hampton et al. argue that health care provider pre-counselling may contribute to sustained depo-provera use and recommends pre-counselling as a method to achieve compliance among young depo-provera users. Follow-up counselling is also recommended during the return appointments. Health care

providers [HCPs] are encouraged to build a rapport with young depo-provera users so that young women on DMPA can be managed and so that compliance can be enforced (Boroditsky, 1999). Follow-up visits also provide an opportunity for the management of side effects, the correction of misinformation, and the assessment of young women's satisfaction with depo-provera (Black, O'Grady & Pymar, 2004; Hampton & McWatters, 2003).

This micro medical literature locates the problem of 'consumer' discontinuation of depo-provera in the need for health care providers to give individual counselling. This approach individualizes the problems and solutions of depo-provera and disconnects it from larger social and political understandings. In advocating pre-counselling and strategies for compliance, this literature does not attend to the problems that Indigenous women face in their contact with the delivery of mainstream health care.

This micro medical literature also does not question how knowledge and problems of depo-provera become articulated. Since the Upjohn Corporation has funded most medical research on the contraceptive depo-provera (Bunkle, 1993; Kaufert, 1990), the studies may focus less on the impact of the side effects of depo-provera on women and more on the rates of continuation and efficiency of the drug. Hampton, Jeffrey & McWatters (2000) and Hampton & McWatters (2003), for example, indicate that Pharmacia-Upjohn partially supported their research funding. Even when research has been carried out that does not mention Upjohn funding, it may still be influenced by the drug company. According to Otremba's (2005) article on depo-provera, "drug company fees make up 70 per cent of the revenue for Health Canada's drug regulatory body," which may influence service provision and research. As a result, the Upjohn Corporation may influence both the construction and control of knowledge of depo-provera while simultaneously silencing women's experiences and concerns.

Feminist literature on depo-provera

Feminist literature on depo-provera challenges the micro level of medical analysis that focuses on the individual and advocates for an analysis inclusive of the social and political context. “Seen from within feminist ethics, these are questions about the ethics (or lack of ethics) in research on women’s health, the power of medicine, the powerlessness of women” (Kaufert, 1990: 122). Feminist approaches have considered individual, social and political concerns of depo-provera in relation rather than in isolation to each other. This concern is evident in feminist research that critically examines contraceptive ‘choice’, and population control and family planning.

Feminist research has been critical of the medical literature that adopts primarily a liberal discourse, which emphasizes that citizens have choices and once they gain information about contraceptives, they are able to decide whether or not to use them. In contrast, feminist research has shown that choice is socially constrained and mediated particularly when women come from socially disadvantaged groups. In her work on sterilization and reproductive freedom among Puerto Rican women in New York city, Lopez (1997) states that medical literature focusing on individual choice disregards the larger social, political and ideological forces influencing choice. In her study of modernization and family planning in India, Ram (2001) shows how the state mediates choice. Ram states that “[p]oor and rural citizens are not trusted to exercise choice in a manner consistent with the goals of the state. The result is that, as far as the poor are concerned, the family planning program has virtually become identified with sterilization” (94). Because the state sought to decrease its population size, it granted limited contraceptive ‘choices’. Ram (2001: 82) further argues that family planning, as a national policy, is “integral to the state’s representation of itself as modern and progressive”.

Depo-provera and the devaluation of reproduction

In specifically examining depo-provera, feminist literature has situated its use with population control and family planning programs in third world countries as well as among poor and racialized women in first world countries (Ivarature, 2000; Littlecrow-Russell, 2000; Kaufert, 1990; Silliman, 2002). Feminist literature suggests that the medical injection of depo-provera occurs within a social and political context that devalues the reproduction of particular groups of women. As Kaufert (1990: 123) notes:

For example, wherever Depo-Provera has been used, it is more likely to have been given to women whose fertility is devalued by their society. These tend to be women in poverty, women with disability, women from ethnic minorities, teenagers seen by health professionals as too young to be sexually active. Questions of fertility cannot be dealt with traditionally, in abstraction from these social and political realities. The actual injection occurs in the context of a physician-patient encounter, but often the reasoning for giving the injection has to do with the relative value placed on the rights of women to control their own bodies. For the strongest support for Depo-Provera has not been medical but comes from those who claim that the fertility of some individuals or groups should be curtailed in their interest, or in the interest of some wider group.

The argument for depo-provera use receives support from those who see pregnancy among third world women, and marginalized first world women, as a risk to their health (Ivarature, 2000) as well as among those who see fertility “as a threat to economic and political order” (Kaufert, 1990: 136). While family planning groups emphasize that depo-provera protects women, particularly those who are young, from unwanted pregnancies, feminist research suggests that the use of depo-provera represents a medicalization of public policy as well as “a rationalization and a bureaucratization of what is perceived as a ‘health problem’” (Ivarature, 2000: 47). More generally, feminist analysis of population control and depo-provera has challenged notions of the ‘population problem’ that situates the cause of poverty in rapid population growth (Canadian Woman Studies, 1995; Ivarature, 2000).

In particular, feminist research is critical of the medicalized procedure of depo-provera that is provider-controlled. Women need to visit a health care provider to have their depo-provera

shot, women cannot administer the needle themselves. Once a health care provider has administered the depo-provera shot to women it cannot be removed and women have to wait the full 3 months (or more) duration for the drug to leave their system (Boroditsky, 1999; Boroditsky & Guilbert, 2000; Bunkle, 1993; Hampton, Jeffrey & McWatters, 2000; Hampton & McWatters, 2000; Otremba, 2005; Ralstin-Lewis, 2005; Sarkadi, 1995; Smith 2002 & 2003). Physicians administer the depo-provera shot to women every 3 months, requiring women to make repeat visits to their doctor.

Feminists point to several problems with the provider-controlled contraceptive depo-provera that emerge when power imbalances exist between the health care provider and women. Littlecrow-Russell (2000) states that health care providers often encourage poor, racialized women accessing federally funded clinics in the United States to take depo-provera and without informing women of alternative contraceptive methods. Without being informed of alternative contraceptive methods women cannot make informed “choices” about contraceptive methods that best suit them. The Canadian Women’s Health Network (1997) further argues that some health care providers assume that particular women (e.g. Indigenous, refugee, Immigrant) will be ‘non-complaint’ in maintaining other forms of contraceptives and offer depo-provera as a first choice contraceptive. This is “[b]ecause Depo doesn’t require daily client action, it is often considered convenient for women who do not/cannot remember to take pills or other client-controlled methods” (para 17). Feminists have been critical of claims that characterize depo-provera as a ‘set-it-and-forget-it contraceptive’ (Littlecrow-Russell) because it decreases the autonomy of particular women over their reproductive health and places power in the hands of the provider administering the depo-provera shot.

Absent within such feminist analysis is the specific focus on the use of depo-provera among young Indigenous women. American Indigenous scholar, Andrea Smith (2002 & 2003), on the other hand has drawn linkages between depo-provera use and the history of the regulation

of Indigenous women's reproduction in the United States. Depo-provera, Smith (2002 & 2003) states, is an example of the continued sterilization of Native American women where Native women were routinely provided with depo-provera as a form of birth control before depo-provera received FDA approval in the early 1990's. Situated within a contemporary context, Smith's work examines how present issues around the surveillance and regulation of Native American women's reproductive health are part of a historical pattern of the devaluation of the bodies and reproductive capacities of Native women. Smith argues that the United States has defined Native women's reproductive capacities as in need of regulation through state programs and that this process has transformed Native women into a risk population.

Few studies in Canada focus on depo-provera, let alone its relevance for young Indigenous women. Studies on the use of depo-provera before Canada's approval indicate that agencies provided prescriptions disproportionately to racialized and/or Indigenous women and suggest that they sought to regulate and suppress their reproduction. Some US studies indicate that this history of regulating Indigenous women's reproduction continues today. Research in Canada, as noted above, correlates depo-provera use with "high risk sexual behaviour" (Boroditsky, 1999: 96) among other characteristics. It has not, however, examined the process by which such knowledge is constructed. Questions remain about how the medical research comes to know about risky behaviour, who it identifies as engaging in such behaviour, and how it articulates or not the group identities implied in the identification of risky behaviour. More specifically, such research does not clarify the degree to which its findings target particular groups of women to use depo-provera and, if so, why. In other words, we know little about the implications for Indigenous women of the health care promotion of depo-provera.

Typically, health documents do not articulate the implications of contraceptive methods specifically for marginalized groups. As the following quote illustrates, family planning programs in Canada can have a vast set of reasons for promoting the regulation of women's reproduction,

none of which suggest that they focus specifically on regulating Indigenous or marginalized women's reproduction:

We live in an era of changing preferences for fertility control, family size, timing of establishing a family, and choice of occupation. The consequences of sexual risk-taking are increasingly significant. Canadians and their health-care providers are thus involved in fertility-related decisions that will fundamentally influence individual lives and society as a whole, well into the future. Family planning decisions affect and are influenced by emotional health, sexual attitudes and behaviours, gender equity, the quality of relationships, and respect between women and men. Family planning choices made today will affect not only the structure of the future population, but also the health, family size, responsibilities and social opportunities, and thus the quality of life of Canadians. (Black et al., 2004: 145)

Yet in emphasizing "the structure of the future population" this quote raises the question of who, according to family planning discourse, may best contribute to its quality. While the meanings of such statements about family planning are not transparently discernible, it is important to call them into question, given a known regulation of Indigenous women's reproduction. It is necessary to "read between the lines" and to attend to the silences as well as the utterances.

This chapter has shown that depo-provera has a history of disproportionate use among young women in the third world and in marginalized first world communities. While the current medical literature is primarily concerned with discontinuance rates of young women's use of depo-provera, feminist research has highlighted their lack of choice and control with this form of contraceptive. Very little research, however, has addressed the significance of depo-provera for contemporary young Indigenous women. The next chapter, which discusses several theoretical perspectives, suggests that colonizing discourses are readily at hand for the promotion of depo-provera aimed at young Indigenous women in Canada.

Chapter Three: Theoretical Perspectives

Introduction

This thesis draws upon Indigenous/decolonizing feminist frameworks to understand the way that documents frame health discourses on the contraceptive depo-provera. Feminist scholars have developed an extensive critical analysis of the patriarchal and medical control of women's reproduction in a variety of contexts (Lock & Kaufert, 1998; Ginsburg & Rapp, 1995). While feminist perspectives are useful for understanding the medicalization of women's reproduction, they have usually emphasized white women's experiences. Anti-racist feminist scholars have criticized 'mainstream' feminism for ignoring the impact of racism on women of colour (e.g. Jolly & Ram, 2001). Anti-racist scholars have emphasized, for example, that while white women may have difficulty gaining rights to prevent their reproduction (e.g. abortion), women of colour have been subjected to strategies that seek to curtail (or constrain) their reproduction (e.g. sterilization) (Silliman, 2002; Association for Women's Rights in Development, 2004). Anti-racist feminists generally argue that scholars need to attend to both gender and 'race' for understanding women's reproductive experiences.

While these feminist approaches highlight the significance of gender and race, they do not adequately address the impact of colonial relations on women's experiences. In drawing on a decolonizing perspective, this thesis aims to explore how colonial relations construct women's reproductive choices and experiences. This perspective provides insight into how and why the documents that I examine frame indigenous women's reproduction as risky, as leading to overpopulation, and in need of a (health) provider-controlled contraceptive such as depo-provera.

Linda Smith's (1999) theoretical examination of decolonization has been influential in the field of medicine. I discuss her theoretical approach and the key concepts of colonial knowledge (Quintero, 2001) and decolonization and how they apply to medical knowledge (Poudrier, 2007; Marks, 1997; O'Neil, Reading, & Leader, 1998). I briefly examine how neoliberal ideologies further marginalize Indigenous women and then look more specifically at scholars who have examined indigenous women's reproduction (Ralstin-Lewis, 2005; Jasen, 1997; Kaufert & O'Neil, 1990; Smith, 2002 & 2003). These scholars provide a theoretical perspective that brings together a focus on decolonization and a feminist understanding of women's experiences of reproductive regulation and surveillance.

According to Smith (1999), critical theories and feminist perspectives have offered an understanding of the social constructiveness of knowledge that is valuable to research in Indigenous communities. Although Indigenous research may be informed by feminist and critical theories, Smith contends that research within an Indigenous framework also stands apart from these theories through the privileging of Indigenous perspectives and experiences and the utilization of concepts such as colonialism, decolonization, and social justice.

In exploring health discourses on the contraceptive depo-provera, it is useful to understand colonization as a process. In her book *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1990-1950* (2005), the historian, Mary-Ellen Kelm uses the sociologist James Frideres' definition of colonization which sees it as a process that

includes geographical incursion, sociocultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level services, and finally the creation of ideological formulations around race and skin colour, which position the colonizers at a higher evolutionary level than the colonized. Canadian colonization – as an expression of the relationship between the First Nations and the Canadian state, settler societies, missions and others – conforms to this process-driven definition. (Frideres, cited in Kelm, 1998: xviii)

Although Frideres' definition of colonialism provides an important starting point in understanding the process of colonialism, Kelm argues that the definition provides too narrow a

focus. Kelm is uncomfortable, for example, with the way in which such a definition constructs Indigenous people as passive victims of colonization. Building on Frideres' definition, Kelm argues that the processes of colonial power need to be further understood as both dialectical and diffuse and subject to contestation from both the colonizer and the colonized. Kelm uses the concept colonization as a process for two reasons. "First, colonization carries with it linkages to imperialism, its practices, policies, and discourses. These linkages connect the Canadian experience to the larger imperial project in ways that Canadian scholars too often ignore" (xix). Second, in conceptualizing colonization as process, Kelm aims to take account of Indigenous practice in defining First Nations' relations with the nation state.

Kelm and Frideres' definitions of colonialism as a process are useful in analyzing the social historical construction of Indigenous women's reproductive health. However, their definitions do not fully reflect the analyses of colonization from an Indigenous location. Linda Smith (1999), in her book, *Decolonizing Methodologies: Research and Indigenous peoples*, introduces the concept of decolonization in relation to analyzing Western science and research. For Smith, decolonization "is about centring our concerns and world views and then coming to know and understand theory and research from our own perspectives and for our own purposes" (39).

Decolonizing science/medicine/health discourse

To explore the theoretical approach to decolonization, I draw on literature that focuses on the decolonizing of science, medicine and health discourse (Poudrier, 2007; Marks, 1997; O'Neil, Reading, & Leader, 1998; Quintero, 2001), the social construction of Indigenous health through colonial knowledge (Quintero; 2001), discourses of difference (Erjavec & Volcic, 2007), and the colonialist lens of culturalism (Fiske & Browne, 2006). Similar to Poudrier (2007), this thesis privileges Indigenous perspectives and knowledges and is grounded in Smith's (1999) work on decolonizing methodologies and Whitt's (as cited in Poudrier) work on "indigenist"

(243) analysis of Western science. Taken together these works suggest ways of examining governing images of the overpopulation of Indigenous people and people of colour.

Although her work does not focus specifically on the reproductive health of Indigenous women, Poudrier (2007) argues that when it comes to race and ethnicity it tends to be social concerns that inform the process of scientific inquiry and conclusions. Similarly, Marks (1997) argues that medical discourses have played a significant role in making “universalizing claims of European ideology” (210) and in producing and perpetuating racial and gendered discourses of difference that create inferior others. These discourses contribute to the legitimation of social hierarchies and relations of domination. Poudrier (2007: 240-241) further argues that “where ethnic populations are epidemiologically at-risk and are considered a financial drain on health care resources” notions of racial difference become the focal point of “regulatory surveillance”.

Poudrier argues that Indigenous peoples are often targets of surveillance in the realm of population health and epidemiological research. To support her claims, Poudrier draws on O’Neil, Reading and Leader (1998), who examine epidemiological knowledge about Aboriginal peoples and how it serves as a powerful form of regulatory surveillance. More specifically, Lupton (as cited in O’Neil, Reading, & Leader, 1998) argues that epidemiology has emerged as a solution “to the political problem of regulating potentially ‘dangerous’ behaviours in the general population,” (p. 230). The authors contend that epidemiological representations of Aboriginal ill health become social tools in constructing Aboriginal identities that reinforce unequal power relations. O’Neil et al. state that “[h]ealth discourse about Aboriginal peoples reflects sick, disorganized, uncontrolled and dependent peoples” (241) and that these images reinforce regulatory surveillance and management over Indigenous health.

