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Risky Subjects, Subjects at Risk: HPV Vaccination and the Neoliberal Turn in Public Health

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**RISKY SUBJECTS, SUBJECTS AT RISK:
HPV VACCINATION AND THE NEOLIBERAL TURN IN PUBLIC HEALTH**

BY

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THESIS

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**B.A., Cultural and Interdisciplinary Studies, Antioch College, 2003
M.A., American Studies, University of New Mexico, 2011**

ABSTRACT

This thesis utilizes the example of *Gardasil* to better understand the dynamics of power at play in discourses of health in the United States, and to identify the neoliberal tenors of some contemporary public health strategies. A neoliberal turn in public health, while not all encompassing, has resulted in distorted and limited conceptions of health that rely on consumerism and notions of personal responsibility. With the example of *Gardasil*, Merck has deployed age-old tropes that pre-date, and are strengthened by, this neoliberal turn. These tropes—of women and girls as simultaneously at-risk and risky subjects, of young women’s bodies in need of state protection, and of immigrants as sources of contagion—strategically displace the focus from the actual risk factors and causes of HPV-related deaths in the U.S. and contribute to an understanding of health as a private issue, privileging consumerism over prevention, and profit over public health.

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Introduction

In June 2006, *Gardasil*, a vaccine produced by Merck & Company, Inc. (Merck) to prevent human papillomavirus (HPV) infection, was approved for use by the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) and introduced to the American market. Various constituencies were soon bombarded with information about the vaccine, via routes strategically charted by Merck—consumer oriented advertising, legislative health policy debates, and medical recommendations, as well as through discourses well out of the pharmaceutical company’s purview, including those of women’s health and immigrants’ rights advocates, members of the anti-vaccine movement, abstinence proponents and reproductive justice activists. The vaccine targeted a sexually transmitted infection linked to cervical cancer and genital warts in girls and women ages nine to twenty-six and was simultaneously hailed as a crucial, pro-woman, public health strategy *and* as an example of the use and abuse of public health policy influenced by state and pharmaceutical interests.¹

This thesis utilizes the example of *Gardasil* to better understand the dynamics of power at play in discourses of health in the United States, and to identify the neoliberal tenors of some contemporary public health strategies. A neoliberal turn in public health, while not all encompassing, has resulted in distorted and limited conceptions of health that rely on consumerism and notions of personal responsibility. With the example of *Gardasil*, Merck has deployed age-old tropes that pre-date, and are strengthened by, this

¹*Gardasil* has since been approved for use by boys and men ages nine to twenty-six (in October, 2009). ACIP endorsed the vaccine for boys and men ages eleven to twenty-one in October 2011. For more see: U.S. Food and Drug Administration. "FDA Approves New Indication for Gardasil to Prevent Genital Warts in Men and Boys," Food and Drug Administration, <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm187003.htm> (accessed October 29, 2011); Gardiner Harris, "Panel Endorses HPV Vaccine for Boys of 11," *The New York Times*, October 26, 2011.

neoliberal turn. These tropes—of women and girls as simultaneously at-risk and risky subjects, of young women’s bodies in need of state protection, and of immigrants as sources of contagion—strategically displace the focus from the actual risk factors and causes of HPV-related deaths in the U.S. and contribute to an understanding of health as a private issue, privileging consumerism over prevention, and profit over public health.

Neoliberalism as an ideology assumes that a free market guarantees individual freedoms, which in turn maximizes social good. It brings notions of individual rights, responsibility and consumerism to the fore.² Merck’s promotion of *Gardasil* illustrates a simultaneous utilization of 1) neoliberal discourse focused on market solutions, individual autonomy, consumer choice and risk management; and 2) contamination discourse that constructs immigrant and female bodies as risky and at risk. The stratified marketing of *Gardasil* reflects the ways in which the industry utilizes these discursive strategies to ensure a broad market for their products and contributes to the struggles over definitions of public health.

This thesis focuses on Merck’s own advertising campaigns placed in contradistinction to an early HPV vaccination mandate for immigrant women in the United States and legislative efforts to mandate HPV vaccination for sixth grade girls in New Mexico. Through a mixed methods approach, I place Merck’s multipronged marketing strategies in conversation with focus groups conducted with vaccine-eligible, adolescent girls and caregivers in three communities in New Mexico.³ After a brief

²David Harvey, *A Brief History of Neoliberalism* (New York: Oxford University Press, 2005).

³While working on my master’s in American Studies at the University of New Mexico, I was fortunate to work as a research assistant with a team working out of the Department of Family and Community Medicine on a project entitled “Participatory Research to Understand the Translation of the HPV Vaccine” led by Andrew Sussman, PhD, MCRP (Principal Investigator) and Deborah Helitzer, ScD (co-investigator). The project, entitled “Participatory Research to Understand the Translation of the HPV

explanation of human papillomavirus and the HPV vaccine *Gardasil*, I outline the context which produced the HPV vaccine. Through examinations of federal and state HPV vaccination mandates and *Gardasil* advertisements targeting mothers and adolescent girls, I explore the ways in which the pharmaceutical industry utilizes neoliberal and contamination discourse to shape public health policy and practice.

Background

HPV Transmission

In order to understand the debates around HPV vaccination it is important to know a few things about HPV and the vaccine itself. Human papillomavirus is transmitted through anal, oral, and vaginal sex and genital-to-genital contact. Infection is positively associated with the number of sex partners an individual has: the more partners, the higher the likelihood of HPV infection. No symptoms are necessary for transmission. While condoms, dental dams and other forms of barrier protection can help lower the risk of HPV transmission during certain sex acts, they do not provide full protection since HPV can infect areas left exposed. The only way to completely prevent the possibility of HPV infection is to avoid all intimate contact.⁴ Realistic discussions about HPV prevention must acknowledge that the infection is transmitted through sexual

Vaccine,” combined quantitative survey methods with qualitative participatory research to better understand the development and implementation of HPV vaccine dissemination policy in New Mexico. The research we conducted around the state serves as the basis for much of my work here. In the focus groups referred to herein, facilitators reviewed basic information about HPV and *Gardasil* before launching into larger discussions. We also provided print copies of the two magazine advertisements included here in the appendix as an elicitation technique for discussion.

