

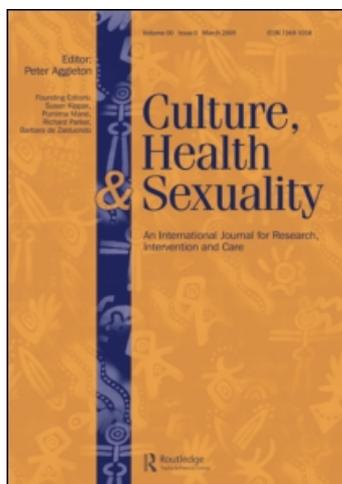
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Consuming contraceptive control: gendered distinctions in web-based contraceptive advertising

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There are over a hundred contraceptives currently on the market in the USA. In this paper, we present a discourse analysis of the stand-alone websites for 43 contraceptives in an effort to understand what contraceptive manufacturers are selling consumers along with their products. Manufacturers tailor marketing messages to promote conventional sex and gender norms using a scientific discourse. In particular, these products appropriate feminist ideals about independence and bodily integrity and promise consumers control and choice over procreation and sexual health, while existing within a larger context of medical surveillance in a patriarchal and capitalist culture.

Keywords: contraception; medicalisation; pregnancy; web-based advertising; USA

Introduction

The Internet is increasingly used by people as a source of health information: 61% of people in the USA consulted the web in 2009, compared with only 25% in 2000 (Fox and Jones 2009). Today, prescription advertising is directed at both doctors and consumers (Conrad and Leiter 2008). Prescription advertising through broadcast media requires consumers be directed to the product's website for the product's package labelling (Food and Drug Administration 1999).

We have conducted a discourse analysis of online contraceptive advertisements to elucidate the ways in which contraceptive companies represent gender and sexual health in the process of hawking their wares. Contraceptive manufacturers seek to keep their products relevant in the face of expiring patents and generic competition through marketing campaigns promoting uniqueness. Pharmaceutical companies – both those who make contraceptives and others – increasingly medicalise human conditions in order to expand their market (Conrad and Leiter 2004). For example, contraceptives are touted for their uses beyond preventing pregnancy or sexually transmitted infections (STIs), such as treating acne (e.g. Ortho Tri-Cyclen®) or potentially limiting the number of periods a woman has to as few as four per year (e.g. Seasonale®). In the case of condoms, which serve the dual-purpose of both pregnancy and STI-prevention (unlike oral contraception), claims are made that sexual pleasure will be enhanced (e.g. Trojan®'s Ecstasy™ condom).

An analysis of contraceptive advertising is important because oral contraceptives are taken by women with little question and manufacturers and healthcare workers promote oral contraceptives as the best form of birth control when other contraceptives can be nearly as effective and are without risky side-effects. Oral contraceptives (OCs) have

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existed for quite some time and are the most commonly used form of contraceptive. The US Food and Drug Administration (FDA) approved OCs in 1960: they ‘prevent pregnancy by suppressing ovulation through the combined actions of the hormones estrogen and progestin’ (Higgins 2002, 152). For women aged 15–44, 19% of women currently use OCs, followed by female sterilisation at 17% and male condoms at 11% (Chandra et al. 2005). Overall, 82.3% of women aged 15–44 years have used OCs at some point (Chandra et al. 2005). Individuals choose contraceptives based on what is considered medically effective but also within a cultural context that reinforces the notion that women are responsible for reproduction and that their bodies are increasingly in need of medical control. Moreover, products aimed at men rely on stereotypical notions that, for men, sex is purely about pleasure. This research examines how contraceptive manufacturers use this cultural context to market their products.

In US society, women are expected to be responsible for reproduction yet they must interact with the medical establishment in order to use common forms of women-controlled contraceptives. The mediation of a healthcare provider (i.e. doctors and pharmacists) in women’s obtaining contraceptives means that the power to prevent pregnancy does not lie with women. Ehrenreich and English ([1978] 2005) argue that the dominant discourse in healthcare is that of biological hegemony, which suggests that medical intervention is necessary for even the most normal of bodily occurrences. For example, normal childbirth requires monitoring by medical experts at all stages. This monitoring extends beyond normal childbirth to cover more and more conditions (e.g. normal menstruation can now be controlled with pills), so that the American healthcare system practices what Armstrong (1995, 393) refers to as ‘surveillance medicine’. These power dynamics are part and parcel of much of procreative experience, whether birth, abortion or menopause. Men’s bodies, too, are increasingly being medicalised, with new conditions such as erectile dysfunction and overactive bladders in need of medical treatment, though it is predominantly women’s bodies that have historically been medicalised. Medicalisation tends to pathologize untrustworthy women and then seeks to manage them (see Martin 1987; Simonds 1996; Simonds et al. 2007). When women conceptualise themselves as at-risk, it is easy for medical authorities to classify all pregnancies (and other conditions unique to women) as risky (Rothman 2007).