In addition, the concept of colonial knowledge is useful, as Quintero (2001) demonstrates in his work that considers the role of statistics and epidemiology in “[m]aking the Indian” (57). Quintero argues that most of what is known about Native American people is part of colonial

knowledge. For instance, pathological images of Native Americans (Quintero uses the example of Indian drinking) are forms of colonial knowledge. Colonial knowledge is enacted through statistics and epidemiology where

(1) they create, standardize, and make into social facts perceived biological, racial, cultural, and social oppositions between the colonizer (white, Euro-American) and the colonized (red, Native American); (2) they are systemically utilized in specific contexts to disempower the colonized by characterizing Indian people as dysfunctional, pathological, or weak, thereby reinforcing the power of the colonizer; and (3) as a result, these theories have the net effect of continuing the colonial program of dispossession and subordination toward Indian people. (Quintero, 2001: 58)

Colonial knowledge of Indigenous peoples contributes significantly to the construction of Indigenous as 'other' and to what some scholars refer to as 'discourses of difference'. Hall (cited in Erjavec & Volcic, 2007) sees 'discourses of difference' as the process of constructing binary oppositions between 'us' and 'them', which are ideologically constructed. Such ideologies are effective because they rely on *common sense* notions and representations that construct and sustain unequal relations of power between different groups in society; the process of differentiating 'us' from 'them' is powerful and rarely questioned because they rely on common sense notions that appear natural. The construction of identities, therefore, is part of the process of differentiation. Colonial knowledge has contributed significantly to discourses of difference. In my study, I am interested in determining how colonial knowledge governs the reproductive lives of Indigenous women by situating them in the position of other.

Closely linked with Quintero's use of colonial knowledge is McConaghty's (as cited in Fiske & Browne, 2006) use of the concept of culturalism. She sees culturalism as a technology of power because it constructs a governing image of Indigenous people where culture is privileged as the explanation for social ills over considerations of colonial, racist, sexist governing structures. In essence, culturalism both constrains and regulates what can be understood and said

about Indigenous people. Fiske and Browne (2006: 99) advocate a decolonizing of culturalism as it applies to health policy:

As a complex praxis, culturalism uses Aboriginal culture as the primary analytical lens for virtually all health, social, political, economic or educational analyses. In the process Aboriginal culture surfaces through a colonialist lens which is not the culture as lived, but the culture as constituted, as written about and described by ethnographic texts. It is this notion of culture that allows indigenous people to be othered in colonialism.

Linda Tuhiwai Smith (1999) advocates decolonizing Euro-western science and examining the implications of their ideological assumptions on Indigenous peoples. As mentioned earlier, decolonizing refers to the privileging and centring of Indigenous perspectives and worldviews and then examining and understanding Euro-western science and research from an Indigenous perspective. As Poudrier (2007) notes, although Smith characterizes Western science as “research through imperial eyes” (243) and considers the impacts of scientific discourse on Indigenous peoples, she does not fully discard Western science but advocates for its decolonization:

[T]he methodologies and methods of research, the theories that inform [western scientific projects], the questions which they generate and the writing styles which they employ, all become significant acts which need to be considered carefully and critically before being applied. In other words, they need to be ‘decolonized’. Decolonization, however, does not mean a total rejection of all theory or research or Western knowledge. *Rather, it is about centering our concerns and worldviews and then coming to know and understand theory and research from our own perspectives and for our own purposes.* [emphasis added] (Smith as cited in Poudrier: 243)

Complementing Smith’s concept of decolonizing Western science is Whitt’s work that focuses on the application of “‘indigenist’ theoretical perspectives” (as cited in Poudrier: 243) for examining Western science, its political implications and its effects on Indigenous peoples. Whitt argues that indigenist perspectives bring into focus the ideologies of Euro-western science and allows for its decolonization through exposing the power structures it rests upon. This process

reveals the structures that mediate and maintain the oppression of Indigenous peoples. Whitt argues that

a key assumption and commitment in Western science is value-neutrality or ‘the belief that science (or science proper) enjoys a certain axiological immunity, and is unaffected by the values-ethical, social, political, and cultural.’ She also argues that this commitment is reproduced in seemingly neutral methodological practices that are envisioned as filters through which science is cleansed. (cited and quoted in Poudrier: 243)

The colonial project, informed by racist ideologies and patriarchal discourses and practices, continues to constrain, regulate, structure and influence present-day institutions, such as health provision and state policies. Trautman’s (2007) argument, which focuses specifically on the American context, has resonance in Canada. He states that:

given the membership and [colonial] goals of these institutions, different hegemonic and propaganda tools have been created and nurtured to convince the average non-Indian American that the acts of genocide committed against Native American is ‘old history,’ and that any kind of early American state involvement in committing such acts has long since ended. (para 1).

Though the practices of colonialism have changed and shifted form throughout history, this thesis suggests that the surveillance and regulation of Indigenous women’s reproduction has not.

Constructing Indigenous women as discredited medical subjects

Central to this thesis is the decolonizing of discourses that construct Indigenous women as discredited medical subjects. Similar to Browne and Smye (2002), my intention is to shift attention away from focussing on Indigenous women as the problem to the adoption of a wider gaze that contextualizes Indigenous women’s lived experiences within colonial processes.

In Canada, the relationship between mainstream health care and Indigenous peoples has been shaped by a history of colonialism that has successfully marginalized Indigenous people from mainstream health care (Browne & Fiske, 2001). A consequence of the legacy of colonialism is the multiple disadvantages that Indigenous women experience when negotiating

individual and institutional discrimination based on race, class, and gender. In their work on Indigenous women's experience with health care providers, Browne and Fiske note that the marginalization of Indigenous people on reserve from the political economy has resulted in high rates of underemployment, unemployment, and reliance on social transfer payments. This marginalization is both shaped by and shapes the social distance between dominant groups and Indigenous people in reserve communities. Browne and Fiske see the foundation of the marginalization of Indigenous people as stemming from racial stereotypes that construct Indigenous people as *other*.

For example, in keeping with the federal government's constitutional duties to all Aboriginal peoples it recognizes as 'Status Indians,' members of the First Nations community are entitled to some non-insured health benefits that are not extended to other Canadians. Although this service is a federal obligation subject to increasingly restrictive interpretations (O'Neil et al., 1999), it has given rise to resentment from the dominant society with respect to 'free' health services and often is seen as an extension of welfare or undeserved charity. (131)

It is within the context of this tense interweaving of social, political, and economic relations that Indigenous women's encounters with mainstream health care are shaped. Browne and Fiske further note that within this context Indigenous women are challenged as credible medical subjects.

In later work, Fiske and Browne (2006) identify three everyday constructions of Indigenous women as discredited medical subjects. These discrediting processes are the racialized subject, entitled subject, and penalized subject. I elaborate on each in turn below.

The racialized subject

Fiske and Browne (2006) argue that racialization is close to culturalist discourses (discussed in the decolonizing science/medicine/health discourse section) and is both a product of and a process of relations of dominance. Racialization refers to socially constructed processes that differentiate 'us' from 'them' (100). Within relations of dominance, racialization is used as a

discrediting tool. Fiske and Browne see culturalist discourses employed in health care as contributing to and supporting racialization processes. Culturalist discourses in health care focus on the medical subject whose needs can be met through an understanding of ‘cultural differences’ or cultural sensitivity³. Fiske and Browne see this discourse as problematic because it reinforces racialization processes rather than focuses on the power relations between health care providers and patients. Racialization and culturalist discourses facilitate decontextualized understandings and can potentially increase the social divide between health care providers and Indigenous women.

In Fiske and Browne’s (2001) study on First Nations Women’s Encounters with Mainstream Health Care Services they found that Indigenous women expressed distress in having their concerns dismissed or invalidated before being assessed and that these assumptions reflected the providers’ stereotypes of Indigenous women as passive who are “not supposed to know these things” (134). This is exemplified in the following statement by an Indigenous women interviewed by Fiske and Browne (133):

Only problems I’ve had were with people who didn’t listen to you. They think they’re the nurse or the doctor, and they don’t really listen to what you’re saying. That’s the only problem I’ve had with them. Maybe because I’m Native. I don’t know. You’re not supposed to know these things [laughs]. That the feeling I got from them, eh?

The entitled subject

Fiske and Browne (2006) also discuss discrediting processes that construct Indigenous women simultaneously as the discredited medical subject and entitled subject. They state that “[d]iscrediting processes become more complex as constitutional rights, health benefits and treaty settlements are conflated in the media” (101). Within this tense context Indigenous people

³ I do not necessarily see cultural sensitivity as completely bad. Some Indigenous women interviewed in Fiske and Browne’s (2001) article on encounters with mainstream health care discuss how they valued their interactions with health care providers who acknowledged and validated their cultures. I do see cultural sensitivity as problematic, though, where sensitivity lacks acknowledgement of colonial processes, social and political marginalization, and systemic barriers to education and economic well-being.

become constructed as “racially privileged dependents” whose call for social justice is understood as reflective of a “culture of entitlement” (101). Fiske and Browne further state that within a neoliberal context entitlements afforded to Indigenous people through legislation become understood as a “threat to democracy and social vitality” (101). This context lays the foundation for dominant perceptions over health benefits where Indigenous people are seen as receiving more benefits than the public at large.

Once perceived as having unfair benefits the rest of “us” are denied, the medical subject finds herself resented. In this manner, discourse conflates the discredited medical subject and the entitled subject. Having been constructed as receiving something for nothing, the Aboriginal subject is no longer deemed an equally contributing citizen. [...] First Nations women are placed in a position of unworthy recipients of generous policies opposed to fellow citizens bearing democratic burdens and obligations. (101)

In Browne and Fiske’s (2001) work on Indigenous women’s interactions with mainstream care they found that Indigenous women expressed common experiences with racism when showing their “Status Indian” card at pharmacies and dental offices. Browne and Fiske argue that considering that health and health care are embedded in a larger social and political history of colonization – that has served to marginalize Indigenous people – the experiences Indigenous women have with health care were not surprising. The Indigenous women in this study link these discriminatory experiences with myths in the dominant society that Indigenous people get everything paid for – such as medical and postsecondary education – and that they are just handed to them from the government.

The penalized subject

Fiske and Browne (2006) argue that when policy manifests as a technology of power it “penalizes subjects and places them under multiple levels of surveillance that intertwine with culturalist assumptions and racial stereotypes” (103). Fiske and Browne provide two examples of

the penalized subject, the first emerges in child protection policies and the second in the application of financial penalties for late or missed appointments in mainstream health clinics.

In the example of child protection policies health professionals are obligated to report to authorities suspected cases of neglect and abuse. Fiske and Browne state that child protection policies result in the surveillance of mothers and simultaneously infer notions of being at risk. In Browne and Smye's (2002) work on the decontextualized discourses focussing on Indigenous women as an at risk group, the risks have the potential to be conceived as lifestyle or personal choices by health care providers and the public. When risk discourses are decontextualized from the complex interweaving of social, historical, political, economic, and colonial conditions they have the effect of blaming Indigenous women and individualizing systemic problems. Decontextualized reproductive health discourses encompass negative stereotypes about Indigenous women as "neglectful and irresponsible" (Fiske & Browne, 2006: 103) and "lascivious, or as lacking willpower, judgement or moral fortitude – characteristics that become representative of women's moral integrity" (Browne & Smye, 2002: 33). Negative stereotypes of Indigenous women intersect with child protection policies and result in the construction of Indigenous women as implausible, discredited subjects. Indigenous women become discredited when suspected of neglecting or harming their children.

Financial penalties for missed or late appointments at medical clinics also contribute to the construction of Indigenous women as discredited medical subjects. This is because financial penalties influence an Indigenous woman's relationship with the health care provider and also have a bearing on her ability to present herself (Fiske & Browne, 2006). In charging cancellation fees for missed appointments, medical clinics completely disregard personal circumstances. Financial penalties to Indigenous women are often applied without consideration of the socio-economic difficulties these women experience. Browne and Fiske (2001) note that the impoverished conditions that many women live in on reserve constrain resources available that

would allow women to arrive on time or call ahead to cancel appointments. Women living in poverty often do not have a vehicle and cannot afford to pay for taxis, or a home phone. Public transportation is also not an option since reserves are not serviced.

Within the neoliberal context of “wise restraint” (Garland, 1997: 177) in social service funding, Indigenous women living in poverty experience heightened levels of surveillance and are constructed as an at risk population. Systemic barriers to resources (financial or otherwise) become understood as personal problems. Within this context Indigenous women may be portrayed as unfit mothers who are neglectful, irresponsible, and unable to financially and materially care for their children.

Neoliberal context

Examining science, medicine, and health discourse from a decolonizing perspective provides an important entry into deconstructing colonial power structures, practices, and discourses. However, focusing only on science, medicine, and health discourse as a way of examining colonial governance, risks moving away from understanding the impacts of the political economy on Indigenous women’s health. Marks (1997) argues that colonial expansion has been driven by economic motivations, namely “the exploitation of material resources and the expansion of capitalist modes of production” (216), which has resulted in high social costs. As colonial relations continue into the present, they have become intertwined with a neoliberal shift in the economy and political governance.

According to Garland (1997: 177-178) neoliberalism

counsels limitation, wise restraint, and respect for the ‘natural processes’ of the economy and civil society. It introduces ‘economy’ into the art of governing, first by its insistence that he who governs least governs best, and second by insisting that ‘the economy’ is a domain with intrinsic laws of its own which must be respected.

This shift in governance has implications for everyday lived experiences because neoliberalism carries specific rationalities and ideologies that discourage direct state interventions into the lives of citizens. Instead, under neoliberalism the state has devolved responsibilities for health care and social services onto individuals and communities while simultaneously casting individuals as rational and capable of exercising regulated freedom. The neoliberal structure results in the marginalization of individuals and groups, such as Indigenous women, who are cast as deviant because of their failure to conform to prescribed neoliberal behaviours and norms (Peterson and Lupton, 1996). This process has disproportionately affected Indigenous peoples in Canada who have suffered historical inequalities that have resulted in the need for social services and supports that address their economic and political circumstances. A 2000 News Release from Indian and Northern Affairs Canada, for example, states that “although Canada is ranked the number one country in which to live according to the United Nations' Human Development Index (based on income, education and life expectancy), Inuit and on-reserve Indians were ranked below many developing nations” (para 1). The News Release also reports that First Nations and Inuit peoples experience housing shortages, and higher rates of dependence on social assistance, and unemployment than the national average. Infant mortality rates in the Indigenous population are twice the national average and most Indigenous people are reported to live at or below the poverty line. Indigenous people living on reserve experience an unemployment rate of 29 percent – three times the national unemployment rate.

The need to address the discrepancies in living standards between Aboriginal and non-Aboriginal people is compounded by the fact that the Aboriginal population is growing about twice as fast as the overall Canadian population. Moreover, almost two-thirds of Aboriginal people are under 30, and about one-third of reserve residents are under the age of 15, which is increasing the demand for school space, housing, public infrastructure, social services and jobs. (Indian and Northern Affairs Canada, 2000: para 3).

Neoliberal rationalities and practices in Canada further exacerbate historical inequalities through the agenda of fiscal restraint. Fiske and Brown (2006: 17) consider the effects of neoliberalism on Indigenous women, they state that:

Health promotion and risk-reduction programs are compromised by tensions resonating between a commitment to prenatal and childhood health on the one hand and the rhetoric of constrained spending on the other. Within this rational model, reproductive health services are not only understood as beneficial for prenatal care but also as a financial burden by the citizen at large, in particular when Aboriginal populations are described as growing at twice the rate as the Canadian population (First Nations and Inuit Health Branch, 2002). When our moral capacity and truth or our moral decision-making is masked by cost analysis, First Nations women as medical subjects are not only marginalized, they are once again discredited.

Within this context, neoliberal rationalities of 'fiscal restraint' and individual responsibility for care intersect with the processes of colonialism that have served to marginalize Indigenous women both within mainstream health care and the political economy through high rates of unemployment. This results in decontextualized discourses. As stated earlier, in decontextualized discourses Indigenous women are constructed as an "at risk group" and are blamed for systemic problems (Fiske & Browne, 2006). This tense context of reproductive health services conceived of as both beneficial and a financial burden (to tax payers) shapes Indigenous women's experiences of reproductive health care services. Indigenous women become constructed as "sexually at risk" and in need of reproductive regulation in this context of 'fiscal restraint'.

Indigenous women's embodied citizenship

Historically, the nation state of Canada regulated and constructed Indigenous women's identities and citizenship through racist and colonial ideologies. Several Indigenous women scholars (Green, 2001; Napoleon, 2001; Lawrence, 2005) have shown how gendered aboriginal citizenship emerged with the Canadian nation state's creation of status and non-status Indians under the 1876 Indian Act and carried through to Bill C-31 in 1985. Through the Indian Act the

Canadian government legislated who was, and who was not Indian. Status women who married non-status men lost their status (though the reverse did not happen for men; they retained their status if they married non-status women). The legislating of Indian citizenship or identity privileged the state's definitions of Indian status and effectively devalued traditional First Nations classifications and criteria for defining citizenship. Under the Indian Act, status Indians are provided certain entitlements including band membership, health and education benefits, tax exemption on reserve lands, the right to live on reserve, and voting privileges in band elections. Napoleon argues that "[o]nce First Nations were redefined as Indians, another step was to reduce the numbers of Indians requiring reserve land or federal resources" (Napoleon, p. 118). Through reducing the number of "status Indians" when women married out, the government could simultaneously reduce future financial obligations to Indigenous peoples.