⁴Centers for Disease Control and Prevention. "Sexually Transmitted Diseases (STDs): Genital HPV Infection-Fact Sheet," Centers for Disease Control and Prevention, <http://www.cdc.gov/std/hpv/stdfact-hpv.htm> (accessed April 24, 2011).

contact. Unfortunately, adolescent sexuality is rarely explicitly acknowledged in the consumer marketing and legislative efforts promoting vaccination as a preventive measure.

HPV Infection

HPV is one of the most common sexually transmitted infections in the world. In the United States, at least fifty percent of all sexually active adults will get HPV at some point in their lives. Some estimates place this number as high as eighty percent.

Approximately twenty million Americans are currently infected with HPV, and six million new infections develop annually.⁵ While HPV can lead to cancers across gendered categories, most scientific and public attention has focused primarily on its relationship to cervical cancer in women.⁶ This link is of particular concern because thirteen of the more than forty types of genital HPV are known to be necessary precursors of the two most common forms of cervical cancer: squamous cell carcinoma which

⁵Ibid.

⁶While important, focusing primarily on cervical cancer, and not on anal, penile, oral, or other HPV related cancers displaces the focus from prevention of all HPV transmission and related cancers to those which are assumedly heterosexual and female. For more on this see Steven Epstein, "The Great Undiscussable: Anal Cancer, HPV, and Gay Men's Health," in *Three Shots at Prevention: The HPV Vaccine and the Politics of Medicine's Simple Solutions*, edited by Keith Wailoo, Julie Livingston, Steven Epstein and Robert Aronowitz (Baltimore: The Johns Hopkins University Press, 2010). With *Gardasil's* approval for boys and men ages nine to twenty-six, vaccine marketing and scientific research has expanded some to acknowledge "male" cancers but mainstream rationale for male vaccination is generally limited to the prevention of genital warts and HPV transmission to assumedly female partners. This points to the ways that heteronormativity frames the pharmaceutical industry's investments, and shapes gendered understandings of subjects at risk.

makes up over seventy percent of cervical cancer diagnoses, and adenocarcinoma which accounts for close to twenty percent.⁷

Given such high rates of infection in the United States, it seems clear that HPV would be understood as a public health problem. There are two important things to consider, however. First, ninety percent of all HPV infections go away on their own within two years. Second, the United States has an incredibly effective screening and treatment infrastructure in place which enables early detection and treatment for high-risk strains of HPV.⁸ HPV related mortality rates in the U.S., while serious, are low compared to the rest of the world. Nationally, close to ten percent of women with high-risk strains of HPV will develop persistent infections that place them at risk for genital warts and cancer. Very few people who have HPV in the U.S. will actually get HPV related cancers and even fewer will die from them. For example, cervical cancer is diagnosed in 12,000 women annually, with an estimated 3,670 deaths per year.⁹ Those whose cases do result in death are important to acknowledge, but they may attest more to the failings of the health care system in this country than to the urgent need for widespread HPV

⁷Jill Barnholtz-Sloan, Nitin Patel, Dana Rollison, Karl Kortepeter, Jill MacKinnon, and Anna Giuliano. "Incidence trends of invasive cervical cancer in the United States by combined race and ethnicity," *Cancer Causes Control* (2009); Elizabeth Garner. "Cervical Cancer: Disparities in Screening, Treatment, and Survival," *Cancer Epidemiology, Biomarkers & Prevention* (2003).

⁸Barnholtz-Sloan et al., 2009; Centers for Disease Control, 2009; Garner, 2003. Serious strains of HPV can cause genital warts, recurrent respiratory papillomatosis (warts inside the throat), cervical cancer, and cancers of the vulva, vagina, penis, anus, head and neck (including cancers of the tongue, tonsils and throat).

⁹CDC, 2009. Other HPV related cancers include: 3,700 cases of vulvar cancer; 1,000 cases of vaginal cancer; 1,000 cases of penile cancer; 2,700 cases of anal cancer in women; 1,700 cases of anal cancer in men; 2,300 cases of head and neck cancers in women; and 9,000 cases of head and neck cancers in men (many of these head and neck cancers are related to smoking and drinking rather than HPV) per year.

vaccination. With more accessible screening, most serious cases of HPV can be identified and treated before they turn into cancer.¹⁰

Cervical Cancer Screening

Papanicolaou (Pap) smear screening was introduced in the United States in the 1940s and significantly reduced the incidence of invasive cervical cancer in the following decades. Most cervical cancers take years to develop, so Pap smear screening can generally identify precancerous changes in order to treat abnormalities before they develop into cancer.¹¹ Paps, and the early treatment that they enable, are largely responsible for the relatively low rates of cervical cancer incidence and prevalence in the United States as compared to many other countries with lower screening rates.¹²

Despite that progress, significant economic, racial, and ethnic disparities exist in the rates of screening and in the incidence of cervical cancer in different populations. Poor women are generally diagnosed later and are more likely to die from cervical cancer than middle class women.¹³ Hispanic, African American and Vietnamese women in the United States exhibit higher rates of cervical cancer incidence and death from cervical

¹⁰Sujana Movva, Anna-Michelle Noone, Mousumi Banerjee, Divya A. Patel, Kendra Schwartz, Cecilia L. Yee and Michael S. Simon. "Racial Differences in Cervical Cancer Survival in the Detroit Metropolitan Area," *Cancer* (2008).