Menstruation, for example, has been medicalised by medical authorities as something in need of control. Oral contraceptives such as Seasonale® allow women to regain control over their body by reducing the number of periods a woman has each year. This benefit has been challenged by the FDA because Barr Research underemphasised the increased risk of spotting between menstrual cycles that can occur with this product (Chitale 2004). Ironically, the typical OC regimen induces bleeding every month, mimicking a period, because when the first OCs were tested, women were dissatisfied with the lack of a period (Oudshoorn 1994) and because the inventor of OCs, John Rock, thought monthly bleeding would make OCs more acceptable to the Roman Catholic Church (Gladwell 2000). Because contemporary US women live longer, have fewer children and breastfeed less frequently, they have more menstrual cycles than US women did in the past. There is ongoing debate over whether this increased number of periods is related to various health problems, including some cancers (Kelley 2003; see also Kissling 2006). Medicalising women’s bodies, then, is nothing new and the way all contraceptives are advertised further medicalises women’s bodies in ways men’s bodies are not.

Unlike male-controlled contraceptives, most women-controlled contraceptives can be used without detection – giving women power over reproduction. Nevertheless, in order for women to obtain this power over reproduction, they must give up power (Bordo 1993).

Women may find liberation through contraceptives (controlling pregnancy), but women gain this control only through a healthcare provider and by using a contraceptive method that does not require her partners' consent. Though women-controlled contraceptives have definitely liberated women in many ways, complete liberation would include women no longer struggling to get partners to wear condoms. As long as women's bodies continue to be regulated by science, they are not free (Marcellus 2003).

In addition to not requiring a male partner's consent in order to be used, OCs and intrauterine contraceptives (IUCs) are promoted as superior by healthcare providers. This superiority is questionable in that OCs and IUCs' effectiveness is based on theoretical-effectiveness and other methods' effectiveness is based on use-effectiveness (Sloane 2002). This perceived superiority of prescriptive contraceptives maintains 'surveillance medicine' because consumers can then believe that all doctor-prescribed products, not only doctor-prescribed contraceptives, are superior to the alternatives. This is of further concern because, as Seaman (1980) argues, doctors promote OCs over other contraceptives because they create higher profits and require physicians to spend less time with patients. In other words, various contraceptives are promoted over others not because they are the most effective or even necessarily the safest, but because they are the most profitable in addition to fitting into the cultural context of women's responsibility over reproduction.

The responsibility over reproduction is promoted as a women's responsibility and new contraceptive technology continues to be centred on women-controlled methods, reflecting this expectation (Oudshoorn 2000, 2003; van Kammen 2000; Riessman 2003). Oudshoorn (2003) argues that this focus has dominated the discourse on contraceptives because of essentialist thinking regarding the biological differences between men and women. 'Ovulation, which occurs "only once each month", is thought to be easier to control than sperm, which can be produced daily in large numbers' (Oudshoorn 2003, 8; see also McNay 1992). In other words, medicine considers it easier to control women's bodies than to control men's bodies. This makes sense when one considers how women's bodies have been controlled by medicine with men's bodies only recently being brought under medical control.

Some women's bodies are thought to be in need of more control than others. Where white feminists see contraceptives as key to women's liberation, women of colour have been pressured and coerced into using methods that require the least compliance and are the most invasive (Roberts 1997). Minority and poor women have been manipulated or forced unknowingly into sterilisation and into using long-term methods that a user cannot reverse herself, such as Norplant® and Depo-Provera® (Roberts 1997; Malat 2000). Today, Mirena® (an intrauterine contraceptive) is being promoted to treat menstrual problems in adolescents with physical or learning disabilities and medical disorders (Pillai et al. 2010). Intrauterine contraceptives typically are not recommended for women who have not yet had children because they increase the risk of pelvic inflammatory disease, which has the potential to cause infertility. Women-controlled contraceptives, then, can and have been used to control women.