In this thesis I further argue that Indigenous women experience differential citizenship not only legally and politically but also culturally, symbolically and medically. This is important to consider because it brings attention to how citizenship becomes an embodied experience especially where social and biological reproduction is concerned for Indigenous women. Fiske (1993) argues, for example, that Canadian state regulations have resulted in Aboriginal women being constructed as childlike and denied full personhood both within Canadian society and Aboriginal communities. The Indian Act served to control both Aboriginal women's social and biological reproduction through controlling their citizenship status, thereby, their access to such provisions as the right to live on reserve, health and education benefits, and band membership. When Aboriginal women had these rights taken from them, it limited their social and biological reproduction; children born from women who lost status also did not have Indian status. Through this process Aboriginal women's reproduction has been simultaneously devalued and regulated. More particularly in regards to this thesis, it can be argued that the extinction of large numbers of Indians who married out from status registration has been coupled by the regulation of Indigenous

women's reproduction that has aimed to reduce the Indian birth rate. With reduced numbers, the state has fewer obligations – exacerbated in neoliberal regimes – to legally enforced claims to lands and resources.

Theoretical issues in Indigenous women's reproduction

While the preceding literature provides useful conceptualizations for decolonizing medical knowledge, it has not focused on Indigenous women's reproduction. The work of researchers presented here make important connections between historical colonization and present-day practices of surveillance and regulation of Indigenous women's reproduction. Their work can be understood as a resistance to or a talking back to notions of regulation and surveillance over Indigenous women's reproduction as 'old history'.

Here I begin by outlining the theoretical approaches by Jasen (1997) and Kaufert and O'Neil (1990), although they are not Indigenous, their work has nonetheless made important contributions to the area of Indigenous women's reproduction in Canada. In particular, I focus on how Jasen and Kaufert et al. examine the simultaneous process of the medicalization of Indigenous women's reproduction and the silencing of Indigenous women's voices. I then outline the theoretical approaches employed in the research by Native American feminist scholars D. Marie Ralstin-Lewis (2005) and Andrea Smith (2002 & 2003). These authors link the effects of the history of colonialism, racialization and gender inequalities to the regulation and surveillance of Indigenous women's reproduction. This section continues the theme of colonization as a process as it applies to the historical development of the medicalization of childbirth in Canada and of population control programs and their impacts on Indigenous women in the past and present.

Medicalizing reproduction, silencing women's voices

In her work on the medicalization of childbirth in Indigenous communities in northern Canada in early twentieth century, Jasen (1997) finds the concepts of infant mortality and the emergence of scientific motherhood as useful. Jasen draws on the work of David Armstrong (1986) who looks at the use of infant mortality as a measure of state modernity. He states that infant mortality is understood as reflecting problems in housing, hygiene, nutrition, and poverty and that these “demand surveillance and intervention at a social level such as through various infant welfare schemes” (213). Armstrong argues that infant mortality rates have been used as a measure of state modernity because mortality rates at that age are understood to be “the most sensitive test of the health of communities” (214) and of the state. Jasen states that scientific motherhood was conceived as the answer to reducing infant mortality rates in Canada. Scientific motherhood refers to the medicalization of childbirth, childcare and

the belief that women require expert scientific and medical advice to raise their children healthfully. As it [scientific motherhood] developed in the nineteenth century, women were exhorted to seek out information for themselves. By the twentieth century, women increasingly were told that they continued to be responsible for the well-being of the families, but needed to follow the directions of their physicians. Such instruction positioned mothers as both responsible for their families and incapable of that responsibility. (Apple, 1995: 161)

Jasen (1997: 395) examines how, historically, the Canadian state utilized infant mortality rates in Indigenous communities “as a prime indicator of its own success or failure as a civilizing agency, not only in its own eyes but those of the world”. Reports indicated, for example, that status Indians and, particularly the Inuit, had higher maternal and infant death rates than the national average. Adding to concerns over high infant mortality rates in Indigenous communities was the fact that birthrates in Indigenous communities were also higher than the national average – despite, as Jasen notes, poor health and ‘unfortunate’ (395) loyalty to traditional customs in pregnancy, birth, and child rearing. Within the context of concerns over infant mortality rates and the promotion of scientific motherhood Indigenous people were “[n]ow regarded as members

of a sickly and misguided race destined to proliferate rather than become extinct, Aboriginal women became the subject of statistical surveys and the development of a far-reaching assimilationist policy aimed at transforming the culture of childbirth” (Jasen, 1997: 395). Infant mortality rates and scientific motherhood were used as a tool to modernize Indigenous families through the displacement of traditional knowledges over pregnancy and birthing practices and the privileging of the expert knowledge of doctors, nurses, and government officials. This knowledge blamed Indigenous women for high infant mortality rates and cast them as “ignorant of healthy child-bearing practices” (383). Jasen notes that the autobiographies of British nurses (chosen to work in northern communities because of their midwifery skills) tended “to devalue the knowledge and coping skills of aboriginal women or assume that such women know little of their own bodies” (396). The medicalization of childbirth in northern Indigenous communities had the effect of silencing, and suppressing Indigenous women’s knowledge of their bodies, birthing, and child-rearing practices and justified Canadian government interventionist policies through the presence of nurses and through the evacuation of pregnant Indigenous women from remote communities to distant hospitals to give birth. Though not examined by Jasen, it can be further argued that the medicalization of childbirth failed to address the problem of infant mortality as a result of the process of colonization and ensuing poverty.

Similarly, Kaufert et al. (1990) focus on the medicalization of Indigenous women’s reproduction in their research on the cooptation, control and reconstruction of Inuit birth in the Northwest Territories of Canada (from the 1970s through to the 1980s). In particular, they examine obstetrical records, which they argue, are the medical equivalent of birth stories but told within the language of the expert. These stories focus on the medical aspects of childbirth.

Kaufert et al. (434) describe obstetrical records as:

not simply a neutral medium for storing information but are constructed in ways which predetermine what information is collected and in what form. Record keeping has its own vocabulary and standard sets of questions. Forms vary in the amount of detail, but spaces are always allotted for recording maternal age and

parity, date of the last menstrual period, expected dates of confinement, blood pressures and weight gains, survival of previous infants, exact timing of each stage of labor, Apgar scores, and notations on the use of analgesics, episiotomy, induction, fetal monitors, and forceps. These are the standard elements seen as important for clinicians to know about a pregnancy and birth. The focus is clearly on the mechanical elements of birth, not the emotional and experiential; we find occasional reference in nursing notes to a woman being lonely, worried or afraid, but no formal place exists for such comments within the record of labor and delivery. The rich and complex experience of birth is broken into parts and packed into categories.

Obstetrical records are used as a tool to socially construct and maintain the authoritative knowledge of experts (doctors, nurses) over childbirth while simultaneously suppressing or ignoring the knowledge and voices of Indigenous women in birthing practices. Kaufert et al. notes that obstetrical records provided by nurses in remote areas (such as the Northwest Territories) were used to evaluate and supervise their performance. The use of standardized forms also facilitated communication between physicians and nurses in remote areas with health providers in cities where women were sent to give birth.

Obstetrical records are also used to define and record 'risk' populations where a high incidence of infant mortality is present. Kaufert and O'Neil (1990) discuss a 1966 report with a graph that shows in 1956 a high rate of Inuit infant mortality (approximately 240 per 1,000) relative to a Canadian rate of approximately 30 per 1,000. By 1963, the Inuit rate had fallen to 90 per 1,000 relative to a Canadian rate of 28 per 1,000 (National Health and Welfare Canada [Medical Services] 1967). Kaufert and O'Neil suggest that this statistical analysis includes "the unstated implication...that prior to the introduction of medical services, traditional Inuit ways of childbirth and child-rearing were dangerous and often deadly. The steeply declining line presents a striking image of the beneficial impact of government intervention" (437). In this instance, the discourse seeks to discipline Inuit women into rejecting traditional child birthing methods in favour of state services.

While it is acknowledged that the process of medicalization resulted in decreased infant mortality rates in Indigenous and Inuit communities, the process of medicalization (as discussed above) is not neutral, objective, or value free. The process of medicalization has entered Indigenous and Inuit communities infused with ideas about modernity, health, hygiene, childbirth, and mothering that have served to marginalize and silence Indigenous women in health care practices.

Indigenous feminist perspectives on colonization and reproductive regulation

Particularly relevant to this thesis are works that theorize the regulation and surveillance of Indigenous women's reproduction. Ralstin-Lewis (2005) connects the involuntary sterilization of Native American women in the United States to racist ideologies embedded in eugenics and population control discourses and practices. Ralstin-Lewis states that "[e]ugenics is defined as 'the method of improving the intellectual, economic, and social level of humans by allowing differential reproduction of superior people to prevail over those designated as inferior'" (74). Eugenicists subscribed to a theory of nature over nurture believing that genes determined human traits while dismissing the influences of the environment; this resulted in a perception of those who were deemed poor, criminal, physically handicapped, and insane as being both socially and biologically inferior. The improvement of society, according to the eugenics movement, rested on identifying and regulating subordinate groups and their reproduction. European settlers, for instance, generally saw Indigenous peoples as inferior; this perception fed into anxieties over higher birthrates among Indigenous peoples and over the declining birthrates of white women.

Ralstin-Lewis also sees the discourse of population control as important to contextualizing her analysis of the reproductive regulation of Native American women. The discourse of population control rests on three assumptions (Hartmann as cited in Whaley Eager, 2004: 38):

First, rapid population growth is a primary cause of Third World's development problems, notably hunger, environmental destruction, economic stagnation, and political instability. Second, people must be persuaded, or forced if necessary, to have fewer children without fundamentally improving the impoverished conditions in which they live. And third, given the right combination of finance, personnel, technology, and Western management techniques birth control services can be delivered to Third World women in a top-down fashion and in the absence of basic health care systems.

Within the discourse of population control large families are constructed as responsible for high levels of poverty rather than inequitable and unbalanced distributions of wealth and resources. Native American women living in poverty and dependent on federally funded health services are particularly vulnerable to population control practices within the American medical profession (Ralstin-Lewis). This analysis suggests that population control is a technology of power that constrains and regulates knowledge on how poverty is produced. The linking of poverty with large families assumes that poverty is a outcome of behavioural/individual choice rather than stemming from the social, historical, and economic marginalization of Indigenous people through the process of colonialism.

In her research on the sexual colonization of Native American peoples, Andrea Smith's (2002 & 2003) unmasks the intersections of race, gender, and class with colonialism in the regulation and surveillance of Indigenous women's reproduction. Smith connects her analysis to the social-historical role of the racialized and gendered character of the state through her use of the concept of 'sexual violence'. Smith argues that sexual violence directed towards Native women is direct and purposeful. Smith sees sexual violence as not simply emerging within the context of colonization but sees the logic of sexual violence as informing colonial process.

Smith (2003) sees sexual violence as the subjugation of Native Women's bodies. In the colonial imagination, for example, Native bodies are constructed as dirty, impure, expendable, and "polluted with sexual sin" (73). Smith argues that colonial images of Native women's bodies have served to strip Native women of personhood and integrity. She states that "[b]ecause Indian

bodies are 'dirty,' they are considered sexually violable" (73). Sexual violence, she argues, is informed by racist colonial ideologies that uphold European principles of patriarchy and hierarchy. Directed towards Native women, sexual violence "is not simply a tool of patriarchy, but is also a tool of colonialism and racism," (71). In Smith's articles, she argues that the historical subjugation of Native women's bodies was and is vital to achieving and sustaining political, economic and cultural colonization of the United States. Smith traces the history of sterilization abuses directed towards Native women and ties reproductive regulation to the American nation state's practices of genocide directed towards Native American peoples. She argues that Native women's ability to biologically reproduce provides obstacles to the continued colonization of Native lands and resources.

Through Smith's critical account of the social construction of Native women's bodies through sexual violence, she reveals a historical trend of stereotypes devaluing Indigenous reproductive lives. These discourses laid the foundation for and continue to inform state surveillance and regulation of Indigenous women's reproduction. Present concerns over reproductive regulation involve the long-acting hormone contraceptives, depo-provera and Norplant. Smith sees Norplant and depo-provera as replacing sterilization through hysterectomies that occurred prior to 1970. Smith (2002: 131) argues that:

[w]hile sterilization abuse in the United States has ebbed since the 1970s, state control over reproductive freedom continues through the promotion of unsafe, long-acting hormonal contraceptives like Depo-Provera and Norplant for women of color, women on federal assistance, and women with disabilities. As the population scare and the demonization of poverty have moved into the mainstream of the dominant culture in the United States, Norplant and Depo-Provera have become frontline weapons in the war against the poor and populations of color.

For Smith (2003) this has particular resonance in Indigenous communities in the United States where the unemployment rate on reserve is as high as 90%. This quote is significant because it reveals who the ideal citizen is through revealing who it is not (poor women accessing federal

assistance). From the quote above we understand the ideal citizen to be productive, as providing for her family, and ensuring that she is not an economic *drain* on the state.

Smith's research is similar to my study because she considers the use of depo-provera among Native American women. While Smith provides a good critique of the sexual colonization of Native American women through the regulation and surveillance of reproduction, she does not consider how Indigenous women are constructed in science, medical, and health discourses or socially constructed as discredited medical subjects through the process of colonialism in mainstream health care. Smith's concept of "sexual violence" is also important to consider. Although I agree with Smith that colonial images of Native American women are powerful and influence Native women's experiences, I argue that the picture of reproductive regulation, surveillance, and provision of depo-provera to Indigenous women is more complex. I see colonial power as being diffuse with several practices and discourses being called up to construct the "sexually at risk" Indigenous women who is *in need* of provider-controlled contraceptives. As discussed in the beginning of this chapter colonial processes have: decontextualized Indigenous women's lived experiences; situated Indigenous women in marginalized positions; silenced Indigenous women through the process of medicalized reproduction; and constructed Indigenous women as discredited medical subjects.

Neocolonialism and the discourse of silence

From an Indigenous/decolonizing feminist perspective, I am interested in examining science, medical, and healthcare discourses as reflecting colonial relations and neoliberal ideals in framing the characteristics of depo-provera users. These discourses reflect a new form of colonial ideology or neo-colonialism. Browne and Smye (2002) define neo-colonialism as the "policies, discourses and practices that maintain the social, economic and political conditions of internal colonialism for aboriginal people" (31). Internal colonialism is characterized by power and privilege of the dominant colonizing group over the subordination of the original inhabitants

of the land. Browne and Smye see neo-colonialism as a new form of colonialism that manifests in institutional policies and practices. Neocolonialism informs institutional racism and results in “racialized discrepancies in access to health care, education, or economic opportunities” (31). Important to note here is Browne and Smye’s claim that neo-colonialism “may be more insidious and difficult to identify and resist than older, more overt forms of colonial practice” (31). The insidious and difficult to identify is reflective of a neo-colonial coded mode of expressing racism and stereotypes – it is a discourse of silence.

In her work on indirect, racist, and anti-Semitic utterances in official discourses in Western Europe, Ruth Wodak (2007) argues that the discourse of silence emerges where explicit racist and prejudiced utterances have become taboo, such as in official political discourses. It can be argued, similarly, that in science, medical, and healthcare discourse a coded mode of expressing prejudices and stereotypes is created. For Wodak this silencing means that racist and prejudiced

contents can only be inferred by listeners/viewers/readers who know the background and also the genesis of such allusions/insinuations or presuppositions. The listeners/viewers/readers have acquired the necessary knowledge through collective memories or narratives handed down through the generations. They were thus socialized into specific cognitive frames (event models, metaphor scenarios) and discourses. (208)

Wodak argues that critical discourse analysis (CDA) is useful where the discourse of silence is present. This is because CDA analyzes the “opaque as well as transparent structural relationships of dominance, discrimination, power and control, as they are manifest in language” (209). Fiske and Browne (2006) also employ a critical discourse analysis in their work on the construction of Aboriginal women as discredited medical subjects. They state that (92):

Critical discourse analysis engages researchers in a series of spiralling critical reflections on strategies of language use. Rather than “collecting” empirical data, the critical discourse analyst plumbs texts for meanings located within and between discursive spaces generated by literary devices employed for rhetorical purposes.