¹¹Barnholtz-Sloan et al., 2009; Garner, 2003; Ravie Kem and Kenneth C Chu. "Cambodian Cancer Incidence Rates in California and Washington, 1998-2002," *Cancer* (2007). In the United States, when a Pap smear shows abnormal cervical cells, colposcopy is used to examine the cervix under magnification which allows for the identification of abnormal or precancerous cells and potentially for cervical biopsies. Biopsies that show low-grade abnormalities are monitored while high-grade lesions or cancers are treated.

¹²Barnholtz-Sloan et al., 2009; Kem and Chu, 2007. Invasive cervical cancer is the second most frequently diagnosed cancer in women globally, with close to 500,000 women diagnosed and 274,000 deaths annually.

¹³Garner, 2003.

cancer than non-Hispanic white women.¹⁴ Watson et al. note that in 2003 for every 100,000 women in the United States, fourteen Hispanic women, thirteen African American women, eight Asian/Pacific Islander women and eight non-Hispanic white women were diagnosed with cervical cancer.¹⁵ This is not to say that being poor or of color is a causal factor in HPV infection or cervical cancer incidence. Rather, these statistics demonstrate the barriers to access to adequate, affordable and appropriate health care that exist for poor women and women of color in the U.S. The disparities described here reflect structural inequities. They are deeply political and enable misinterpretations of health data which result in pathologizing communities and perpetuating understandings of certain populations as “risky” or “at risk.” These factors play a large role in determining who receives HPV health education and whether a woman who has HPV gets the necessary screening and monitoring, whether persistent infections are dealt with before cancer develops, and whether treatment is available. With access to frequent screening and treatment, cervical cancer deaths are largely preventable.¹⁶

The global demand for cervical cancer prevention, coupled with the inroads that technoscientific enterprises have made into the study of HPV, has resulted in prevention efforts that revolve primarily around vaccines that prevent cervical cancer (and

¹⁴Maria E. Fernandez, Jennifer D. Allen, Ritesh Mistry, and Jessica A. Kahn. "Integrating Clinical, Community, and Policy Perspectives on Human Papillomavirus Vaccination," *Annual Review of Public Health* 31 (2010).

¹⁵Meg Watson, Mona Saraiya, Vicki Benard, Steven S. Coughlin, Lisa Flowers, Vilma Cokkinides, Molly Schwenn, Youjie Huang and Anna Giuliano. "Burden of cervical cancer in the United States, 1998-2003," *Cancer* 113 (November 2008).

¹⁶While the language of health “disparities” works to identify structural inequity that results in disparate health outcomes, it has also been criticized for depoliticizing health inequities, and for enabling misinterpretation of health data resulting in perpetuating understandings of certain populations as “risky” or “at risk”. The indicators noted here illustrate and simultaneously hide failings of the health system.

secondarily, genital warts).¹⁷ There are very real reasons to focus on developing an HPV vaccine for use in countries where Pap smears are not standard practice. In the U.S., where significant screening infrastructure exists, however, resources spent promoting legislative policy mandating HPV vaccination may be better utilized in efforts to improve health care access and cervical cancer screening.

Gardasil

Gardasil, a quadrivalent vaccine produced by pharmaceutical giant Merck & Company, Inc. and introduced to the U.S. market in June of 2006, prevents infection by the two types of HPV (sixteen and eighteen) that are responsible for over seventy percent of cervical cancers and the two types (six and eleven) that cause over ninety percent of anogenital warts. Since the vaccine is most effective if given prior to sexual activity, (ensuring that patients have not yet been exposed to HPV), the CDC and Advisory Committee on Immunization Practices (ACIP) of the Department of Health and Human Services (DHHS), recommend HPV vaccination for girls ages eleven and twelve with catch-up vaccination approved for thirteen to twenty-six year-old girls and women in the United States. In 2011, ACIP extended their recommendation to include boys and men ages eleven to twenty-one. The vaccine is expensive, costing approximately \$130 per shot with three required doses for a total expense of \$390 for completion of vaccination (not including the cost of a clinical visit and other related expenses).¹⁸

¹⁷Steven Epstein points to the ways in which anal cancer, though widespread in the United States with current diagnoses of 3,050 women and 2,020 men each year, is left out of public discourse of HPV and HPV vaccination because of its association with nonnormative, specifically gay, male sex. See Epstein, “The Great Undiscussable,” 61-90.

¹⁸Fernandez et al., “Integrating Clinical, Community” 2010; Harris, 2011.

Clinical trials of *Gardasil*, which included over 21,000 women, show ninety to one hundred percent efficacy in preventing HPV types sixteen and eighteen in participants who were not infected with those types before vaccination *and* if they received all three shots required in the vaccine series in the recommended time period. In addition, the vaccine was nearly one hundred percent effective in preventing precancerous vaginal and vulvar lesions. Though the study period was not long enough for cancer to develop, the vaccines' capacity to prevent cervical cancer was extrapolated from the successful prevention of cervical precancerous lesions. Two additional studies were used to support the claim that women and girls ages nine to fifteen would have similar immune responses to the vaccine as the sixteen to twenty-six year-olds included in the trials.¹⁹

The FDA approved *Gardasil* on a special fast track review process approved for pharmaceuticals with the potential to "significantly benefit health." The review process itself was completed in only six months.²⁰ Clinical trials, in conjunction with active vaccination of the American public over the past five years, attest to the relative safety of the vaccine. The trials did not reveal any serious, short term, adverse events.²¹ Since the vaccine is so new, however, there is no proof of its efficacy, or safety, past five years.²²

¹⁹Fernandez et al., "Integrating Clinical, Community," 2010; Elizabeth R. Sheyn, "An Accidental Violation: How Required Gardasil Vaccinations For Female Immigrants To The United States Contravene International Law," *Nebraska Law Review* 88 (2010).