Feminists in particular have critiqued the medical management of procreation, yet there has been limited analysis of how marketers use this very critique – feminist tenets of control and choice – to sell women contraceptives (see Dworkin and Messner [1999] 2000; Wienke 2005). The goals of this research are to understand how a product held up as a key symbol of women's liberation might in fact actually be repressive, how the language of feminism (choice and control) is co-opted in contraceptive marketing messages, how contraceptive advertising reifies conventional gender and sex norms and how all of this is done using a scientific discourse that continues to medicalise women's bodies

as problematic. Marketers use both a scientific discourse and reinforce conventional gender and sex norms to sell contraceptives to men and women.

Methods

We use discourse analysis to understand the messages and meanings in the words and images of web-based advertising for 43 contraceptives. By discourse analysis we mean that we studied the language and visuals on these websites to understand how power is both reproduced and deemphasized (Foucault 1972). We began by describing the messages and then moved onto interpreting the meaning behind these messages (Deacon et al. 2007) found in both words and images on the websites. What do these messages mean in our culture? What do these messages say about gender, sex and reproduction? What schools of knowledge (i.e. discourses) do these marketers appeal to in their messages?

Our list of contraceptives comes from a variety of sources. No complete listing of the websites for all of the contraceptives exists; therefore, there is no clear way to obtain a representative sample. Also, there is rapid turnover of websites so if a complete list existed yesterday, today it would be out of date (McMillan 2000). We used WebMD's (2007a, 2007b) lists of FDA approved medications for pregnancy contraception and postcoital contraception and Planned Parenthood's (2007) list of birth control methods. WebMD's list contains 147 items, of which 21 have stand-alone websites. Planned Parenthood's (2007) list included an additional five contraceptives not listed by WebMD that had stand-alone websites. We used the website *condomania.com* (2007) to find condom brands because it is cited in a *Consumer reports* (2005) study of condom effectiveness. *Condomania.com* identifies 21 male and 1 female condom brand. Three additional brands were found listed under types of condoms on *condomania.com* or through the website of one of the brands already listed. The female condom VA w.o.w. Condemelle™ was found in a general search for 'female condoms'. Fifteen male condom and two female condom brands had stand-alone websites and are included in this analysis. The final sample includes 43 websites (see Appendix 1).

We restricted our analysis to contraceptives available in the USA because consumers are often asked to specify their country to get the country specific website. As US-based researchers, we could be assured access to US websites, making analysis consistent. Moreover, many of these websites exist so that pharmaceutical companies fulfill FDA requirements in order to directly advertise to consumers. Furthermore, the USA and New Zealand are the only industrialized nations allowing direct-to-consumer advertising (Almasi et al. 2006); however, this does not prevent people outside of the USA and New Zealand from accessing pharmaceutical websites (Fox, Ward, and O'Rourke 2006).

Conventional sex and gender norms

Product depictions entail a variety of constructions of hetero-sex. The explanatory discourse found on most websites presumes heterosexual sex that begins with 'foreplay' and culminates in penile-vaginal penetration. The discourse includes information on STI-protection, especially in cases where the method offers protection; but safe sex is clearly a secondary concern on the majority of sites. Lesbians, bisexuals and gay men, who might use contraceptive methods to prevent STIs, do not exist in these ads. For example, the Durex® (2007c) website has a section devoted to sex tips, most of which centre on penile-vaginal penetration.

Condom companies distinguish themselves from each other primarily with promises of enhanced pleasure (for everyone) and performance (for men); thru claims of company superiority based on technological breakthroughs, social consciousness and creative innovation, despite their primary purpose being STI prevention. Condom advertisements reinforce the notion that women have more complicated bodies than men do. For example, Durex®'s website provides advice about cunnilingus and fellatio (Durex® 2007a, 2007b). Men are urged to take the plunge and perform cunnilingus because women want to receive it more than men want to perform it. Men are further instructed to make sure the woman's genitals are clean, to turn on the light so they can see what they are doing and are given a detailed description of where to find the clitoris. Women are told none of these things regarding fellatio. For men, sex for her pleasure is something new; for women, sex for his pleasure is normative.