The next chapter discusses how and why I use CDA in my study for understanding the role of depo-provera in the regulation of Indigenous women's reproduction.

Chapter Four: Methodology

In examining how depo-provera texts frame and regulate Indigenous women's reproduction, I employ the methodology of discourse analysis. Broadly defined, it is a method that studies language and texts⁴ (Hammersley, 2002; Phillips & Hardy, 2002; Wetherell, Taylor & Yates, 2001; van Dijk, 2001). At its foundation, discourse analysis is "a set of methods and theories for investigating language in use and language in social contexts" (Wetherell, Taylor & Yates, 2001: i). During the past several decades, the social sciences and humanities have taken what scholars often refer to as a "discursive" (Mason, 1996: 57) or "linguistic turn", which recognizes that language does not merely reflect reality – it constitutes it (Phillips & Hardy, 2002; Wetherell et al., 2001). As a field of research, discourse analysis contains diverse approaches, methods and epistemologies (Taylor, 2001; Phillips & Hardy, 2002). Wetherell et al., for example, identify five central traditions within the field of discourse analysis – sociolinguistics, discursive psychology, conversation analysis, Foucauldian analysis and critical discourse analysis. While Hammersley (2002) notes that these approaches differ in various ways, he distinguishes between analysis that focuses on conclusions about discourse itself (e.g. conversation analysis) and that which focuses on conclusions about social processes or structures (e.g. critical discourse analysis). The latter rejects the "discursive social distinction – on the grounds that all discourse is action and all action is discursive" (Hammersley, 2002: 2).

Because of its concern for the political implications of discourses and how they locate and produce social historical subjects, this thesis draws upon the theory and methodology of critical discourse analysis (CDA). Fairclough and Kress (as cited in Wodak, 2001:2) argue that:

⁴ The word *texts* is used in a broad sense and includes both written and printed texts (pamphlets, documents, news paper articles, transcripts of interviews) and visual texts (images, television programs, and the internet) (Fairclough, 2003).

In contrast to other paradigms in discourse analysis and text linguistics, CL [critical linguistics] and CDA focus not only on texts, spoken or written, as objects of inquiry. A fully 'critical' account of discourse would thus require a theorization and description of both the social processes and structures which give rise to the production of a text, and of the social structures and processes within which individuals or groups as social historical subjects, create meanings in their interaction with texts.

Critical discourse analysis explores the ways that power, history and ideology produce textual practices and how they in turn create subjectivities (Fairclough, 1993; Phillips & Hardy, 2002). As van Dijk (2001: 96) suggests, "CDA research combines what perhaps somewhat pompously used to be called 'solidarity with the oppressed' with an attitude of opposition and dissent against those who abuse text and talk in order to establish, confirm or legitimate their abuse of power". In reproducing racist ideology, he argues, majority group members present pejorative stories about minorities as 'facts'. By exposing how texts are laden with values and ideology to serve dominant interests, CDA contributes to the process of resistance and emancipation of subordinated groups (Wodak, 2001).

As a methodological and theoretical approach, CDA has the potential for resistance and emancipation for several reasons. For instance, CDA is able to focus on the privileging of particular discourses and their role in situating and marginalizing others (Phillips and Hardy, 2002). Wodak (2001) notes that CDA is valuable because it is a process of deconstructing and demystifying discourses and the ideologies upon which they rely. Fairclough (2001) argues that CDA raises the consciousness of the significance of language in constructing and maintaining power of some people over others. Consciousness of this process contributes to emancipation because it challenges a foundation, portrayed as commonsensical, natural and universal.

For these reasons, CDA is important in this study of how depo-provera texts frame Indigenous women's reproduction. Indigenous scholar Linda Smith (1999) would frame this process as a form of "'researching back', in the same tradition of 'writing back' or 'talking back', that characterizes much of the post-colonial or anti-colonial literature" (7). She states that this

involves a “a knowingness of the colonizer’ and a recovery of ourselves” (7). This methodology helps to uncover how discourses of difference shape the subjectivities of Indigenous women in depo-provera texts. As suggested in the previous chapter, theories of feminism, anti-racism, and colonial knowledge locate Indigenous women as racialized, colonized or marginalized social historical subjects within dominant discourses that seek to regulate their reproduction. By using CDA, I explore how these discourses provide a “repertoire of concepts” that “influence the social construction of identities...to support the institutionalization of practice and patterns of resource distribution” (du Gay, cited in Phillips and Hardy, 2002: 32). In giving justification for reduced resource allocations for First Nations women’s reproduction, I suggest, neoliberal discourses further marginalize their experiences.

Reflexivity in discourse analysis

As van Dijk (2001) suggests, CDA does not deny its own sociopolitical position. Indeed it makes explicit its own ‘biases’ about its opposition to dominating power. Perhaps, less polemically, it is important for researchers to reflect on how their own positions in society are implicated in their studies.

Linda Smith (1999) argues that the positioning of oneself as an Indigenous woman in research involves a “claiming [to] a genealogical, cultural and political set of experiences” (12). As an Indigenous woman, for instance, I have experiences and knowledges resulting from a shared history of colonialism within the Canadian nation state that has engendered particular ways of seeing and understanding the positioning (or situating) of Indigenous women. My concern with depo-provera emerged out of informal discussions with Indigenous friends, fellow students, and younger family members and their experiences with depo-provera. As an Indigenous woman (whose perspectives are informed by Indigenous knowledges, antiracist feminism and critical theory) these discussions on depo-provera concerned me. Of particular interest to me with this topic was to understand how dominant and colonizing discourses

construct, misconstrue and obscure Indigenous experience with depo-provera. These experiences do not mean that I fully understand the implications of depo-provera for Indigenous women, but they provide me a specific entry point for exploring their historical and social contexts.

Critical approaches to research do not make claims about universal truths; instead they contribute to “interpretations and versions” of reality, which can only be partial understandings (Wetherell et al., 2001:11). Because the social world is dynamic and complex and involves the reflection and viewpoints of the observer, neutral universal truths are unachievable. Truths and realities are multiple, partial and situated (Wetherell et al., 2001). More particularly, CDA recognizes how “the constructive role of language problematizes the very nature of research as the objectivity, neutrality, and independence of the researcher are called into question” (Phillips and Hardy, 2002: 12). CDA, itself – and the researcher – cannot escape from discourse.

In my critical interpretation of depo-provera texts, I draw on particular experiences that call into question how the texts frame and produce the category of young ‘minority’ or disadvantaged women, how the discourses denigrate this category, directly or indirectly, in what they say or do not say. The discourses do not address social contexts and lived experiences of women as social historical subjects – which feminist, anti-racist and anti-colonial theories help to reveal.

Still, the theories and the experiences that I bring to the research give a particular reading and interpretation of the texts. Other readers of the texts do not necessarily ‘read’ them as intended by the authors or by my interpretation of their discussion. While CDA helps to elucidate the socially-laden meanings of texts, it is limited in that it does not examine how readers, whatever their social position, interpret them⁵ (Fairclough, 2001). In my focus on depo-provera texts and the way they target young women ‘at risk’, I cannot say how those who are ‘captured’

⁵ Fairclough (2001) states that interpretations of texts involve an interplay between the formal properties within the text and the discourse analysts’ knowledge, values, beliefs, assumptions, and understandings of the social world.

by this discursive category interpret the texts nor how they make decisions about using depo-provera. In particular, a study of texts is unable to understand discourse in the context of everyday life, how individuals and groups engage with it, how they combat, circumvent or redefine it – how, in other words, they resist and exercise agency. Discourse sets limits to knowledges, practices and resources, but it does not determine them. Other methodologies, such as ethnography or qualitative interviews would have to be employed to explore such questions. CDA is valuable in addressing other questions about the prevailing anxieties and preoccupations embedded in medical, legal or state ‘disciplinary discourses’. The seemingly innocent statistics of growing Aboriginal fertility rates, for example, can tell a tale about colonial knowledge and fears of a burgeoning ‘Indian problem’ linked to fetal alcohol syndrome and anything else that defines groups ‘at risk’.

Design and methodology

Critical discourse analysis does not subscribe to a single methodology and is understood more as an approach to social analysis (Phillips & Hardy, 2002; van Dijk, 2001). Rogers (2004) further states that “[t]he intentions of the analyst always guide the theory and method of CDA. Within this framework of ‘critical,’ the analyst’s intention is to uncover power relationships and demonstrate inequities embedded in society” (3).

The texts examined in this thesis are framed by governing discourses that selectively depict women’s reproductive health and its implications for their lives (and the developed and/or developing world). In particular, discourses of neo-liberal rationality play a major role in the constructions of women of colour and women’s reproductive health subjectivities. Fairclough argues that “[d]iscourses, as a form of social action enacted primarily through texts and narratives, provide parameters for what can be known, said and thought in specific places and historical contexts” (as cited in Rudman, 2006: 184).

In my thesis, I explore how discourses of difference in governing texts shape the subjectivities of Indigenous women and render them vulnerable to reproductive regulation. To conduct this research I employ a critical discourse analysis of several key Canadian and international texts. The objective of this thesis is to examine the governance of Indigenous women's reproduction (through the prescribing of depo-provera), with a focus on the intersection of neoliberalism and risk discourse at the site of contraceptive prescription. The research questions for this thesis include: (i) How do contemporary medical documents construct Indigenous women as depo-provera users and why? and (ii) How does this construction correspond with the socio-political and ideological framework of regulating Indigenous women's reproduction?

Data selection

Although there is no "typical" (Meyer, 2001: 23) approach to generating data in CDA, a common approach to selecting data tends to be guided by the research question and the theoretical grounding of the research topic. This approach is similar to purposeful sampling. Mason (1996) defines purposeful sampling as "selecting groups or categories to study on the basis of their relevance to your research questions, your theoretical position and analytical framework, your analytical practice, and most importantly the argument or explanation that you are developing" (124). van Dijk (2001) states that a complete discourse analysis is impossible because a full analysis of a small text would in itself fill several hundred pages. In conducting a critical discourse analysis, choices about the selections of text to be analyzed need to be made consistently and with relevance to the social issue studied (van Dijk).

For a meaningful analysis, Phillips and Hardy (2002) suggest that texts should be analyzed in their interconnection with other texts and diverse discourses upon which they rely. Fairclough (2001) places importance on the process of intertextuality which he defines as "the idea that any text is explicitly or implicitly 'in dialogue with' other texts (existing or anticipated)

which constitute its 'intertexts'. Any text is a link in a chain of texts, reacting to, drawing in, and transforming other texts" (233). CDA is an analysis of the dialectical relationships between texts and their constructions of objects, subjectivities and concepts.

Because I am interested in examining broader societal level discourses specific to Indigenous women and reproduction I have chosen to consult texts that are widely available. I've chosen to analyze both Canadian and international texts because they reveal the intertwining of international and national governing discourses around reproductive regulation. Similar to McKinley's (2003) work which looks at the effects of global population and development initiatives on the identities of rural, indigenous women in the Peruvian Amazon, this thesis acknowledges the effects of the harmonization of national policies with neoliberal globalization on the lived experience of reproductive health for Indigenous women. The five texts included in this study are produced by Allan Guttmacher Institute, the Society of Obstetricians and Gynecologists of Canada, Pfizer, the Vancouver/Richmond Health Board, and Health Canada. I outline each of these texts below and briefly discuss their relevance to this study on the social constructions of depo-provera users.

The text, *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care* (Singh, Darroch, Vlassoff & Nadeau, 2003) is a policy report created by The Allan Guttmacher Institute. The Guttmacher Institute is a nonprofit organization that is based in the United States and is a 'special affiliate' (Coleman, Rue, Maxey, Coyle, 2006: 631) of the Planned Parenthood Federation of America (PPFA)⁶. For the *Adding it Up* text, specifically, the Guttmacher Institute acknowledges the United Nations Population Fund (UNFPA) both for their financial support and for giving vision to and aiding in the production of the text. On the Guttmacher Institute's website it states that:

⁶ The Guttmacher Institute shares both common funding sources and board members with the PPFA (Jones, 2006).

The Institute's mission is to protect the reproductive choices of all women and men in the United States and throughout the world. It is to support their ability to obtain the information and services needed to achieve their full human rights, safeguard their health and exercise their individual responsibilities in regard to sexual behavior and relationships, reproduction and family formation.

The *Adding it Up* text claims that its intended audience is international and local policy makers. The text is important to examine because it provides policy suggestions that construct reproductive regulation as the answer to development internationally and locally. The Guttmacher Institute argues that “investments in health care services, including those related to sexual and reproductive health, can make valuable contributions to wider development goals. For example, family planning allows women to achieve higher levels of education and a better balance between family and work” (5). This text provides insights into prevailing reproductive regulation discourse in agency and medical provisions of contraceptives and their understandings of targeted populations. This text has significant relevance to the study of the prescribing of depo-provera to young Indigenous women because it provides ‘common sense’ rationales for its use. It is important to critically analyze these rationales since, as discussed in Chapter 2, research suggests that women of colour, women in the Third World, and Indigenous women in the first world have been disproportionately prescribed depo-provera.

While the *Adding it Up* (Singh, Darroch, Vlassoff & Nadeau, 2003) document is oriented towards a broad international approach concerning a range of contraceptives, a Canadian document that I examine is primarily focused on clinical practitioners’ knowledge about depo-provera. In 2000 the Clinical Practice Gynaecology Committee, under the Society of Obstetricians and Gynaecologists of Canada (SOGC), published *Injectable Medroxyprogesterone Acetate for Contraception* (Boroditsky & Guilbert). This text provides a review of policy practices for health providers in prescribing and maintaining women’s use of depo-provera. The SOGC creates national clinical guidelines on women’s health for the public and medical professionals. The SOGC (n.d.a) is comprised of 3,000 health care providers, including family

physicians, nurses, gynaecologists, obstetricians, and midwives, and positions itself as a “leading authority on reproductive health care” (para 2). The mission of the SOGC is “to promote excellence in the practice of obstetrics and gynaecology and to advance the health of women through leadership, advocacy, collaboration, outreach and education” (para 3).

This article is important to consider because it is recently published and it reveals the assumptions and guidelines influencing the provision of health care for depo-provera. This document favours evidence-based models and biomedical approaches that focus on the individual while ignoring broader social and political contexts. The pharmaceutical industry's construction of knowledge is paramount here where the discourse focuses primarily on problems of women's rates of discontinuance in their use of depo-provera – in other words, their lack of compliance.

The third text examined in this study is a depo-provera pamphlet produced by the Vancouver/Richmond Health Board (1999). While in the process of locating texts I decided to visit two locations that provide health services specific to Indigenous women in Vancouver. At these locations, I browsed the information centres for materials specific to depo-provera. Of the two locations visited one carried this pamphlet on depo-provera. This text is significant because it is publicly available and is intended for use among young women considering contraceptive use.

The fourth text examined is taken from the Pfizer (n.d.b.) website on depo-provera. Pfizer is the largest pharmaceutical company globally and is based in New York⁷. According to Pfizer's (n.d.a) website, their vision is to “become the world's most valued company to patients, customers, colleagues, investors, business partners, and the communities where we live and work” (para 1). This Pfizer website is complex and covers topics from what to expect while on

⁷ On Pfizer's website (<http://www.pfizer.com/pfizer/are/index.jsp>) it states: “Every day we help 38 million patients, employ more than 100,000 colleagues, utilize the skills of more than 12,000 medical researchers, and work in partnership with governments, individuals, and other players for healthcare to treat and prevent illnesses—adding both years to life, and life to years.

depo-provera to the advantage of depo-provera as a contraceptive over other forms of birth control. While browsing these websites I looked for a website that best addressed my research questions and settled on a website titled “Is depo-provera right for you?” because it provides opportunities to examine the ideologies of Pfizer specific to depo-provera prescription.

Health Canada produced the fifth text that I have chosen to look at. This text, *A Statistical Profile on the Health of First Nations in Canada: For the Year 2000*, was published in 2005 and focuses on population projects specific to the Aboriginal population in Canada. The growth of the Aboriginal population is compared with the statistics in the *general* Canadian population. This report is interesting because of its focus on the current fertility rates of Aboriginal people. Although this text does not focus specifically on depo-provera it may influence its promotion in discussions that concentrate on the growing Aboriginal fertility rates in Canada and possibly elsewhere.

Finding documents specific to Indigenous women and contraceptive use or reproductive health in Canada was challenging. It was even more challenging to find documents referring specifically to Indigenous women and depo-provera. When initially searching for documents in the journal articles and databases through the SFU library and then through internet I found very little.