²⁰Sheyn, 2010.

²¹Sylvia Law, "Human Papillomavirus Vaccination, Private Choice, and Public Health." *UC Davis Law Review* 41 (June 2008).

²²Centers for Disease Control and Prevention, "Vaccine Safety: Reports of Health Concerns Following HPV Vaccination," *Centers for Disease Control and Prevention*, <http://www.cdc.gov/vaccinesafety/vaccines/hpv/gardasil.html> (accessed April 24, 2011). Since 1989, the National Childhood Vaccine Injury Act's Vaccine Adverse Event Reporting System (VAERS) requires physicians to report any

The public response to the HPV vaccine has been a mix of celebration, acceptance, skepticism and fear. Some criticism is based on the relatively short period of time that the vaccine was tested before being released to the public, and the relatively small trial size.²³ Trials did not evaluate the impacts of receiving only one or two shots in the three shot series. This is important because many women and girls begin the series but do not complete it—for a number of reasons, including cost.²⁴ Since trials did not test what happened when the vaccination series was incomplete, it is difficult to evaluate the risks and benefits of encouraging vaccination of such an expensive vaccine with low completion rates. As a medical technology addressing issues of sexual health, *Gardasil* provides a timely opportunity to understand the ways in which the industry of medicine and the field of public health have grown and transformed.

***Gardasil* in Context**

Neoliberalism and Public Health in the United States

vaccine related adverse events to the CDC and FDA. Thirty-three million doses of *Gardasil* had been distributed in the United States as of February 14, 2011 and 18,354 incidents of adverse events had been reported to VAERS. Of events reported, ninety-two percent were considered to be non-serious (fainting, pain and swelling at site of injection, headache, nausea, and fever), and eight percent were considered serious (requiring hospitalization, permanent disability, life-threatening illness, congenital anomaly or death). Serious reported events include Guillain-Barré syndrome; blood clots in the heart, lungs and legs; and fifty-one reports of death (thirty-two of which have been confirmed). As with all VAERS data, there is no clear way to determine if reported events are actually caused by the vaccine. According to the CDC, in the case of Guillain-Barré syndrome the reports reflect the number of cases in the general population and do not indicate increased risk due to vaccination. Women and girls who reported blood clots generally shared risk factors unrelated to vaccination (i.e. they were smokers, took oral contraceptives etc.). A number of the deaths indicated a cause of death unrelated to the vaccine. When a patient dies within the reporting period, they are included in the VAERS report even if there is no obvious link.

²³Law, 2008.

²⁴Also, the early federal mandate - which required certain immigrant women to show proof of vaccination - only required that those women get the first in the three-shot series.

In the United States the institution of public health is premised on a belief in necessary medical paternalism at the state level which enables the protection of the nation's health through social policies and preventive measures.²⁵ Public health policies and practices are shaped by a commitment to the health of populations rather than individuals.²⁶ As an institution, public health runs counter to the anti-statist ideology and narrow framing of individual rights that typify neoliberal policy. John Stuart Mill's harm principle—that the only justifiable instance when the state can exercise power over an individual member of society against their will is when it protects others from harm—was used as the basis for public health interventions throughout the twentieth century. Legal and human rights frameworks rely on this notion and allow for government intervention into private lives to protect the larger population.²⁷ Such intervention is justified by a social contract of sorts, contingent upon the implicit consent of those populations being

²⁵Robert Bayer and Amy L Fairchild. "The Genesis of Public Health Ethics." *Bioethics* 18 (2004): 473-492. In their work to define an ethics of public health, Bayer and Fairchild note that "those involved in the practice of public health embrace a set of values that are often, if not always, in conflict with the autonomy-centred values of those who take an individualistic and anti-paternalistic stance" (Bayer and Fairchild, 488).

²⁶James Colgrove, Gerald Markowitz, and David Rosner, "Introduction: The Contested Boundaries of Public and Population Health." In *The Contested Boundaries of American Public Health*, edited by James Colgrove, Gerald Markowitz and David Rosner, (New Brunswick: Rutgers University Press, 2008). The majority of public health activities in the nineteenth and early twentieth centuries focused on limiting the spread of epidemic diseases in populations (cholera, smallpox, typhoid) through sanitation projects, quarantine, surveillance, and vaccination campaigns. In the early 1900s, public health authorities, as empowered by the activist state, employed their police powers to implement programs of risk management and surveillance. While the population level priorities of public health always differed from the individual priorities of clinical medicine, the two fields formally split in the 1920s. Colgrove et al. note that "[t]he medical profession claimed authority over the domain of most individual patients, while public health retained narrow responsibility for a few perennially unpopular categories of care that the medical profession didn't want to provide: services for the indigent, treatment of sexually transmitted diseases, and control of once-epidemic but increasingly vestigial contagions such as tuberculosis and smallpox" (Colgrove, Markowitz and Rosner, 5).

²⁷Bayer and Fairchild, 2004; John Stuart Mill, *On Liberty*. (New York: Longman's, Green and Company, 1913).

protected and the assumed benevolence of the state. While geared towards protecting populations, this “contract” relies on an abstract, liberal notion of equality that does not reflect the true dynamics of power and privilege in the U.S. The danger here is that the needs of individuals and populations who are excluded from full national participation are neglected.

Public health is largely managed at the state and local level where legislators, health advocates and other policy shapers effectively set the parameters for certain health practices and decisions for the “public.” General police powers enable states to enact legislation intended to protect the public’s health. While U.S. constitutional and common law clearly establish that individual adults have the right to make their own medical decisions and that parents can make such decisions for their young children, the tenets of public health validate policies that privilege population health over individual choice.²⁸

While it is important to understand the ways in which public health policies generally work for health equity, it is also necessary to interrogate the motivations behind such policies in order to ensure that they are indeed working towards benevolent ends. In addition to the important successes of the U.S. public health system, discourses and practices of public health have also been used to construct notions of good and bad citizens and to rationalize inequality, marginalization, and the exclusion of certain populations from full national participation.²⁹

²⁸Law, 1751.