In addition to reinforcing conventional views regarding both gender and sex, contraceptives also appear to be marketed mainly to young, white people as evidenced by the visuals on the websites. Injectables are long-term healthcare-provider-administered contraceptives promoted for women not ready have children. In contrast, IUCs are also long-term healthcare administered contraceptives for women but are marketed to women who already have children (IUC complications can make it difficult to become pregnant after use). Only one OC website included visual depictions of racial minorities (i.e. Ortho Tri-Cyclen® Lo). Overall, both white and non-white women are portrayed as young, independent women with careers, apartments and busy lives. Monogamy is the norm, with only Cylessa® acknowledging that the user may have multiple partners or otherwise might be at risk of contracting an STI and encourages her to have her partner also use a condom. These are women who presumably are living very exciting lives because they do not have children. The prescriptive contraceptive websites show independent women; there are rarely any men present on the sites, though presumably, these women are having sex with men if they are using oral contraceptives for birth control purposes and not just to treat acne.

The condom websites are visually hip media experiences – popular music might play; heterosexual couples might make out in the background, little factoids about condoms might float in and out – all to make using their products during sex seem, most of all, sexy. In contrast, the websites for other non-prescriptive contraceptives are much less sexy. There are no scantily clad couples, only photos or drawings of the product box itself, smiling women's faces or cartoon figures of slim women carrying boxes of products under their arms. There are no games or gimmicks and sometimes very little product description; for instance Encare® Vaginal Contraceptive inserts are described as offering 'double protection,' but it is never clearly explained what that means beyond that they kill 'sperm on contact' (Encare® 2007). One female condom, VA w.o.w. Condemelle™, does not have its own site but is tacked on at the end of the Inspiral (men's condom) page (IXÜ 2007). In other words, prescriptive contraceptive websites reinforce the idea of liberation through their products – through scientific protection. Women may be liberated through prescriptive contraceptives in that they do not need their male partner's consent to use these products, yet at the same time they do have to pass through various healthcare gatekeepers. True liberation would come in the form of contraceptives that do not require anyone's permission to use, men who would voluntarily and willingly wear condoms if that is the desired form of contraception, or both.

A scientific discourse

Manufacturers use a scientific discourse to emphasize their product's superiority over other contraceptives. For example, condom companies routinely seek to contradict

anti-condom sentiment, claiming that their condoms will enhance sexual experiences. The recurrent promise is the presence of a condom one cannot feel. Scientific engineering makes the absence of ‘nature’ – raw skin – unnoticeable or even *better* than nothing. For example, ONE® Condoms (2007a) claims it provides ‘a safer and more pleasurable experience for both of you’.

Many of these ‘scientific’ claims are not at all impressive. For example, Pleasure Plus® states ‘Five women reported Pleasure Plus® provided them more stimulation than when using no condom at all’ (ONE® Condoms 2007b). There is no way of knowing whether this statistic means 5 out of 10 or 5 out of 10,000 women felt this way, because there is no link to any study. Similarly, VCF® provided no links to the studies used to bolster their claims, but only include an endorsement from former US Surgeon General Jocelyn Elders (Apothecus 2007b). In another case, the FDA has required Bayer Healthcare to produce advertising correcting some of its misinformation in previous advertising regarding their claim that Yaz® improves moods and treats acne (overstating benefits), while underemphasising its risks (Singer 2009).

Scientific claims extend beyond pleasure to safety; websites for non-latex condoms, which cannot make safety claims, suggest their products are safe in a roundabout way. For instance, the eZ-on® condom site reads:

There are several laboratory tests for eZ-on. These tests show that organisms, even as small as sperm and viruses like HIV/AIDS cannot pass through. ... Latex condoms for men, if used correctly and consistently, are highly effective at preventing pregnancy, as well as STDs, including HIV/AIDS, although no contraceptive can proved [sic] 100% protection. (Mayer Laboratories 2007)

With no data to support the claim that non-latex condoms constitute a protective barrier, the statement about ‘highly effective’ latex condoms seems purposefully confusing; by the end of this discussion it sounds like eZ-ons may as well be considered the same as latex condoms.

One scientific discourse that the OC websites appeal to is that of control through a pill. In fact, both Lybrel®’s and Seasonique®’s websites state that periods that occur using other OCs are not menstrual periods at all but instead are ‘pill’ periods – ‘hormone-withdrawal bleeding’ (Wyeth 2007) – and since these are not menstrual periods, there is no reason to have them. With the help of her healthcare provider, now a woman can control her menstrual cycle scientifically. Loestrin 24 FE encourages women – along with healthcare providers – to determine how to avoid periods occurring on a weekend and Seasonale®’s website contains a calendar that users can use to schedule their periods so they do not conflict with important events as diverse as ‘romantic encounters and family reunions’ (Duramed® Pharmaceuticals 2007a).