Process of analysis

The approach to critical discourse analysis used in this thesis is guided by the work of van Dijk (2001) and Fairclough (2001). I read the selected texts of this study several times, categorized them according to subject (international policy around reproductive health, depo-provera literature, and Indigenous women and reproductive health) and systematically analyzed them. I applied van Dijk’s (2001: 102) suggestion of listing topics discussed within each text. He states that topics present “macrostructures” that provide “a first, overall, idea of what a

discourse or corpus of texts is all about”. The listing of topics facilitates the surfacing of the texts’ positions. Through listing the topics discussed within each text I was able to see more clearly the positions claimed within the texts (see Appendix 1 for an illustration of this process). Following this process I then applied Janks’ (1997:50) version of Fairclough’s (2001) model of CDA to each text in turn (see Figure 1).

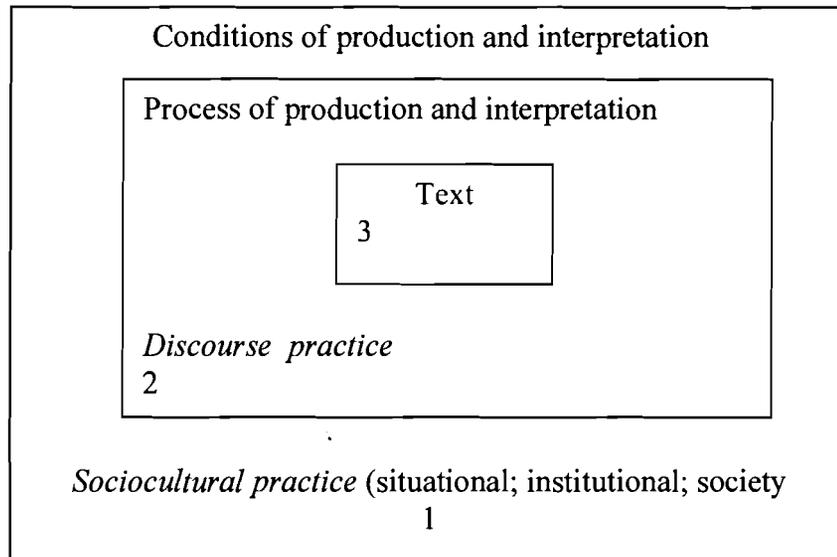


Figure 1: Fairclough’s model of CDA as text, interaction, and context.

Fairclough’s model of CDA reflects an understanding of discourse as referring to the entire process of social interaction of which the text is a part. According to Janks (1997: 49), Fairclough’s model of CDA

consists of three interrelated processes of analysis which are tied to three interrelated dimensions of discourse. These three dimensions are:

1. the object of analysis (including verbal, visual or verbal and visual texts);
2. the processes by which the object is produced and received (writing/speaking/designing and reading/listening/viewing) by human subjects;
3. the social-historical conditions that govern these practices.

Related to these three dimensions of discourse are three stages of critical discourse analysis.

Fairclough outlines these as:

1. text analysis or description. This stage is focused on the composition of the text (verbal and visual). The concern here is with labelling and identifying features in the text.
2. Interpretation. This stage is concerned with the connection between text and interaction – this is specifically meaningful to understanding texts “as the product of production, and as a resource in the process of interpretation” (Fairclough, 2001:21). Janks states that central to interpretation are situation context and intertextuality.
3. explanation/social analysis. Fairclough notes that the objective of this stage “is to portray a discourse as part of social process, as a social practice, showing how it is determined by social structures, and what reproductive effects discourses can cumulatively have on those structures, sustaining them or changing them” (135).

In Chapter 5, I use these three stages for organizing my discursive analysis to reveal the social location of medically-oriented documents that focus on women’s reproduction and its regulation.

Order of discourse

The order of discourse provides an important framework for examining how the social practices (e.g., health provision) of reproduction are associated with institutionalized sets of ideas (e.g., colonial knowledge, neoliberal governance, neutrality/objectivity/paternalism of science) and how these are networked in particular ways. Fairclough defines the order of discourse as the social ordering of relationships between diverse discourses and genres within a specific social domain (Fairclough, 1995) (such as prescribing practices of depo-provera). Phillips and Jorgensen (2002) further argue that the order of discourse controls what genres and discourses can be called upon as resources in communication because the order of discourse constrains the resources (genres and discourses) that are possible. Important in the order of discourse is understanding that not all discourse is equal. Some discourses are dominant or mainstream whereas others are considered marginal, or alternative (Fairclough, 2001). These orders are important because they provide an entry point to examining the power relations that construct marginalized women as depo-provera users. The order of discourse both shapes and is shaped by

discourses and genres available within the order of discourse. Fairclough encourages constructing a 'flow chart' (253) to demonstrate the order of discourse and to show how different types of meaning making (discourse and genres) are linked together. Below I map out the order of discourse as it applies to the texts analyzed in my thesis on the disproportionate prescribing of depo-provera to Indigenous women.

Order of discourse: mapping the five documents

Singh, Darroch, Vlassoff, Nadeau (2003). *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care*

Genre: Reproductive health policy at both international and local levels
 Social practices: national health care provision, public policy, population policy
 Institutionalized ideas: neoliberal rationalities; emphasizes individual responsibilities for the regulation of risk
 Discourses: reproduction as a barrier to economic growth in third world countries; constructions of third world women as 'at risk' for unintended pregnancies; modern contraceptives as answer to women's empowerment and the spacing, limiting of births; medicalization of reproduction and the silencing of women's voices and the devaluation of traditional knowledge over reproductive health

Boroditsky & Guilbert (2002)
Injectable Medroxyprogesterone Acetate for Contraception

Genre: clinical guidelines
 Social practices: health care provision, depo-provera provision
 Institutionalized ideas: objectivity/neutrality of health services
 Discourses: discourses of difference between 'us'/active (physicians, gynaecologists) and 'them'/passive (women prescribed depo-provera)

Pfizer (n.d.b). *Is Depo-Provera Right for you?*

Genre: pharmaceutical, website, promotional
 Social practices: communicating information, depo-provera provision
 Institutionalized ideas: individual responsibility for the regulation of 'risk'
 Discourses: constructions of women 'sexually at risk', women burdened by the pill, women who forget to take birth control, women wanting sexual freedom

Vancouver/Richmond Health Board (1999). *Depo-Provera Pamphlet*

Genre: health care provider, promotional
 Social practices: health care provision, depo-provera provision
 Institutionalized ideas: individual responsibility, individual choice
 Discourses: the neoliberal ideal family, individual responsibility

Health Canada, (2005). *A Statistical Profile on the Health of First Nations in Canada: In the Year 2000*

Genre: government document, health document, statistics
 Social practices: policy making, health care provision
 Institutionalized ideas: colonial knowledge, neutrality & objectivity of statistics & Health Canada
 Discourses: decontextualized discourses, individualization of systemic problems

Chapter Five: Discursive Constructions of Indigenous Women's Reproduction

As discussed previously, this thesis is an exploratory study of discourses and practices focussed on the regulation of Indigenous women's reproduction through the prescribing of depo-provera. In this chapter, I apply Linda Tuhiwai Smith's (1999) concept of decolonization to medical and health discourses and I illustrate the presence of racialized, discrediting, and decontextualized discourses in 5 texts. In my analysis I show that texts aimed at Third World women and/or "sexually at risk" women living in "confounding life situations" seek to control their reproduction with (health) provider-controlled contraceptives such as depo-provera. I argue that these 5 texts draw on colonial assumptions and neoliberal rationalities in framing the characteristics of depo-provera users.

Adding it Up: Producing the "sexually at risk"

In 2003 the Alan Guttmacher Institute (AGI) with financial support from the United Nations Population Fund (UNFPA⁸) published the *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care* (Singh, Darroch, Vlassoff and Nadeau) document. The Alan Guttmacher Institute was established in 1968 as the research and development division of Planned Parenthood Federation of America (PPFA). The Institute is named after Alan F. Guttmacher, an obstetrician/gynecologist and author, who served as president of the PPFA in the

⁸ The United Nations Fund for Population Activities (UNFPA) was founded in 1969 and was renamed as the United Nations Population Fund (UNFPA) in 1987. The UNFPA works in partnership with governmental and nongovernmental organizations and is the largest financial contributor to sexual and reproductive health programs globally. Most Third World countries are dependent on contraceptive supplies (such as Depo-Provera) through nongovernmental agencies like the UNFPA. The UNFPA has a history of providing Depo-Provera to Third World countries that stretches back to before Depo-Provera was approved for use in the United States in 1992 (Singh, 1995) and Canada in 1997.

1960s. Dr. Guttmacher believed that "No woman is completely free unless she is wholly capable of controlling her fertility and...no baby receives its full birthright unless it is born gleefully wanted by its parents" (Guttmacher Institute, n.d.b.: para 8). At inception the AGI's statement of purpose was

devoted to systematic research and action in fertility regulation, population size and health and social policy. Its principal purposes in these fields are to aid in the development of sound public policies, to promote understanding of issues of national and international importance, and to assist in the creation of adequate public and private sector programs. (Jaffe, 1974: 1)

The underlying objective of the AGI remains similar today but is now framed within the discourse of neoliberal rationalities, which is evident in the following quote:

The Institute's mission is to protect the reproductive choices of all women and men in the United States and throughout the world. It is to support their ability to obtain the information and services needed to achieve their full human rights, safeguard their health and exercise their individual responsibilities in regard to sexual behavior and relationships, reproduction and family formation. (Jaffe, 1974: 1)

In this mission statement, AGI emphasizes individual 'choices', ability 'to obtain' information and services, and 'responsibilities'. The network of social practices within which the text and the Alan Guttmacher Institute promote sexual and reproductive health is located within neoliberal global governance and is linked to practices in national health care provision (public policy), population policy and in the everyday life of women both in the United States and the developing world. This network is evident in the text's objective of asserting international influence over local policies (specific to sexual and reproductive health) in developing countries as well as through advocating for foreign investment in contraceptive provision in the Third World. This text applies neoliberal rationalities through encouraging the devolution of state responsibilities onto private organizations and through advocating partnerships between government, non-governmental organizations, and multinational investments in service provision.

The *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care* text falls within the genre of policy that significantly shapes and manages the way contraceptive *need* is perceived through the creation of discourses around sexual and reproductive health. The intended audiences for the report are policy makers at national and local levels as well as nongovernmental organizations and multinational investors (4).

Textual analysis

The cover of the report includes a visual text of what seems to be a nuclear, heterosexual family seated on a motorbike. The photograph is situated in a rural setting with grass, low-lying trees, and sunlight in the background. The family is situated on the right side of the picture and they are faced away from the camera and moving into the sun. The shot clearly brings the family into focus and has the effect of blurring the background. The photo allows the viewer's gaze to rest on the positioning of the family on the bike as well as on details of clothing that the family is wearing. The man in the picture is driving the bike and is dressed in a sun hat and wearing what could be a scarf, shirt and slacks. The woman is seated second in the picture and is wearing a sun hat, shirt and skirt. The hat completely covers her face. Seated last is a little girl whose long hair peeks out from underneath her hat. The little girl is wearing a sleeveless shirt and short pants. The details of the family brought into focus by the photograph both allows the viewer to assume some knowledge of the family and positions the family as an object of focus.

The photograph conveys a portrayal of a heterosexual nuclear family in a developing country. The background of this photo suggests that the family is in a rural, 'undeveloped' setting. The greenery in the picture is blurred and not distinguishable. Of importance to consider are the obscured faces of the family. As the faces of this family are unknown to the viewer, the family becomes generalizable and avoids any specific characterizations such as racialization. This process makes it possible for this family to represent any family in a developing country.

A final important detail to note in this photograph is the fact that the woman is holding a computer monitor with her left hand and is balancing it on her knee. This image suggests that the woman is embracing modernization while balancing the needs of her family. The presence of a computer monitor also implies that because the family is small they have adequate resources and a disposable income. The composition of the picture also suggests that the little girl is the beneficiary of belonging to a small family that values education. This picture implies that small families are the key to financial security, social mobility and higher degrees of educational attainment. It also implies that girls will have a future through acquiring a Western form of education. This interpretation is reinforced by the positioning of the text on the cover of the report. The cover of the report is divided into two parts. The top half of the page contains the Alan Guttmacher Institute and the UNFPA insignia. This section also includes the title of the document, *ADDING IT UP: The Benefits of Investing in Sexual and Reproductive Health Care*. The bottom half of the page contains the photograph of the family. The first part of the title “*ADDING IT UP*” dominates the top half of the cover page and provides context for the photograph below. This positioning conveys authority and privileged knowledge. This pattern is important to note because it is repeated throughout the document. The report is divided into two parts, the top half of the document is a designated space for statistics, bar graphs, pie charts, and select quotes from studies that the report draws on and also from the report itself. The bottom half of the page contains the report. It is in the bottom half of the page that the Guttmacher Institute constructs its argument for investment in sexual and reproductive health care in developing countries. This process is very much a top down approach. The *benefits* of the proposed sexual and reproductive health care are taken for granted as factual, yet reflect the imposed beliefs of the authors.

Interpretation: analysing the processes of production and reception

The frame of the *Adding it Up* text follows an objective – problem – solution structure. There are several examples of this throughout the document (objective = achievement of the Millennium Development Goals, poverty reduction, women’s *emancipation*; problems = *traditional* contraceptive use, inadequate provision of sexual and reproductive health services, high infant and maternal mortality rates, closely spaced children, *non-working mothers*, large families, inadequate financial resources; solution = provision of *modern* contraceptives, increased sexual and reproductive health services). Fairclough (2001) sees the problem - solution structure as key to constructing the promotional nature of texts where one-sided arguments are presented and perceptions are managed – in the case of this document the arguments and perceptions presented are informed by the neoliberal rationalities to which the AGI subscribes. It implies that failure to make the right reproductive choices and to become modern rests with the individual.

This positioning asserts the authority of the Guttmacher Institute’s knowledge over sexual and reproductive health. To support their claim of authority the Institute uses research conducted by the World Bank and World Health Organization that has focused on the “the societal burden of ill health, and the cost of prevention and treatment” (5). In using data gathered by the World Health Organization and the World Bank, the report provides statistics, bar graphs, and pie charts. Interestingly, the report uses statistics and graphs without referring to their sources and repeats routinely words like data and evidence without referring to sources. This process constructs the illusion of unquestioned authority.

The Guttmacher Institute further claims to be an authority on assessing the broad social impacts of sexually and reproductive health interventions. The word intervention is utilized often in the report. The use of this word both constructs reproduction and sexual health as in need of regulation as well as rationalizes the intervention process. The report states that (5):

Contraception can avert significant economic, social and psychological costs, especially those arising from a mistimed or unwanted pregnancy. Such nonmedical costs can limit the life options for women and undermine the well-being of families. They can also hold back social and economic development and hinder efforts toward gender equality and poverty reduction.

This argument is laced throughout the report and has the effect of constructing reproduction as a social and economic burden. It also constructs the idea of ‘development’ in specific ways that are shaped by western notions of modernization⁹.

Discourses at work in the text

Throughout the document, the text constructs a discursive divide between the modern and the traditional. It constructs this dichotomy in the form of statistics of women of reproductive age in developing countries, and in discussions around contraceptive methods. For example, the text calls attention to the dichotomy between modern and traditional by discussing statistics that link reproduction to the achievement of the Millennium Development Goals (MDGs) showing that reproduction hinders economic development. The report states that (15):

Sexual and reproductive health are not simply about health; nor are they simply a factor influencing macroeconomic growth. They are fundamental to personal identity and fulfillment, and to family social relationships. Sexual and reproductive health services help individuals and societies achieve a range of social and economic goals.

The divide between modernity and traditional reinforces the claimed authoritative voice of the Guttmacher Institute (a western research group) on sexual and reproductive health. This authority is achieved through the privileging of western scientific discourse and research in the *Adding It Up* document.

⁹ Ginsburg and Rapp (1995: 9) note that “transnational or global processes are those through which specific areas of knowledge and power escape the communities of their creation to be embraced by or imposed on people beyond those communities. When such ideas flow from the West to the Third World, the process is often implicitly read as a modernist narrative that presumes Westernization as the inevitable outcome [of development]”.

Colonial knowledge is also enacted in the report through the use of studies and statistics that show the effectiveness of modern contraceptives¹⁰ in limiting and spacing births while simultaneously demonstrating the ineffectiveness of traditional methods in regulating births. In the report traditional methods are equated with “high failure rates” (18), and “likelihood of discontinuation” (18) because of the “high levels of knowledge and motivation required for sustained and successful use” (18). The report further emphasizes that women are choosing to discontinue use of traditional methods¹¹ in favour of modern methods. To illustrate this, the report provides pie charts for “Women at risk seeking to space births (234 Million)” (17) and “Women at risk seeking to limit births (471 Million)” (17). Under the subheading “Women at Risk seeking to Space Births”, the chart shows that 57% of women utilize modern reversible methods (e.g. IUD, long-acting hormonal methods, oral contraceptives, and condoms), 11% utilize traditional methods and 32% utilize no method. Of interest to note here is the assumed neutrality of ‘modern contraceptives’ and statistics.