²⁹See Emily K. Abel, "From Exclusion to Expulsion: Mexicans and Tuberculosis Control in Los Angeles, 1914-1940." *Bulletin of the History of Medicine* 77 (2003): 823-849; Natalia Molina, "Borders, Laborers, and Racialized Medicalization: Mexican Immigration and US Public Health Practices in the 20th Century." *American Journal of Public Health* (April 2011): e2-e9; Natalia Molina, *Fit to Be Citizens? Public Health and Race in Los Angeles, 1879-1939*. (Berkeley: University of California Press, 2006);

Social movements committed to civil rights and equality in the 1960s, feminism and women's health in the 1970s and a focus on the rights of the consumer in the 1980s all altered the way medicine and public health were understood and practiced in the U.S. Some of these movements focused specifically on preventing medical exploitation and neglect and on expanding access to medical care for underserved communities. Others focused on strengthening the individual rights of health consumers. The resulting notions of informed consent and patients' rights which shifted the dynamics of power in medical practice and public health, were utilized both by those activists working for health equity and justice and those pushing a neoliberal agenda where autonomy and individual responsibility took precedent.³⁰

As neoliberalism permeated U.S. politics in the late twentieth century, long-present notions of individual rights, personal responsibility and consumerism shaped the discourses through which people came to understand health and disease.³¹ Marxist

Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown*. (Berkeley: University of California Press, 2001).

³⁰Bayer and Fairchild, 2004; Susan E. Bell and Anne E Figert, "Gender and the Medicalization of Healthcare." In *The Palgrave Handbook of Gender and Healthcare*, edited by Ellen Kuhlman and Ellen Annandale (Palgrave Macmillan, 2010) 107-122; Angela Coulter, "Paternalism or partnership? Patients have grown up - and there's no going back." *British Medical Journal* 319 (September 1999): 719-720.

³¹Dorothy Porter, *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times*. (Routledge, 1999). The application of neoliberal values to health has both deepened and challenged paternalistic medicine in the United States. Early public health reforms in the United States were rooted in Puritan morality (invested in social cleanliness and its relationship to godliness) rather than a centralized state power (as in Great Britain). Such practices were associated with paternalistic charity – wealthy members of society providing for the needy through sanitation reforms to protect the health of the masses. In early nineteenth century America, as the rural population became more urban, “[p]overty was no longer seen as a charitable estate by the wealthy, who increasingly blamed the poor for their condition. . . .Paternalism gave way to a rising tide of rugged individualism in which community responsibility was dismissed in favor of the importance of individual self-sufficiency” (Porter, 1999, 148). As notions of individualism deepened, and as industry expanded, self-sufficiency won out over community-oriented policies. The practice of blaming individuals for their predicaments, including ill-health, has receded and reemerged ever since.

geographer David Harvey defines neoliberalism as “a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade.”³² While the state provides the institutional framework, neoliberal values require the withdrawal of state support, limited state intervention, deregulation and privatization.³³

Arguments that personal habits and lifestyle choices were the actual cause of an unhealthy country circulated in academic and policy circles in the 1970s, strengthening conservative efforts that challenged the utility of government intervention, through public health initiatives, for “personal” issues like drug abuse and sexually transmitted diseases. Neoliberal ideologues underlined the point that the responsibility for health problems lay with individuals rather than with structural inequities, argued that health solutions were the responsibility of the individual rather than the government, and looked to the market for their consumerist fix.

The ascendance of neoliberalism in national politics in the United States in the late twentieth century coincided with the rise of medicalization in everyday life. Medical sociologist Irving Zola first articulated the concept of medicalization, in the 1970s, in order to capture the ways in which people’s lives were increasingly brought under medical jurisdiction in the twentieth century.³⁴ Conrad and Schneider refer to this shift as

³²Harvey, 2.

³³Ibid.

³⁴Adele E. Clarke, Laura Mamo, Jennifer Ruth Fosket, Jennifer R. Fishman, and Janet K. Shim, *Biomedicalization: Technoscience, Health, and Illness in the U.S.* (Durham: Duke University Press, 2010). After World War II, the expanding field of medicine increasingly came to be understood as a social good and, simultaneously, as a profitable enterprise. State and private institutions invested in medical research and medical goods and services. Clarke et al. identify this moment as the onset of the process of

the move from “badness to sickness”.³⁵ Zola understood this process as a reflection of the societal desire for technical solutions to social problems. Once an issue becomes medicalized at the individual level the medical route provides the only rational solution, effectively disallowing for any other types of intervention or response.³⁶ Building on legacies of medical paternalism, medicalization explicitly reaffirmed the importance of medicine in people’s lives, normalized the medical diagnosis of previously non-medical issues and their concomitant medical solutions, and brought additional conditions under the capitalist project of medicine. Medicalization worked to obscure larger structural causes of health inequities and focused on individual “health,” with an emphasis on treatment rather than prevention.³⁷ This focus on individual responsibility and market

medicalization which redefined the way health was understood. “Conditions” that were previously recognized as social or legal became medicalized (alcoholism, sexuality). The results were complicated. Understanding certain issues in medical terms often removed individual blame or shame and enabled access to care and treatments. In other cases, such medical labeling resulted in stigmatization and the perpetuation of stereotypes and blame.

³⁵Peter Conrad and Joseph Schneider. *Deviance and Medicalization: From Badness to Sickness*. (Philadelphia: Temple University Press, 1992).