Some websites even provide online tools for women to use to track their bleeding. In the case of Lybrel®, this tracking serves as evidence that periods are becoming shorter. All of this advice encourages women to take on the role of self-monitoring self-researchers, on the lookout for pathology – ‘severe symptoms’ – working in partnership with the real authorities – doctors. Moreover, these products minimise their failure rates by placing the blame for the products failure squarely on women.

Women fail, science does not

Apothecus (2007a), which makes Vaginal Contraceptive Film and Foam, begins its sex-education information page with:

... more than 3 million unintended pregnancies ... occur in the US each year, it’s obvious that many women have a lot to learn about sex and birth control. ... Sexual activity and birth

control usage are responsibilities that should not be taken lightly. If a woman is sexually active and does not intend to have a child in the near future, she should protect herself by understanding her reproductive system, the different types of contraception available, identifying which is best for her, and following the directions exactly.

Not only are women to be held accountable for unintended pregnancies, but they are also depicted as fully responsible for birth control. Several brands of OCs offer women tips to remember to take their pills or even daily emails or text messages (e.g. Yaz®). Non-daily prescriptive contraceptives (i.e. injectables) also allow women to sign up for emails reminding them to get their next shot.

Not all women are forgetful; some just fail to follow instructions. The Yasmin® website admonishes women, stating that most women who become pregnant while using OCs ‘do not correctly follow the instructions given in their pill packs’ (Bayer 2007b). Forgetful women and women unable to follow instructions can turn over the responsibilities of administering contraceptives to their healthcare providers. Injectables and IUCs are promoted as preferable to other contraceptives because they are administered by healthcare providers and not consumers. Moreover, they provide ‘around-the-clock protection against pregnancy’ (Pfizer 2007) because they do not have to be taken every day like OCs (some OCs must be taken at approximately the same time each day to be effective). Implanon™ was the only healthcare-provider-administered contraceptive that suggested its effectiveness depends on the skill of the healthcare provider administering the product.

‘You might have forgotten to take your pill, or another birth control method you used might have failed, like your condom broke’ (Duramed® 2007b). Plan B® reinforces the idea of the forgetful woman (who forgets to take her pill) and the superiority of the pill over OTC contraceptives (the ‘condom broke’). The implicit suggestion here is that the only way for OCs to fail is if the user fails. In contrast, condoms are subject to failure independent of the user. Plan B® recognises that ‘things do not always go as planned’ (Duramed® Pharmaceuticals 2007b), which is in direct contrast to websites for other OCs that tout the idea that women are in control of their periods and their sex lives.

Plan B® probably had the most sophisticated scientific discourse because of its status in the US. It is a prescriptive to women younger than 16 and non-prescriptive to women 17 years and older. It was the only product that mentions sexual assault as a reason for its use (one of its selling points is that it can be used after intercourse – consensual or not). Plan B® also went to great lengths to distinguish itself from other OCs (not as effective) and from RU-486® (Plan B® ‘prevents’ pregnancy, whereas RU-486 ‘ends’ pregnancy). Plan B® is intended to be used as a backup form of birth control rather than a primary form of birth control though it is unclear from the website why it could not be used as a primary form of birth control.

Companies manufacturing women-controlled contraceptives invoke science to make claims for a discreet and convenient birth control options. Femcon® FE is chewable – convenient and discreet – despite requiring 8oz. of liquid be taken with it (Warner Chilcott 2007). Convenience also comes through nifty gadgets like Lybrel®’s convenient storage case. ORTHO EVRA® (i.e. the patch), is to be changed once a week (compared to taking a pill each day, which could be easily forgotten) and is marketed as discreet. ORTHO EVRA® can be worn on the upper arm, upper torso, abdomen or buttocks, all easily concealed by clothing, but are clearly visible if one is naked – as often occurs during sex. Who is supposed to remain unaware of its use: sexual partners, non-sexual partners or both? Mirena® – an IUC – is ‘birth control you don’t have to think about’ (Bayer Healthcare 2007c). It provides users with ‘hassle-free’ protection from pregnancy for up to five years, ‘to help simplify’ women’s lives (Bayer Healthcare 2007c).