This document mirrors the process of medicalization of reproduction noted by Jasen (1997) and Kaufert and O’Neil (1990) where authoritative (doctors/nurses/government officials) knowledge over childbirth was privileged and women’s knowledge and voices over birthing practices were suppressed and silenced. In the *Adding it Up* document the voices of the intended recipients of reproductive and sexual health services are noticeably absent. In the place of the voices of women are statements and headings such as “More than half of all women in developing countries are at risk of unintended pregnancy”(17) “About 200 million have an ‘unmet need’ for effective contraceptives” (18) “most women who discontinue traditional methods switch to a modern method” (18). These depictions advantage governing discourses at

¹⁰ Modern contraceptives is divided into two categories in the report, these are modern reversible methods and sterilization.

¹¹ Traditional methods are defined in the report as “withdrawal, periodic abstinence or another nonmodern method” (18).

the expense of the understanding and experiences of women of reproductive age in the developing world in their specific social, cultural, economic and political contexts.

The report also enacts colonial knowledge through the use of research that quantifies the “social and economic costs of ill health and the benefits of prevention” (8), such as family planning. As stated earlier, the Guttmacher Institute relies on research by the World Bank, the World Health Organization, and the Harvard School of Public health. This research has focused on the benefits of reducing government spending to education and health services through the provision of family planning programs. The focus on the reduction of government spending for social welfare services is reflective of neoliberal ideals that favour individual responsibility for the regulation of risk. The *Adding it Up* report states that (20):

Women who can avoid unplanned births and hence pregnancy related disabilities have more opportunities for education, training, employment, and community political activities. They also have more time and resources to invest in their children. Just as important, the ability to decide freely and responsibly the number, timing and spacing of one’s children is a basic human right.

What is interesting about this quote is that it simultaneously constructs the subjectivity of the ideal citizen – the one who manages reproduction properly – while also revealing what an ideal citizen is not. This quote also draws a clear link between the use of modern contraceptives and women’s empowerment and quality of life.

The *Adding it Up* text promotes the productive-mother subjectivity. The productive mother is depicted as the ideal parent who participates in paid work to ensure that her family has adequate resources and therefore minimizes her family’s risk of becoming an economic drain on the state. Women’s access to and use of modern contraceptives are constructed as key to women’s practices of self-improvement. The text emphasizes, for example, that “[w]omen point out that delayed childbearing and smaller families, achieved through contraceptive use, allow more leisure time as well as educational and economic opportunities” (23). Readers are informed that contraceptive use may “reduce gender discrimination in the long term” (24) and increase gender

equality through the construction of smaller families and the resulting economic and educational opportunities that this may bring women, as productive mothers. The productive-mother is depicted as a person who makes choices that maximize her ability to “contribute economically to her household” (23). The productive mother decides “freely and responsibly the number, timing and spacing of [her] children” (20). The productive-mother plans her family.

Social analysis: social historical processes which govern these processes

The report reflects neoliberal governance ideologies in its emphasis on the need to reduce government spending through calling upon individual citizens (in this case, fertile women) to regulate risk. The text positions modern contraceptive choice as a great step forward. However, when we look below the surface we find that the promotion of modern contraceptive use to women in the Third World is framed within a neoliberal rationality that links the composition of small nuclear families to adequate distribution of resources. The use of progressive language, such as empowerment and equity, is part of the shift in the redefinition of state involvement in everyday life under neoliberalism. Peterson and Lupton (1996), for example, note that “[n]eoliberalist rule operates not through imposing constraints upon citizens but rather through the ‘making up’ of citizens capable of exercising regulated freedom” (11). The productive-mother is called upon to regulate the spacing, timing, and number of her children.

Depo-provera texts

Although produced by different agencies (e.g., SOGC, Pfizer, Vancouver/Richmond Health Board) at different times, these texts bring together several discussions covered in Chapter 3. Specifically this analysis illustrates the colonization and assumed neutrality and objectivity of medical/epidemiological/and health discourse, the medicalization of reproduction and the simultaneous silencing of Indigenous women’s voice. The following three depo-provera texts work to construct similar subjectivities – revealing their intertextuality or “the idea that any text is

explicitly or implicitly ‘in dialogue with’ othertexts” (Wetherell, Taylor & Yates, 2001: 233). We see that each text perceives women who have been prescribed depo-provera as possible patients who experience “confounding life situations “ (Boroditsky & Guilbert, 16) (read: racialized women, poor women, marginalized women, Indigenous women), women who are passive and silenced (Boroditsky & Guilbert), women who desire sexual spontaneity (Pfizer, n.d.b), irresponsible women who cannot remember to take a birth control pill on a daily basis (Pfizer, n.d.b). These texts target particular women -- constructed as conforming to these subjectivities – as potential depo-provera users. These subject positions reflect the images of Indigenous women discussed in Chapter 3.

In this section I examine three texts. The first text that I consider is the *Injectable Medroxyprogesterone Acetate for Contraception* (SOGC, 2002). The second text is Pfizer’s website, *Is Depo-Provera Right for you?* (n.d.b). The final text examined in this section is a *Depo-Provera* (1999) pamphlet published locally by the Vancouver/Richmond Health Board.

Injectable Medroxyprogesterone Acetate for Contraception

The document published by the Society of Obstetricians and Gynaecologists of Canada (SOGC) focuses specifically on depo-provera (DMPA). SOGC members are comprised of 3,000 health care providers, including family physicians, nurses, gynaecologists, obstetricians, and midwives. This organization positions itself as a “leading authority on reproductive health care” (SOGC, n.da: para 2). The SOGC creates national clinical guidelines on women’s health for the public and medical professionals. The mission of the SOGC is “to promote excellence in the practice of obstetrics and gynaecology and to advance the health of women through leadership, advocacy, collaboration, outreach and education” (SOGC, n.d.b.: para 3).

The *Injectable Medroxyprogesterone Acetate for Contraception* was published in the Society of Obstetricians and Gynaecologists Canada Journal (also referred to as SOGC Journal);

the SOGC Journal is the single peer reviewed publication in Canada dedicated to Obstetricians and Gynaecology. It is published monthly and includes articles and abstracts from national and international sources that have particular importance to SOGC members. The SOGC Journal also contains policy statements, editorials, and committee opinions. The SOGC website states that “[i]n the interest of promoting and advancing the art, science and practice of Obstetrics and Gynaecology in Canada, the SOGC Journal is distributed to all SOGC members, medical libraries, Schools of Nursing, Health Ministries and other specialties” (SOGC, n.d.b: para 2).

Text analysis

The *Injectable Medroxyprogesterone Acetate for Contraception* article has been reviewed and approved by the “Clinical Practice Gynaecology Committee” (14) and represents the “SOGC Committee Opinion” (14) in the SOGC Journal. Under the article’s title is a list of authors, two principal authors (Boroditsky and Guilbert) followed by a list of seven members from the Clinical Practice Gynaecology Committee. This document is 5 pages in length. The central focus of this document is the clinical management of several side effects (such as menstrual irregularity, long-term risks on bone density, weight gain, depression and fatigue, decreased libido, headaches, and delay in return of fertility) of depo-provera. In this document each side effect is identified, described, and then followed by clinical tips on its management.

This document is written for an audience of physicians and provides guidelines on the knowledge doctors should have of depo-provera’s side effects (or injectable medroxyprogesterone acetate – as it is referred to in this text), how side effects should be discussed with patients, and how effects should be managed. Listing the agreed upon side effects and management practices has the effect of standardizing depo-provera’s side effects and physician’s responses to them. It can be argued that this document continues the process of medicalization over reproduction that Jasen (1997) and Kaufert & O’Neil (1990) identified whereby medical professionals used official records (such as infant mortality rates or obstetrical records) as tools in the social construction of

authoritative knowledge of experts over the reproductive health of Indigenous women. As noted by Jasen and Kaufert and O’Neil, the process of medicalization occurred hand-in-hand with the suppression and devaluation of women’s knowledge and voices over their bodies – this will be explored in the analysis below.

This document is important to examine because it is recently published and it reveals medical assumptions and guidelines that frame health care provision of depo-provera. The SOGC’s clinical guidelines for depo-provera state that they are informed by “evidence-based research” and medical literature. My intention in this section is to explore the ways in which this document employs discourses of difference. As noted in chapter 3, discourses of difference refers to the process of constructing binary oppositions between ‘us’ (in this case physicians, gynaecologists, obstetricians) and ‘them’ (women prescribed depo-provera) – this difference is ideologically constructed.

The SOGC asserts its authority in several ways in this document. For example, the SOGC draws on medical literature that complements the association’s views to inform their clinical guidelines; they privilege objective medical discourse over women’s experiences; and they construct health care providers as active subjects and women as passive recipients. Related to the pattern of authority that the SOGC document creates, it consistently relies on the discourse of science. The text throughout portrays scientific discourse as natural, neutral and objective.

The document encourages health care providers to “clinically manage” side effects: to counsel and advise their patients on the possible side effects of depo-provera, as well as provide ongoing support and regular follow-ups. The objective of these gestures appears to encourage women to use depo-provera over a prolonged period of time. The text also assumes the objectivity of doctor/patient relations, the safety of medical services, and easy access to health care.

Discourses at work in the text

The text inscribes discourses of difference in several ways. In particular, it establishes who has knowledge and who does not; who is active and who is passive. In both cases, health care professionals have command and authority and women who use DMPA do not. By drawing on evidenced based medical literature, health care professionals have access to certainty and to what is known whereas women live in the realm of uncertainty and lack knowledge. This is illustrated in the discussion over women's experiences of weight gain while on depo-provera and the conflicting evidenced based reports called upon in the text (discussed further below). This pattern of certainty and uncertainty establishes a hierarchy of power and knowledge.

In working with the dichotomy between active and passive subjects, the document constructs discourses of difference. Active subjects have the power to name, influence what is known, as well as guide clinical practices around the management of depo-provera's side effects. This article inscribes the active subject as the authors of the document, the SOGC committee members who reviewed and approved the article, medical literature, as well as health care providers of depo-provera. For example, in reference to menstrual irregularity, the document states that "[i]rregular or frequent bleeding and spotting are more common than prolonged episodes of bleeding during the first 90 days of use (25% versus 1.5%), and decreasing to less than 15 percent after one year of use. Rarely heavy bleeding may occur" (14). In this example, the document describes the side effect of menstrual irregularity in authoritative clinical terms and reflects the active voice of a health care provider. On the other hand, the document constructs women as passive. They are objects determined by their bodily functions who need to accept the side effects of the DMPA regime: "Menstrual changes occur in all women who use DMPA" (14).

The document creates women as absent or passive, particularly in places where it gives the side effect a *biological certainty*. This certainty exists in the discussions around menstrual irregularity, long-term risks to bone density, delay in fertility, and the use of DMPA while breast-

feeding. This pattern of certainty ceases, however, in the side effects of weight gain, depression and fatigue and decreased libido. In these side effects, women's experiences are called into question; their judgements lack foundation. For example, in reference to weight gain, the document states that "women tend to associate weight gain with their hormonal contraceptive method" (15). This portrayal of uncertainty continues with the discussion on depression and fatigue where the document states that "[t]hese side effects may occur relatively infrequently, but are very difficult to study in women using hormonal contraception. [...] Depression and fatigue may be markedly affected by confounding life situations that result in the use of contraceptives, rather than by the contraceptives itself" (16). As "confounding life situations" may possibly lead to depression and fatigue – which, however, are uncertain, subjective side effects – and the need for women to use contraceptives, they interfere with the contraceptive, which is inherently neutral, and indeed, harmless. When they become visible in the document, women's lives "confound". Women are passive and a problem. Finally, this pattern is also illustrated in the focus on decreased libido where the text states that "[l]ibido is influenced by numerous factors, including the couples relationship" (16) this statement assumes that only couples should be engaged in sexual relationships where decreased libido may pose a problem. As well, such an observation leaves aside the possible inequitable nature of sexual relationships and downloads the problem of depo-provera onto individual circumstances.

In describing depo-provera side effects in authoritative, distanced and clinical terms, the text has the effect of determining and limiting what is known. It creates a dichotomy between what is known (medical literature and evidence based research) and what is unknown (women's experience). This document sets up a hierarchy of knowledge and reinforces the SOGC's claim to authority in its description of depo-provera's side effects.

The dichotomy set up in this document between what is known (evidenced based research) and what is unknown (women's experience) contributes to the maintenance of the

SOGCs authority on reproductive health and serves to discredit women's experiences and knowledge of depo-provera's side effects. This pattern illustrates a discourse of paternalistic superiority over women's experiences and bodies that exists in biomedical discourse and has allowed the production of the SOGC text. Janks (1997) states that "texts are instantiations of socially regulated discourses and that the process of production and reception are socially constrained" (49). The discourse of biomedical paternalism over women's experiences and bodies exists within the parameters of medical discourse. This discourse is evident in the guidelines' consistent focus on helping women to manage the side effects of depo-provera.

Social analysis

In their analysis of Aboriginal women's encounter with health care professionals, Fiske and Browne (2006) argue that "[i]t is fair to say therefore that policy is a form of power that works upon an individual's sense of the other. It is this positioning on the sidelines that recreates [...] women as subjects of powerlessness" (106). The positioning of women on the sidelines is evident in the SOGC document that constructs women as passive recipients of health care. They are helped by health care providers to manage the side effects of Depo. This positioning of women as the *other* in this medical document has consequences for constructing the subjectivities of women prescribed depo-provera.

In constructing the subjectivities of women prescribed depo-provera as the passive *other*, this document employs a discourse of difference similar to Quintero's (1997) concept of colonial knowledge. Quintero sees colonial knowledge enacted through epidemiology as working to disempower the subject (e.g. women) through inscribing characterizations of powerlessness, dysfunction, weakness that work to justify and reinforce the power of colonizer (in this case health care providers). du Gay argues that "dominating and emerging discourses in organizations and societies provide a repertoire of concepts, which can be used strategically by members of the community to influence the social construction of identities and to support the

institutionalization of practice and patterns of resource distribution (as cited in Phillips and Hardy, 2002:32). Discourses of difference in the SOGC text serve as *facts* that have the effect of *othering* women and women's experiences and knowledge of depo-provera's side effects. As noted earlier, where texts discuss women's experiences of depo-provera's side effects, they discredit them as being *subjective* accounts, or the effect of *life circumstance* and not the contraceptive itself. This document sidelines women as powerless and constructed as not having valuable knowledge to contribute to *objective* scientific discourse.

Though the text refers to "women", it assumes and infers – but does not articulate – that DMPA provision targets particular kinds of women. The text suggests that women who use this contraceptive may live in "confounding life situations" a notion that suggests multiple disadvantages but does not spell them out. In her work on the historical context of depo-provera in North America, Bunkle (1993) states that in developed countries high rates of depo-provera use are found in groups that most resemble Third World stereotypes – this includes Indigenous women. Studies indicate that Indigenous women – who fall into the category of experiencing confounding life situations - disproportionately use depo-provera (Bunkle, 1993; Kildea & Bowden, 2000; Ralstin-Lewis, 2005; Smith, 2002 & 2003; Canadian Woman Studies, 1995; Sarkadi, 1995; Hawaleshika, 2005). In their study, Kildea and Bowden (2000) found that 23% of Aboriginal Australian women utilizing contraceptives were prescribed depo-provera. Similar statistics are found in New Zealand where 25% of Maori utilizing contraceptives were prescribed depo-provera (Bunkle, 1993). A recent study in Canada indicates that 2% of Canadian women prescribed birth control use depo-provera (Black, O'Grady, Paymar, 2004); this contrasts with suggested estimates of Indigenous women in Canada where depo-provera is prescribed at a range from 10 to 20 percent to those utilizing contraception (Hawaleshika, 2005). But few studies articulate how health professionals target Indigenous women to use depo-provera, how the

women come into contact with health professionals, how they come to use depo-provera in the context of their lives, or their experiences with depo-provera.

Is Depo-Provera right for you?