³⁶Elianne Riska. "Gender and Medicalization and Biomedicalization Theories." In *Biomedicalization: Technoscience, Health, and Illness in the U.S.*, edited by Adele E. Clarke, Laura Mamo, Jennifer Ruth Foskett, Jennifer R. Fishman and Janet K. Shim. (Durham: Duke University Press, 2010).

³⁷The process of medicalization propped up medical professionals as experts with the power to diagnose and treat patients. However, the concept of medicalization provided a way to understand how people’s acceptance of and participation in the process of medicalization simultaneously fed its legitimation *and* challenged its innate paternalism. Diagnoses that are accepted as normal today - like premenstrual syndrome, post-traumatic stress disorder, and attention deficit disorder – are testaments to the pervasiveness of medicalization processes in contemporary medicine. The frequency with which people accept their doctor’s recommendations or turn to medical solutions – plastic surgery, anti-depressants, and Viagra for example – illustrates the normalization of medicalization. But many of these same diagnoses also provide an important, medically legitimized, and sometimes self-directed way for people to understand their bodies and address important issues in their lives. Medicalization does not always work explicitly in favor of the medical establishment. There are numerous examples of individuals and communities strategically taking up medical discourse in order to access medical technologies for purposes deemed unnecessary or inappropriate by the medical establishment. The utilization of medical discourse to secure support for the hormonal and surgical transformation of trans bodies is one clear example. The fight for access to medical treatment and inclusion in medical trials is another. For those individuals and communities who have been denied access to medical technologies the fight *for* medicalization is an important one. See Bell and Figert, 2010 and Epstein 2007.

solutions both embraced and was embraced by neoliberal ideology and was used to justify the withdrawal of the state in matters of population, or public, health.

The attack on “big-government” ushered in by Ronald Reagan in the 1980s contributed to a national ethos that made it difficult to advocate for public health efforts that focused on the prevention of conditions that were increasingly being framed as the result of individual choice and lifestyle.³⁸ This mentality went hand in hand with deregulation of industry and the defunding of federal social programs which also had severe implications for health. In a drastic shift from addressing health at the population level through political efforts, preventive medicine became more focused on individual lifestyles.³⁹ Public health became much less public. The promise of consumer citizenship implied in neoliberal discourse forwarded pharmaceutical consumption as a means to take responsibility for one’s own health. Nancy Tomes notes that “[r]ather than acting collectively in political or policy domains, enlightened consumers were to make their wishes known by the exercise of individual choice: to discipline the marketplace by choosing to enroll in an HMO . . . to abstain from risky behaviors such as smoking or unprotected sex,”⁴⁰ or to pop the right pill for what ailed them. Public policy, and public health efforts, continue to bear the mark of this neoliberal turn. The capitalist undercurrents of medicalization—the sense that for every problem there is a medical solution that can be bought—work in tandem with the increasing emphasis on individual

³⁸Colgrove, Markowitz, and Rosner, "The Contested Boundaries," 2008.

³⁹Porter, "Health, Civilization," 1999.

⁴⁰Nancy Tomes, "Speaking for the Public: The Ambivalent Quest of Twentieth-Century Public Health." In *The Contested Boundaries of American Public Health*, edited by James Colgrove, Gerald Markowitz and David Rosner, (New Brunswick: Rutgers University Press, 2008). 76.

health promoted in neoliberal discourse as individual rights, autonomy, and choice. The result has been a privatization of health and health care, and the increased understanding of health as a consumer issue.

Risky Subjects / Subjects at Risk

Medicalization works to frame all people as potential patients, and all patients as in need of medical expertise and guidance. Certain bodies, however, are constructed as especially in need of this direction. Women, communities of color and immigrants have too often and unjustly been identified, through medical and public health practice, as vectors of disease emergence and as in need of medical intervention. This has effectively limited these groups from participating fully in their own health decision-making and in U.S. society. Placing *Gardasil* in this context helps to understand the passionate response to proposed mandates for HPV vaccination.

Mandates around issues of sexual health invoke a long history of the ways in which certain populations have been labeled as “risky,” posing a threat to the health of the nation and in need of state intervention, or as “at risk” and in need of state protection. This dynamic is similarly expressed in characterizations of certain people who get sick as innocent victims, and others as deserving of their illness—especially when it comes to issues of sexual health. *Gardasil* advertising frames vaccination as an empowering act for mothers and girls choosing to manage their own health risks, while state mandates were justified as a response to a pressing need to protect young girls at risk of getting cervical cancer, and the federal mandate reflected assumptions about the riskiness of immigrant women as potential sources of contagion.

Medical sociologist Adele Clarke and her colleagues offer the concept of biomedicalization in an attempt to name the ways in which neoliberal discourse and values have become normalized in the health arena since the mid-1980s.

Biomedicalization captures the ways in which the process of medicalization has changed and expanded with the growing reliance on technoscience in biomedicine through five basic processes: “(1) privatization and commodification, (2) risk and surveillance, (3) expanding technoscientific practices, (4) the production and distribution of knowledges, and (5) transformations of bodies and subjectivities.”⁴¹

A core component of the process of biomedicalization is the use of the concept of “risk” to construct all bodies as always potentially ill or in the process of becoming ill. Risk factors, then, help to identify the signs of this potentiality in individuals and populations. Symptoms are not necessary. Foskett asserts that in the biomedicalization era, “at all times, everyone is potentially *not* normal, inhabiting tenuous spaces between illness and health.”⁴² Risk is understood as a health problem in itself, with treatments and biomedical solutions. She notes that “[w]ith the expansion of technoscientific tools of biomedical surveillance into ever greater areas of people’s bodies and lives, being ‘at risk’ becomes an increasingly common diagnosis, with its own set of proscriptions, prescriptions and treatments.”⁴³ Clarke, Shim et al. understand this shift in Foucauldian terms wherein the bodily discipline that results from the medical gaze extends beyond

⁴¹Clarke et al., “Biomedicalization,” viii.