This product is advertised as convenient (compared to OCs), easy to use (compared to diaphragms or condoms) and ‘worry-free’ – implying that other contraceptives are not very convenient, are more difficult to use and are anxiety-producing. With an IUC, there is no decreased effectiveness through user error compared to other birth control methods because a doctor inserts the device and the user does nothing. Intrauterine contraceptives, sterilisation and implants are termed ‘forgettable contraception’ by family planning experts because women can forget about them and they still will be effective (Grimes 2009, 497).

Though appealing to science sells many products, there is a ‘natural’ living trend in the USA (i.e. eat organic or avoid vaccinations) and marketers also appeal to this elite cultural predilection. Anecdotal evidence suggests that some women are no longer using OCs because of the health risks associated with them (Lunau 2009). Vaginal barriers and IUCs are marketed as hormone-free alternatives. In the case of FemCap, it is also ‘latex-free birth control for health-conscious women’ (FemCap, Inc. 2007). FemCap allows women to ‘enjoy natural sex’ (without hormones or condoms) and spontaneity (though it does need to be inserted – of course, discreetly – prior to sexual intercourse, so it requires some planning in advance) and control.

Conclusion

There are dozens of prescriptive contraceptives on the market and, unlike non-prescriptive contraceptives, the manufacturers have to win over not just women, but also healthcare providers. Non-prescriptive contraceptives have to win over both men and women. Overall, women alone do not make the decision as to which contraceptive works best for them. Despite this lack of choice, manufacturers promote their product to women reminding them that they have ‘many options’ and that being a woman is great because you have ‘the power to make your own decisions’ (Bayer Healthcare 2007a). Women are told to ask their doctors about a particular brand and these requests for particular brands are portrayed as a simple collaboration between women and healthcare providers, in which they share decision-making power.

How much choice do women really have? In the case of obtaining OCs, a woman must visit a physician to obtain a prescription, visit a pharmacy to have it filled and pay for the product herself, through insurance or Medicaid. There are at least three gatekeepers to OCs. Healthcare administered products do not require a trip to the pharmacy but still require the other two gatekeepers. Non-prescriptives require the cooperation of a women’s sexual partner. There currently exists no contraceptive that women choose to use without the cooperation of another person. Plan B® might come the closest but it is not as effective as other methods and requires a prescription (for those under age 17). Moreover, Plan B® can be difficult to obtain, as many pharmacies refuse to stock it. It is also important to remember that OCs are hormonal treatments and therefore not easily comparable with condoms because of the risks associated with hormone use (see Barot 2008 for more on the debate over risks of hormone use).

Advertisements for contraceptives have changed very little since Marcellus’s (2003) analysis of a birth control pamphlet from the 1930s. Science is everywhere, justifying the choice of nearly every product. Today there is an acknowledgement that the woman-consumer may not be married; but it is presumed she is in a monogamous relationship. Men’s product websites aim to appear funky and titillating; women’s product websites are more staid.

In our study, the contraceptive companies seem to be marketing contraceptives for so much more than pregnancy or STI prevention, emphasising choice and control.

In particular, women-controlled products are said to do more than just prevent pregnancy – they give women control over their bodies. The implication is that a woman's body requires medical control whereas a man's body does not.

In addition to control, manufacturers of contraceptives emphasise choice. Women can choose when to become pregnant, when to menstruate and what type of product they want to use to control procreation. The reality is that women's choice is limited as long as contraceptive options are controlled by healthcare providers or require a man's consent to be used.

Though choice and control are common marketing messages on these websites, in reality women's choices are constrained by their situations – their levels of access to information and to healthcare mediation required to obtain prescriptive methods. In contrast, men-controlled methods offer the advantages of being non-invasive, protecting against both STIs and pregnancy and are available over the counter.

Overall, contraceptive Internet advertising relies on gendered stereotypes about sex and procreation. Women may have more contraceptive choices than ever before, but these choices are quite limited. In the case of OCs, the main difference between products is in benefits unrelated to birth control (e.g. acne treatment). Men, too, have more choices regarding contraceptives. The choice here typically involve increasing sexual pleasure and making sex with a condom as much like sex without a condom as possible. The viewer of these websites comes away the impression that for men sex is supposed to be fun and feel good and for women sex is risky and not to be done without taking precautions.