The third depo-provera text I examine is Pfizer's (n.d.b.) website, *Is Depo-Provera right for you*. Located in New York, Pfizer is the largest pharmaceutical company globally. In 2002, the Pfizer company took over the Upjohn Corporation, the original developers of depo-provera. This buyout is consistent with and follows Pfizer's period of growth in the 1980s and 1990s during which they merged with and bought out several pharmaceutical companies. The Pfizer company produces several popular drugs including Viagra (used for erectile dysfunction), Liptor (for lowering blood cholesterol) and (the anti-inflammatory drug) Celebrex or Celebra (Wikipedia, n.d.). Pfizer produces three contraceptive brands: Demulen - a 21 day birth control pill; the three month depo-provera shot, and Depo-subQ provera 104 - similar to depo-provera in having a 12 – 14 week effectiveness but differs from Depo in containing a lowered dose of hormones (Pfizer, n.d.c.). Pfizer is the only pharmaceutical company that produces depo-provera.

Text analysis

Pfizer's Depo-Provera website is publicly accessible and is an important tool for communicating information to women for both promotional and educational purposes. The website is complex and provides a wide variety of information about the advantages of taking depo-provera, how depo-provera works, whether depo-provera is right for you, and what to expect. The website offers viewers/readers an opportunity to ask questions about depo-provera from an online physician and also provides viewers with a video of a woman's experience of taking depo-provera. Finally, viewers are given the opportunity of joining an online reminder email list where woman receive emails reminding them of the date of their next dose. For the purpose of my thesis I chose to look at the section *Is Depo-Provera right for you?* because I am

interested in how Pfizer constructs the subjectivities of women they target as possible consumers/patients.

The website is a form of promotional genre. Promotional genres manage perceptions and shape the way people understand (in this case) depo-provera. The website appears to communicate information about depo-provera to the public. The process of communication is skewed because it privileges the perceptions of the pharmaceutical company and presents a one sided view on who depo-provera is suited for. The composition of the website contributes to the promotional nature of the text. For instance, the website is composed of questions and answers focused on depo-provera. This structure both limits questions posed and possible answers. It is written as though the questions and answers in the website are all that one needs to know to be informed; this process establishes common sense notions around depo-provera and its use. Through the process of constructing common sense notions around depo-provera the website constrains what can be asked of depo-provera and what can be known.

Discourses at work in the text

The following extracts are taken from Pfizer's Depo-Provera website, *Is Depo-Provera right for you?* and consists of three of its four paragraphs.

Extract 1

Is it a burden to take your pill everyday?

If you answered yes, then Depo-Provera may be a smart choice for you – you only have to think about it 4 times a year.

- You just get a dose every 3 months, and you're protected.
- There's no pill to take at the same time every day, so there's no daily hassle.

Your time is your time. Because you're too busy to let your birth control control your schedule!

Extract 2

Have you ever forgotten your birth control and worried?

Another reason Depo-Provera could be right for you – it's 99.7% effective. And it starts working immediately.

- Depo-Provera works better than condoms and the Pill. It's birth control you can feel confident about

- Depo-Provera allows for sexual spontaneity. You don't have to panic about having missed a pill or fear your patch has come loose

As long as you get each dose on time, you can feel confident that Depo-Provera is working. With Depo-Provera, there's no daily hassle – just daily confidence.

Extract 3

With Depo-Provera, you have the freedom to:

- Think about your birth control just 4 times a year, not 365 times
- Have lighter periods or no periods at all
- Feel confident your birth control is working

Discourses of women sexually 'at risk'

In the above extracts a patient/client prescribed depo-provera is spoken of or constructed:

- ◇ as a woman who cannot be bothered to take care of her reproductive health – (because to a woman on depo-provera the birth control pill is perceived as a daily burden)
- ◇ as irresponsible (because she is prone to forgetting to take the pill)
- ◇ as a woman who is not confident in the types of birth control she's used – condoms/pill/patch
- ◇ as a woman who is or wants to be sexually spontaneous
- ◇ as a woman who desires the freedom to think about birth control 4 times a year rather than 365 times
- ◇ as a woman who desires to have the freedom of lighter or no periods

In the discourse of women sexually 'at risk', particular women of reproductive age are grouped together in Pfizer's depo-provera website. In the extracts above a variety of discourses are called upon to produce a discourse of women at risk. These include discourses about sexuality, morality, unintended pregnancies, and women's responsibility/irresponsibility in reproductive health. These discourses come together to constitute women 'at risk' as a problem while simultaneously constructing depo-provera as an answer to this problem.

Through invoking a discourse of women's responsibility/irresponsibility over reproductive health in particular with regard to contraceptive use this text opens up the

possibility of constructing sexually active women as at risk if they use contraceptives that require some action on their part: taking a pill on a daily basis; ensuring that the patch doesn't come unattached; or condom use. It is acknowledged in studies of condom use that the degree of women's influence over condom use is variable and negotiable, and reflective of power in sexual relations (Kaler, 2001). In this discourse women are constructed as responsible for their reproductive health and at the same time constructed incapable (or at risk) of that responsibility; this is similar to use of scientific motherhood (Jasen, 1997) where women were constructed as requiring scientific and medical advice to ensure their well-being and the well-being of their families. In this website women are informed that if taking a pill on a daily basis is a burden that depo-provera is a "smart choice" for them. Women only need to think of having their depo-provera shot four times a year.

Unstated is the fact that depo-provera is provider controlled; women need to visit the physician's office to have their shot. As discussed earlier in Chapter two, many feminists have discussed concerns over provider-controlled contraceptives, like depo-provera and Norplant. Feminists have argued that provider-controlled contraceptives (such as depo-provera) tend to be administered to marginalized women who are constructed as responsible for overpopulation (Kaufert, 1990).

Social analysis

The discourse of women sexually 'at risk' has had particular effects in the reproductive regulation of Indigenous women's reproduction through the prescribing of depo-provera. As stated previously, evidence suggests that depo-provera is disproportionately prescribed to particular women (e.g. Indigenous women, racialized women, poor women) living in confounding life situations. The combined effect of the discourses within women at risk is the portrayal of moral messages around appropriate behaviour (e.g., being sexually responsible, having planned pregnancies) for sexually active women of reproductive age.

Depo-Provera pamphlet

In 1999 the Vancouver/Richmond Health Board published the *Depo-Provera* pamphlet. This pamphlet reflects the Vancouver/Richmond Health Board's position on depo-provera and reveals their stance on public information about depo-provera as a contraceptive. The Vancouver/Richmond Health Board is a governing body responsible for organization and provision of health care service for North Vancouver, West Vancouver, Vancouver, and Richmond. The Vancouver/Richmond Health Board falls under the Vancouver Coastal Health Authority, (Vancouver Youth: City of Vancouver Outreach Team, n.d.). The Vancouver Coastal Health Authority serves 25% of B.C.'s population, (<http://www.vch.ca/about/numbers.htm>). The *Depo-Provera* pamphlet is a form of promotional genre that works to manage perceptions and shapes the ways women understand depo-provera and its use. This pamphlet is widely available.

Text analysis

Similar to the Pfizer website *Is Depo-Provera right for you?* this text is also a form of promotional genre, which is evident in the questions posed and answers given. This structure both limits questions posed and possible answers. It is written as though the questions and answers in the pamphlet are all that one needs to know to be informed; this process contributes to creating common sense notions around depo-provera and its use.

The Depo-Provera pamphlet includes both verbal/written and visual texts. Wrapped around the verbal text in this document are visual cues that carry moral meanings. For example, the front cover of the pamphlet is divided in two, on the top section is the title "DEPO-PROVERA" in large upper case letters. This positions the text as having authority on what depo-provera is. Interwoven throughout the lower section of the pamphlet's cover is a portrayal of a nuclear, heterosexual family consisting of a man, woman, girl and boy. The caricature is presented as neutral – containing little defining characteristics and colour, and includes a house, car, and dog. This picture is completed with an atmosphere of hearts and stars scattered around

the family. Beneath the title are words and pictures against a dark background. The words are also in upper case letters but are composed of varying smaller fonts. Words such as “LEISURE,” “RESPECT,” “PLEASURE,” “LOVE,” “FAMILY,” “RELATIONSHIPS,” “SEX,” and “FUTURE” are also positioned with the visual text in the lower section of the pamphlet’s cover. The combination of visual and verbal text on the pamphlets cover make up the texturing work of the text.

The composition of the pamphlet’s cover constructs certain qualities of small, nuclear, heterosexual families as being valued. The stars and hearts positioned on the cover, for example, suggest that small nuclear families bring happiness and love. Through the words “Leisure,” “Respect,” “Family,” “Future,” the reader is informed of the possibilities that the contraceptive depo-provera may bring. In constructing small, nuclear families as highly valued, the text assumes shared values and ideals in family composition. ‘We’ see small nuclear ‘families’ as highly valued; ‘We’ also see nuclear families as constituting a ‘respectful’ and respectable ‘relationship’.

When the pamphlet is opened the reader is presented with three sections following the folds of the pamphlet. The first and second sections are informational and consist of questions and answers about depo-provera. For instance, in the first section questions posed in the text are “WHAT IS DEPO-PROVERA?”; “HOW DOES IT WORK?”; “HOW EFFECTIVE IS IT?”; “HOW DO YOU USE DEPO-PROVERA?”. The middle section is composed of a solid black panel with large white letters stating “PROTECT yourself”; “PROTECT your future”.

Discourses at work in the text

Critical discourse analysis encourages consideration of social conditions that provide parameters, or constrain, what can be said, known and thought in particular contexts and that have influence over textual production (Rudman, 2006; Janks, 1997). In this text the reader sees how a variety of discourses are both available and called upon to produce the present-day discourse of

family. These include discourses about marriage (represented through the picture of the heterosexual couple on the cover of the pamphlet), future families (explicitly stated in the text), planning families (or future family), morality (single representation of a heterosexual couple with two children), parenting, and adequate resources (achieved through the composition of small nuclear families – which allows for the ownership of a house, car, and pet). What emerges in this text as the ideal family is the ideal family within neoliberalism. The ideal family is planned, can provide for itself, and is not an economic drain on society.

Although this document does not directly state what ‘type’ of women is in ‘need’ of depo-provera we can assume that they are women who aspire to have small families and/or women ‘at risk’ of having large families. The targeting of women who are ‘at risk’ of having larger families has potentially detrimental effects on reserve First Nations women where, according to Health Canada (2005) statistics, “two-thirds of First Nations families had more than two children, compared with just over half for Canada; and one-third had more than three children, versus about sixth for Canada” (23).

This pamphlet also targets women who are interested in delaying childbirth as well as women who may be ‘at risk’ for unplanned pregnancies. This is illustrated in the claim to ‘protect your future’. This text calls on the individual women to ensure that she ‘protects [her] future’ and ‘protects [herself]’ through delaying childbirth. The neoliberal rationalities that this text draws on become clear through the document’s focus on individuals and individual responsibility, and the delaying of childbirth until some form of economic and material security is achieved.

The analysis of the following document illustrates the ways that colonial processes persist in discourses and practices focused on Indigenous women. I discuss how socioeconomic, historical and political marginalization become decontextualized in the *Statistical Profile on the Health of First Nations in Canada: For the Year 2000* and how this decontextualization

contributes to reproductive regulation. I also make linkages between this document and the characterizations of Indigenous women it invokes with the characterizations of depo-provera users and “sexually at risk” women discussed above.

A Statistical Profile on The Health of First Nations in Canada: For the Year 2000

The fifth and final document that I chose to examine is Health Canada’s *A Statistical Profile on The Health of First Nations in Canada: For the Year 2000* (2005). This document was published in 2005 and is currently the most recent document providing statistics on the health of First Nations. This document is located in the network of social practices of government and is linked to practices in health care provision and in the everyday life of Indigenous people on reserve. This report seeks to

contribute to improving First Nations health by increasing the information available to health professionals, researchers, community leaders and policy makers. It contains detailed statistics and figures on a range of health related topics, including hospitalization, perinatal health, life expectancy, and communicable diseases among First Nations people.

This report presents a “national description” (8) of current health status of First Nations people living on reserve. The report states that these statistics may be used to “monitor trends and detect emerging health issues” (8). The report further states that (8):

In keeping with the health determinants’ model that is complementary to Aboriginal perspectives of wellness – one that encompasses physical, social, emotional, and spiritual domains – a section on some of the non-medical determinants of health have also been included. This section presents information obtained from Health Canada’s First Nations and Inuit Health Branch (FNHIB), Indian and Northern Affairs Canada (INAC), and Statistics Canada on education, employment, housing conditions, water quality and sewage treatment.

This document is 123 pages long and is written in both of Canada’s official languages of English and French.

Text analysis

This text is comprised of four chapters. Chapter one introduces the document. Chapter two discusses demographics and vital statistics that cover population trends by age and sex, life expectancy, birth rates, family composition, perinatal health, infant mortality, and mortality statistics. Chapter three covers health status and includes discussions on notifiable infectious diseases, morbidity rates, dental health, non-traditional tobacco use, substance abuse, and the impacts of health status trends on communities. Chapter four covers the non-medical determinants of health including educational attainment, employment and income, housing and community infrastructure, traditional language and culture, remoteness, access to health care providers, and impact of health determinant trends on communities.

Interpretation: analyzing the processes of production and reception

Government statistics tend to be understood as authoritative, neutral and objective. This view is reinforced by Health Canada's portrayal of itself as presenting a "national description" (8) or *Statistical Profile on The Health of First Nations in Canada* that can be used by health providers, policy makers, and community leaders to improve the health of First Nations. In this document it is important to consider whose description or profile of First Nations health is reflected in the data. I argue that the statistics presented in this text are not neutral or objective, but provide a particular lens for perceiving First Nations' health. A compelling example of this is found in the introduction to the text. The introduction is important because it frames the context of the text that follows. In this text the reader is informed that "detailed statistics and figures on health related topics" (8) are covered (e.g. population trends, life expectancy, family composition, birth rates, and infectious diseases) but that these are discussed separately from "non medical determinants of health" (8) (e.g. employment, housing condition, education) which are considered in a separate section of the document. This means that each health variable discussed is considered in isolation from larger social and historical contexts. This separation neglects the detrimental effects on Indigenous women of marginalized experiences in health care services,

education, and employment through the processes of colonialism. The *Statistical Profile on The Health of First Nations in Canada* decontextualizes the experiences of First Nations in Canada by not situating statistics within a broader social historical context. Where health determinants are considered – because they provide “Aboriginal perspectives of wellness” (8) – they remain marginalized and divorced from the health variables for which they could provide explanations.

Browne and Fiske (2001) argue that health care – and by extension Health Canada – is itself a social product that has been shaped through historical colonial processes. Colonial processes have served to create binary oppositions between ‘us’ and ‘them’ and has resulted in the social construction of Indigenous women as discredited medical subjects in health care. Quintero’s (2001) concept of colonial knowledge is important to consider while analyzing this document. He argues that colonial knowledge is enacted through statistics that ‘make the Indian’. Statistics “create, standardize, and make into social facts perceived biological, racial, cultural, and social oppositions between the colonizer (white, Euro-American) and the colonized (red, Native American)” (57).

Discourses at work in the text

For this section I’ve chosen to examine three extracts, these are Birth Rates, Family Composition, and Infant Mortality. The extracts selected from the Health Canada document were chosen because they directly relate to my research questions on how documents construct Indigenous women as depo-provera users. These extracts also provide a contemporary government perspective on issues related to Indigenous women’s reproductive health as discussed in Chapter 3. These extracts have been grouped sequentially in the document and are located under the heading *Demographics and Vital Statistics*. These sections are composed of text, statistics, and graphs.

Extract 1

Birth Rates (Health Canada, 2000: 21-22):

First Nations females aged 10 to 14 years had a birth rate over six times that of their Canadian counterparts; for females aged 15 to 19 years, the birth rate was over four times higher. Recent Registered Indian projections have assumed an annual 3% growth rate of the Registered on-reserve population for the period 1998 to 2008 (Indian and Northern Affairs Canada 2000).

Extract 2

Family Composition (Health Canada, 23):

Lone-parent families have been shown to be more prevalent among Aboriginal people in the Canadian population (Hull 2001). In 2001, 65% of on-reserve Aboriginal children lived with both parents, compared with 82.5% of non-Aboriginal children in Canada. The same year, 31.9% of on-reserve Aboriginal children aged 0-14 years were living in lone-parent families, compared with 16.9% of non-Aboriginal children across the country.

Approximately one in three Aboriginal mothers in 1996 was a lone parent, compared with one in six in the Canadian population. As well, Aboriginal women aged 15 to 24 years were three times more likely to be single mothers than Canadian women of the same age.

In terms of family size, almost two-thirds of the families had more than two children, compared with just over half for Canada as a whole; and one-third more than three children, versus about one-sixth for Canada. Single mothers had lower labour force participation, lower skill levels and lower family income.

Extract 3

Infant Mortality (Health Canada, 23-24):

Infant mortality has been regarded as the single most comprehensive measure of health in society, providing an important measure for the overall well-being of infants, children, and pregnant women. It is associated with a wide variety of factors, such as maternal health, access to health care, the quality of that care, socioeconomic conditions, and public health practices. Over time, infant mortality has dropped for all groups but there are still substantial disparities.