⁴²Jennifer Ruth Fosket, “Breast Cancer Risk as Disease: Biomedicalizing Risk.” In *Biomedicalization: Technoscience, Health, and Illness in the U.S.*, edited by Adele E Clarke, Laura Mamo, Jennifer Ruth Fosket, Jennifer R Fishman and Janet K Shim. (Durham: Duke University Press, 2010), 332.

⁴³Ibid. 331.

traditional sites of medicine to “implicate each of us *and* whole populations through constructions of risk factors, [and] elaborated daily life techniques of self-surveillance.”⁴⁴

Clarke et al. describe the stratification of biomedicalization, evident in the different ways in which communities and identities are targeted with the example of *Gardasil*. Wealthy individuals learn about “designer” or “boutique” biomedical services offering the opportunity to transform, or re-make, their bodies and improve their health in whatever ways they desire. Advertising the expensive HPV vaccine to mothers (assumed to be citizens, with health insurance and access to health care) and tapping into their desire to protect vulnerable daughters exemplifies this. These are innocent subjects, at risk, and in need of protection via the choice to vaccinate. Other bodies face increasing barriers in their attempts to access medical care and have less autonomy in their own health decision-making. These are those risky subjects posing a threat to the health of the nation, whose regulation is justified. Mandating vaccination, while potentially enabling access to those considered to be the most vulnerable and in need, still results in pathologizing particular communities. This process cannot be separated from broader projects of racialization and differentiation of groups within the broader U.S. population. It reflects the neoliberal discourses of health that have contributed to the process of biomedicalization: individuals are responsible for their own health and ill-health is a reflection of individual deficiencies. And yet, through epidemiology and public health

⁴⁴Adele E. Clarke, Janet K. Shim, Laura Mamo, Jennifer Ruth Fosket, and Jennifer R. Fishman. "Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine." In *Biomedicalization: Technoscience, Health, and Illness in the U.S.*, edited by Adele A. Clarke, Laura Mamo, Jennifer Ruth Fosket, Jennifer R. Fishman and Janet K. Shim, (Durham: Duke University Press, 2010). 64.

interventions, the state determines which populations are at risk and which are risky (to others). This justifies biomedical interventions, like vaccination mandates, and pathologizes racialized and sexualized communities.⁴⁵

In her ethnographic work in *favelas* in northeastern Brazil, Jessica L. Gregg argues that assumptions about women's sexuality serve to silence women and those silences manifest in illness—due to a lack of preventive care, dismissal of symptoms and a tendency to blame women for their own illness. Gregg argues that “[b]lame for the spread of disease, particularly diseases associated with sexuality, has often illuminated the culturally marginalized status of different groups at different times.”⁴⁶ An alternate way of understanding this blame is as risk that carries moral implications. Maren Klawiter's notion of woman as “the risky subject” is also useful here in understanding how, as with her example of breast cancer, women are encouraged to think of their health in terms of future risk and individual responsibility. Reflecting neoliberal narratives of health, women's bodies are thus perpetually at risk and women are implicitly blamed for not being ever vigilant.⁴⁷ Much of this argument can be applied to the discourses surrounding HPV vaccination, in which adolescent girls' and immigrant women's bodies are framed by state and federal government as always in need of disciplining. Following this logic, theirs are bodies that can and should be controlled, whether by parents or by the state. Vaccination thus serves as a means to protect the nation at large from the

⁴⁵Clarke et al. 2010; Janet K. Shim, "The Stratified Biomedicalization of Heart Disease: Expert and Lay Perspectives on Racial and Class Inequality." In Clarke et al. *Biomedicalization*, 2010.

⁴⁶Jessica L. Gregg, *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. (Stanford, Stanford University Press, 2003). 41.

⁴⁷Maren Klawiter, *The Biopolitics of Breast Cancer: Changing Cultures of Disease and Activism*. (Minneapolis: University of Minnesota Press, 2008).

assumed threat of racialized and sexualized adolescent and immigrant women and to protect those young girls who have not yet been corrupted from the sources of contagion that threaten their purity.

Mandating Pharmaceutical Solutions

While there have been too many instances when state powers have implemented discriminatory and damaging policies in the name of public health, the life-saving work of many public health measures is indisputable. Mandatory vaccinations are one such measure, keeping rates of vaccine-preventable disease down in the U.S. since they were first implemented in the 1850s.⁴⁸ The intervention into individual lives that results from such large-scale public health projects has faced popular resistance, however, and the paternalistic role of state power fosters an always suspicious populace.⁴⁹

The first compulsory vaccination laws in the U.S were put in place in the 1850s. In *Jacobson v. Massachusetts*, in 1905, the U.S. Supreme Court ruled that the state had the right to require vaccination during an epidemic. Importantly, the decision required

⁴⁸Robert R. Field, Arthur L. Caplan, "A Proposed Ethical Framework for Vaccine Mandates: Competing Values and the Case of HPV." *Kennedy Institute of Ethics Journal* 18, no. 2 (2008): 111-124. In order for vaccination efforts to be effective nationally they must be large-scale and far-reaching, ensuring what is called herd immunity. This refers to the percentage of the population that needs to be vaccinated (usually 90%) in order to guarantee eradication. In the United States, herd immunity has traditionally been dependent on state enforcement of vaccination through mandatory administration. Such efforts are credited with the eradication of smallpox and other epidemics that were responsible for enormous pain, suffering and death.