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Appendix 1. The websites

Brand	Website
<i>Diaphragm</i>	
ALL-Flex® Arcing Spring Diaphragm	www.orthowomenshealth.com/products/diaphragmsprods.html
<i>Emergency contraceptive</i>	
Plan B®	www.go2planb.com/ForConsumers/Index.aspx
<i>Female condoms</i>	
FC Female Condom	www.femalehealth.com/
VA w.o.w. Condemelle™	www.inspiral.tv/index.html
<i>Implant</i>	
Implanon™	www.implanon.com/
<i>Injectables</i>	
Depo-Provera®	www.depoprovera.com/index2.asp?story=1
Depo-subQ Provera104™	www.depo-subqprovera104.com/
<i>Insert</i>	
Today Sponge	www.todaysponge.com/
<i>Intrauterine contraceptives</i>	
Mirena®	www.mirena-us.com/index.jsp
ParaGard®	www.paragard.com/paragard/index.php
<i>Male condoms</i>	
Beyond Seven®	www.beyondsevencondoms.com/
Durex®	www.durex.com/cm/?browser=ok&flash=ok
eZ*on	www.mayerlabs.com/consumer/products/ezon.asp
Gorilla™ Condoms	www.bananabob.com
Inspiral	www.inspiral.tv/inspiral.html
Joe Lube™	www.joelube.com/
Kimono Condoms®	www.mayerlabs.com/products/products_list_cdm.asp
Lifestyles®	www.lifestyles.com/
Line One Lab	www.lineonelabsusa.com/index.php
Naturalamb®	www.naturalamb.com/
Night Light®	www.nightlightcondoms.com/
ONE® Condoms	www.onecondoms.com/design.php
Pleasure Plus®	www.pleasureplus.com/
TheyFit	www.theyfit.com/
Trojan® Brand Condoms	www.trojancondoms.com/
<i>Oral contraceptives</i>	
Cyclessa®	www.cyclessa.com/
Estrostep® FE	www.warnerchilcott.com/products/estrostep/index.php
Femcon® FE	www.chewablepill.com/
Loestrin®24FE	www.loestrin24.com/
Lybrel®	lybrel.com/
OrthoTri-Cyclen®	www.orthotricyclen.com/
OrthoTri-Cyclen® Lo	www.thepill.com/
Seasonale®	www.seasonale.com/home.aspx
Seasonique®	www.seasonique.com/
Yasmin®	www.yasmin-us.com/index.htm
Yaz®	www.yaz-us.com/front
<i>Spermicide</i>	
Encare Vaginal Contraceptive Inserts	www.blairsex.com/Encare.html

Appendix 1 – continued

Brand	Website
Vaginal Contraceptive Film	www.vcf-contraceptive.com/
VCF® Vaginal Contraceptive Foam	www.apothecus.com/foam.html
<i>Transdermal</i>	
ORTHO EVRA®	www.orthoevra.com/
<i>Vaginal barriers</i>	
FemCap	www.femcap.com/
Lea's Shield®	www.leasshield.com/
<i>Vaginal ring</i>	
NuvaRing®	www.nuvaring.com/

Résumé

Il existe actuellement plus d'une centaine de contraceptifs sur le marché aux USA. Dans cet article, nous présentons une analyse du discours des sites web autonomes sur 43 contraceptifs, pour approfondir la compréhension de ce que les fabricants vendent à leurs consommatrices en même temps que leurs produits. Les fabricants adaptent les messages de marketing pour promouvoir les relations sexuelles conventionnelles et les normes de genre, mais en employant un discours scientifique. En particulier, ces produits s'approprient les idéaux féministes d'indépendance et d'intégrité corporelle, et promettent aux consommatrices le contrôle et le choix en ce qui concerne la procréation et la santé sexuelle, tout en existant dans un contexte élargi de surveillance médicale au sein d'une culture patriarcale et capitaliste.

Resumen

Actualmente hay más de cien anticonceptivos en el mercado de los Estados Unidos. En este artículo presentamos un análisis discursivo de los sitios web independientes para 43 anticonceptivos con el objetivo de entender qué es lo que los fabricantes de anticonceptivos venden a los consumidores además de sus productos. Los fabricantes adaptan los mensajes de mercadotecnia para promover normas convencionales sobre sexo y género pero usando un discurso científico. En particular, estos productos se apropian de ideales feministas sobre la independencia y la integridad corporal y prometen a los consumidores control y opciones sobre la procreación y la salud sexual, a la vez que existen en un contexto más amplio de vigilancia médica en una cultura patriarcal y capitalista.