[T]he First Nations infant mortality rate has been steadily decreasing since 1979, when it peaked at 27.6 deaths per live births, 2.5 times the Canadian rate (Lemchuk-Favel, 1996). In 2000, the First Nations infant mortality rate had dropped to 6.4 deaths per 1,000 live births, compared with 5.5 per 1,000 for Canada.

Decontextualized Discourses of 'sexually at risk' Indigenous women

In the above extracts Indigenous people are spoken of or constructed as:

- ◇ different from the dominant group. Statistics provided of Indigenous people are in relation to the general Canadian population.
- ◇ having sexually ‘at risk’ youth with birth rates that are four to six times higher than in the general population. Birth rates under 25 years of age are higher in the Indigenous population than in the non-Indigenous population. Birth rates of Indigenous women 25 years of age and over are comparable to or lower than birth rates of non-Indigenous women.
- ◇ having a “prevalence” of lone parent families.
- ◇ having a rate of 31.9% of children under 14 years of age living in a lone parent family – compared with 16.9% of non-Indigenous families.
- ◇ having a large proportion of single mothers – especially young (15 – 24) single mothers
- ◇ having more children than the general Canadian population
- ◇ having a large percentage of non-productive single mothers with “lower labour force participation, lower skill levels and lower family income”
- ◇ having higher infant mortality rates than the general population

In the above extracts a variety of discourses are called upon to produce decontextualized discourses of ‘sexually at risk’ Indigenous women. These include discourses about morality, dependency, family and parenting. The discourses of ‘sexually at risk’ are, however, not only about negative discourses about Indigenous women. These discourses can be understood as part of a process where acceptable families are produced and normalized. Through providing statistics of Indigenous people in relation to the general Canadian population a norm of what is acceptable and not is produced – this is the discourse of difference. Throughout this document, the text constructs a divide between Indigenous and non Indigenous people. This ‘us’ and ‘them’ dynamic both supports and reinscribes social distances between Indigenous and non Indigenous people.

The discourses presented in this text are decontextualized discourses. Through decontextualized statistical discourses a particular portrait of Indigenous women is constructed. For example, in this document Indigenous women under the age of 25 are presented as sexually ‘at risk’ having birth rates that are four to six times higher than Canadian women in the same age group. Furthermore, statistics indicate that there is a large proportion of single mothers on

reserve and that this is especially true with young Indigenous women under the age of 24. The discourse of dependency is invoked in this text. In this text we can see strands of what Fiske and Browne (2006) term as “racially privileged dependents” in dominant perceptions of Indigenous people and that are present in this text in the discourse of dependency. In this text Indigenous women are constructed as being ‘at risk’ for dependency because they are portrayed as irresponsibly having children at a young age (15-24), are likely to be a lone parent, and be a non-productive single mother with “lower labour force participation, lower skill levels and lower family income” (Health Canada, 2005: 23). The discourse of dependency seems to imply that Indigenous women can achieve self-sufficiency through wage labour. Ignored in this assumption are the systemic barriers experienced by Indigenous women to securing employment that is full-time and that pays a living wage, especially on reserve.

These discourses represent Indigenous women as living in “confounding life situations” (Boroditsky and Guilbert, 2000: 16) and as “disorganized, uncontrolled and dependent peoples” (O’Neil, Reading, Leader, 1998: 241). Decontextualized discourses have the effect of blaming Indigenous people on systemic problems. Fiske and Browne (2006) argue that decontextualized discourses that shape ‘risk factors’ or ‘risk groups’ are divorced from greater social, historical, and economic contexts. When divorced from larger contexts systemic problems become understood as individual, behavioural or lifestyle problems. Poudrier’s (2007: 240-241) work is especially important to note here. She states that “where ethnic populations are epidemiologically at-risk and are considered a financial drain on health care resources” notions of racial differences become the focal point of “regulatory surveillance”. A clear example of this is located in the infant mortality rates.

These discourses are decontextualized because they place the problem of inadequate resources and historical and contemporary processes of colonialism solely on the shoulders of Indigenous women.

Health Canada (2005) provides statistics on the infant mortality rates of Indigenous women on reserve from 1979 to 2000. These statistics show a steady decline in infant mortality rates for the Indigenous population, however, statistics for the Year 2000 show that infant mortality rates continue to be greater in the Indigenous population than in the general population. Jasen (1997) argues that infant mortality rates were used, historically, by the Canadian state as an indicator of state modernity and to justify the medicalization and surveillance of childbirth on reserves. As stated earlier, the medicalization of childbirth in northern Indigenous communities had the effect of silencing and suppressing Indigenous women's knowledge of their bodies, birthing, and child rearing practices and justified Canadian government interventionist policies into experiences of reproductive health for Indigenous women.

Chapter Six: Conclusion

Conclusion

This study takes an Indigenous decolonizing/feminist approach in examining discourses embedded in documents that focus on reproduction. The study illustrates how colonial processes (or neo-colonialism) and neoliberal rationalities inform discourses and practices focused on the regulation of Indigenous women's reproduction through the prescribing of depo-provera in Canada. By examining five health-related documents, this thesis explores how "discourses are variable ways of 'speaking of' an issue which cohere or come together to produce the object of which they speak" (Carabine, 2001: 273). Overall, this study shows how discourses produce the identity of young Indigenous women as a risk population in need of reproductive regulation.

Both of the documents, *Adding it Up: The Benefits for Investing in Sexual and Reproductive Health Care* (Singh et al., 2003) and the *Depo-Provera* pamphlet (Vancouver/Richmond Health Board, 1999), portray the nuclear family as the ideal family who is able to provide economically and materially for themselves, therefore reducing their 'risk' of becoming an economic *drain* on the state. The discourse of the nuclear family, as explored in these texts, reflects neoliberal ideals of individualism and individual responsibility for 'risk'. As discussed in Chapter three, when individuals and groups fail to conform to prescribed neoliberal behaviours and norms (Peterson and Lupton, 1996) they are cast as deviant and 'at risk'. Such discourses overlook historical and contemporary processes of colonialism that prevent Indigenous women from providing economically for themselves and their families.

The discourse of the nuclear family implies that lone Indigenous mothers are an economic drain on the state. The document, *Statistical Profile on The Health of First Nations in*

Canada: For the Year 2000 (Health Canada, 2005), singles out the prevalence of single Indigenous mothers: “[a]pproximately, one in three Aboriginal mothers in 1996 was a lone parent” (23). The document reports that young (15-24) Indigenous women are three times more likely to be a lone parent than women in the general Canadian population. This decontextualized analysis situates Indigenous mothers’ reproduction as a problem that needs to be fixed.

More specifically, the medical document *Injectable Medroxyprogesterone Acetate for Contraception* (Boroditsky and Guilbert, 2000) provides a solution for high birth rates of Indigenous young women. This document constructs depo-provera users – who are disproportionately Indigenous women -- as ‘sexually at risk’, living in “confounding life situations” (Boroditsky and Guilbert, 2000: 16) and in need of modern contraceptives, such as the provider-controlled contraceptive depo-provera. The discourses in this document focus on the social construction and maintenance of the authority of scientific, medical, and health discourse in the prescribing of depo-provera to women. Central to this document is the discourse of difference (Hall, 2007) through the division between ‘us’ (e.g. physicians, health care providers) and ‘them’ (women receiving depo-provera). This discursive division interacts with and mirrors Browne and Fiske’s (2001) concept of Indigenous women as discredited medical subjects in mainstream health care. Browne and Fiske maintain that in Canada, the relationship between mainstream health care and Indigenous peoples has been shaped by a history of colonialism that has successfully marginalized and silenced Indigenous women from and within mainstream health care. In ignoring women’s concerns about depo-provera’s risks for women such as its side-effects – which are often long-term – this document focuses on the high rates of discontinuance in women’s use of depo-provera and on strategies to encourage them to continue its use.

The fifth document under consideration in this thesis – Pfizer’s website – underscores the rationales of why depo-provera is “right for you”. In promoting its use, the pharmaceutical company invokes a discourse of women’s responsibility – and irresponsibility – over

reproductive health. It advocates the use of depo-provera for women who have difficulty with the routine use of other contraceptives such as the pill, patch or condoms. Unstated, is the fact that depo-provera is provider-controlled, often administered to marginalized women who are constructed as (ir)responsible for overpopulation, who need a contraceptive that is long-term and out of their control. Indeed, it can be argued that depo-provera, while reversible, is a contemporary, temporary form of sterilization. Fairclough (2001) refers to the particular networking of discourses in which the texts are “explicitly or implicitly ‘in dialogue with’ other texts (existing or anticipated) which constitute its ‘intertexts’”. Any text is a link in a chain of texts, reacting to, drawing in, and transforming other texts” (233). This thesis seeks to ‘add up’ the discourses in these five documents from a different position than the texts themselves – which reflect neocolonial and neoliberal concerns. I argue that the decontextualized discourses have served to situate Indigenous women in marginalized positions and have rendered them vulnerable to reproductive regulation through the prescribing of depo-provera.

It is important to consider how the discourses discussed in this thesis would differ if they took into account an Indigenous decolonizing/feminist theoretical position. Smith (1999) argues that critical theories and feminist approaches are important in Indigenous research because they acknowledge the social constructiveness of knowledge. Adding to this, Smith also argues that decolonizing “is about centering our concerns and world views and then coming to know and understand theory and research from our perspectives and for our purposes” (39). This approach transforms views about dependency into an understanding and consideration of the social and historical processes that have created conditions of poverty in Indigenous communities. An Indigenous decolonizing/feminist approach to poverty and dependency discourse understands them as systemically, institutionally, and ideologically constructed. Rather than seeing Indigenous women as in poverty or as *dependent*, a decolonizing/feminist framework understands Indigenous women to be *situated* in poverty and as economically and socially marginalized

through the processes of colonialism. From an Indigenous decolonizing/feminist position, 'risk' itself is understood as socially, ideologically, and economically constructed.

Directions for future research

This study could be built upon in several ways. Future research in the regulation of Indigenous women's reproduction through the prescribing of depo-provera could address the limitations outlined in the first chapter. Research could examine how status Indigenous, non-status Indigenous, Metis, and Inuit women actively incorporate, resist or negotiate depo-provera use into their daily lives. This approach would place Indigenous women's voices at the centre of the research. In addition, in this study I focused on the medical, science, and health care discourses to explore how Indigenous women become constructed as depo-provera users. An extension of this study would include an examination of how health care providers receive, interpret, understand and implement clinical guidelines focused on depo-provera. Further research could also include an examination of the interactions between Indigenous women receiving depo-provera and the health care provider.

APPENDICES

Appendix 1: A list of topics within each text

ADDING IT UP: The benefits of Investing in Sexual and Reproductive Health

Topics:

1. There are “[b]enefits of Investing in Sexual and Reproductive Health,” (i).
2. “Sustained and increased investment in sexual and reproductive health in developing countries promises tremendous benefits to women, families and societies” (ii).
3. “[F]amily planning allows women to achieve higher levels of education and a better balance between family and work” (5).
4. “Ideally, and often, childbearing is a healthy, planned reproductive act voluntarily undertaken by a woman and her partner in their desire to build a family” (5).
5. “[C]ontraception can avert significant economic, social and psychological costs, especially those arising from a mistimed or unwanted pregnancy” (5).
6. Sexual and reproductive health “programs aimed at high-risk groups were found to be much more cost-effective than those aimed at the general population” (10).
7. Contraceptive use will improve health conditions, decrease infant mortality rates, limit childbearing and will allow families to devote more resources to each child.
8. Contraceptive use will lead to the empowerment of women and improve quality of life.
9. Family planning programs and economic development are correlated with declines in fertility.
10. “One in four people in developing countries – more than 1.32 billion - are women of reproductive age (15 -49)” (17).
11. “More than half of women 15-49 in the developing world some 705 million – are at risk of unintended pregnancy” (17).
12. “About 200 million women have an ‘unmet need’ for effective contraceptives” (18). The category of ‘unmet need’ includes women who are not using contraceptives, “[w]omen who are using a traditional method (withdrawal, periodic abstinence or another nonmodern method)”(18). Nontraditional methods are included because of their “high failure rates and discontinuation” (18).

13. “Women who can avoid unplanned births and hence pregnancy-related disabilities have more opportunities for education, training, employment, and community or political activities” (18).
14. “[T]he ability to decide freely and responsibly the numbers, timing, and spacing of one’s children is a basic human right” (18).
15. Providing sexual and reproductive health programs “can help policymakers reach such goals as promoting gender equality, accelerating economic growth and productivity, improving social equality and expanding community and political participation” (22).

Depo-Provera texts

Injectable Medroxyprogesterone Acetate for Contraception

Topics:

1. The biomedical perspective comprises the conceptual framework for understanding depo-provera (medroxyprogesterone acetate) as a contraceptive in this document.
2. The purpose of this document is to guide clinical decisions around the providing of depo-provera and the management of its side effects.
3. The document is based on evidence-based research on depo-provera.
4. Constructs health care providers as active and women receiving depo-provera as passive.

Depo-Provera (pamphlet produced by the Vancouver/Richmond Health Board)

Topics:

1. The purpose of this pamphlet is educating women on depo-provera and encouraging its use.
2. Depo-Provera use is associated with “leisure”, “respect”, “pleasure”, “love”, “family”, “relationships”, “sex”, and the “future”.
3. The type of family that depo-provera is associated with is presented in pictures of a nuclear heterosexual family of man, woman, two children, a dog, house and car.
4. Through depo-provera use you “PROTECT *yourself*” (original emphasis) “PROTECT *your future*” (original emphasis).
5. Depo-Provera is presented in the pamphlet as being accessible through the use of plain language, and graphics (stars, hearts).

6. Depo-Provera is defined as “a hormone called medroxyprogesterone” that “is injected by needle every 12 weeks in the arm or buttocks”.
7. Depo-Provera works by stopping “the ovary from releasing an egg each month”.
8. Depo-Provera is explained as being “**excellent** (original emphasis) in preventing pregnancy if you get an injection every 12 weeks”.
9. Women can access depo-provera through obtaining a prescription from their physician.
10. The advantages of Depo use are listed as “less menstrual bleeding”, “less menstrual cramps and other PMS”. “It can be used by some women who cannot use the birth control pill because of high blood pressure, blood clots or because they have just had a baby”. Birth control supplies would not be kept at home.
11. The cost of depo-provera is “\$24 - \$34 for each injection (every 12 weeks)”.

Depo-Provera website

<http://www.depoprovera.com/isitright.asp> (last accessed April 26, 2007)

Topics:

1. Daily burden of the birth control pill.
2. With depo-provera you only need to think of it 4 times a year.
3. Depo-Provera is highly effective – 99.7%.
4. Depo-Provera works better than the pill and condoms, it’s a “birth control you can feel confident about”.
5. Depo-Provera allows sexual spontaneity.
6. Depo-Provera provides freedom – lighter or no periods – and you can feel confident that it’s working.

Indigenous women and reproductive health literature

A Statistical Profile of The Health of First Nations in Canada

Topics:

1. Aims to “contribute to improving the health of First Nations by increasing information available to health professionals, researchers, community leaders and policy makers” (8).
2. Presents a national description of current health trends of First Nations people living on reserve.
3. Statistics are used to “monitor trends and detect emerging health issues” (8).
4. Health topics covered: demographics and vital statistics (population trends by age, life

expectancy, birth rates, family composition, perinatal health), health status (e.g., infectious diseases, morbidity rates, dental health, substance abuse)

5. Non-medical determinants of health discuss educational attainment, employment and income, housing, access to health care providers)
6. Birth rates: “First Nations females aged 10-14 years had a birth rate over six times that of their Canadian counterparts; for females aged 15-19 years, the birth rate was over four times higher” (8).
7. Between 1998 and 2008 there is a projected growth of 3% in the on reserve population.
8. Family composition: lone parent families are more common among the First Nations population. In 2001 31.9% of on-reserve First Nations children aged 0-14 lived in lone parent families compared with 16.9% of non First Nations children across Canada.
9. “Approximately one in three Aboriginal mothers in 1996 was a lone parent, compared with one in six in the Canadian population” (23).
10. Approximately two thirds of on reserve families have more than two children.
11. “Single mothers had lower labour force participation, lower skill levels and lower family income” (23).
12. Infant mortality: “The First Nations infant mortality rates have been steadily decreasing since 1979, when it peaked at 27.6 deaths per 1000 live births, 2.5 times the Canadian rate. In 2000, the First Nations Infant mortality rate had dropped to 6.4 deaths per 1000 live births, 2.5 times the Canadian rate” (24).

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