⁴⁹Michael Willrich, "'The Least Vaccinated of Any Civilized Country': Personal Liberty and Public Health in the Progressive Era." *The Journal of Policy History* 20, no. 1 (2008): 76-93. Willrich's study of compulsory smallpox vaccination and the social and legal resistance to it offers a history of the early efforts to counter paternalistic public health practices with notions of civil liberties. Willrich offers the opportunity to sharpen the distinction between state and individual rights. Asking what the difference between legitimate public health policies and the imposition of racist or imperial power is, draws attention to the potential tensions in national public health policy.

that such vaccination orders must be in response to an epidemic and must not be enforced through physical force. Exemptions from vaccination for those with health conditions that might put them at risk were also included in the ruling. The *Jacobson* decision was used to uphold the power of the state in determining what sacrifices were reasonable to expect from citizens.⁵⁰

Today, states across the country enforce vaccination requirements for newborns and for public school entry. These requirements include clauses for parents and students to opt out of required vaccination for health, religious and/or ethical reasons. Though vaccines are hailed by many as crucial to public health and safety, a number of people continue to see mandated vaccination in the same light as the plaintiffs in *Jacobson* did: as government exercising too much control over private lives and individual choice. Suspicion surrounding the safety of vaccines and the motivations of the pharmaceutical industry compound critiques of public health mandates involving vaccination. HPV is a unique case because its (sexual) mode of transmission distinguishes it from other diseases that are highly communicable—like typhoid or measles. The question, then, is what are the conditions under which it is justifiable to use state power to override personal autonomy, if ever? Does the public health “threat” posed by HPV meet these conditions? The way in which *Gardasil* has been marketed, both as an individual *and* a public health strategy, brings forth the tensions present when a pharmaceutical technology is packaged in public health terms.

⁵⁰Willrich, 2008. This power was then, dangerously expanded by Justice Oliver Wendell Holmes Jr. when he utilized the *Jacobson* decision to allow the State of Virginia to sterilize a supposedly “feeble-minded” woman, Carrie Buck, without her consent. This decision legitimized widespread sterilization before World War II in the United States.

Sociologist Simon J. Williams defines the process of pharmaceuticalization as “the transformation of human conditions, capacities or capabilities into pharmaceutical matters of treatment or enhancement.”⁵¹ This concept captures the powerful role of the pharmaceutical industry as it influences individuals and states in the regulation of bodies. Neoliberal policies rely on individuals actively embracing their roles as health consumers. Pharmaceuticalization more specifically relies on the normalization of pharmaceutical technologies as the medical solutions that those health consumers seek. Joao Biehl’s notion of the pharmaceuticalization of public health articulates the expansion of medicalization to the state level where drugs take the place of more prevention-oriented public health strategies.⁵² This concept is useful in understanding the context that produced the HPV vaccine. Rather than focusing on improving access to the widespread and effective cervical cancer screening efforts in the United States, or on other preventive measures that are more in line with traditional public health practices, Merck worked to create a sense of urgency around the issue of cervical cancer and produced a pharmaceutical solution in the form of a very expensive vaccine which was

⁵¹Simon J. Williams, Clive Seale, Sharon Boden, Pam Lowe, and Deborah Lynn Steinberg. "Waking up to sleepiness: Modafinil, the media and the pharmaceuticalisation of everyday/night life." *Sociology of Health and Illness* 30, no. 6 (September 2008): 839-855.

⁵²Joao Biehl, "Pharmaceutical Governance." In *Global Pharmaceuticals: Ethics, Markets, Practices*, edited by Adriana Petryna, Andrew Lakoff and Arthur Kleinman, 206-239. (Durham: Duke University Press, 2006); Joao Biehl and Torben Eskerod, *Will to Live: AIDS Therapies and the Politics of Survival*. (Princeton: Princeton University Press, 2007). In his work on antiretroviral (ARV) policies in Brazil, Joao Biehl identifies what he terms the pharmaceuticalization of public health in state policy guaranteeing ARVs to HIV positive Brazilians. As Brazil worked to secure access to ARVs, the focus on prevention and clinical care shrank. Though he illustrates the ways in which pharmaceuticalization can be harnessed by individuals, communities, activists and the state to access life-saving resources, Biehl also exposes the ways in which those deemed most at risk, are in many ways written out of the solutions forged through the private-public partnerships that constitute public health work today. “This pharmaceutical approach to AIDS. . .coexisted with a moral politics that kept ‘sanitizing AIDS discourse,’” (Biehl and Eskerod,172), through an effective exclusion of Brazil’s most “at risk.”

promoted in health policy circles as an important and necessary public health intervention. HPV as public health epidemic appeared almost simultaneously alongside its pharmaceutical fix and states were encouraged to purchase the vaccine as a way to protect their vulnerable populations. This protection came in the form of vaccination mandates at the federal and state level.

The following sections explore attempts to mandate HPV vaccination at the federal level for women and girls attempting to become residents or citizens of the United States and at the state level for girls entering the sixth grade. Proposed mandates, placed in contradistinction to Merck's advertising efforts to health consumers, complicate what public health means in the U.S. today. The simultaneous utilization of neoliberal and contamination discourse illustrate the neoliberal turn in public health.

Gardasil on the Ground

Though mandates of HPV vaccination for school-entry largely failed across the country, a mandate (at least temporarily) that *was* implemented with much less public discussion and active resistance was the requirement that all immigrant girls and women ages eleven to twenty-six show proof to U.S. Citizenship and Immigration Services that they had received the first *Gardasil* shot—of the three shot series—in order to successfully apply for a visa or to become a U.S. citizen. Due to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, all immigrants attempting to make these changes in immigration status must be in compliance with all of the Advisory Committee on Immunization Practices's (ACIP) recommendations for residents of the United States. The requirement, which quietly went into effect in July 2008 as a result of ACIP's recommendation in 2006, makes what is a recommendation without the weight of law for

U.S. citizens, an official rule backed by the power of the law and the possibility of permanent national exclusion for immigrant women. This is an undue burden not only because of the hypocrisy there, and because of the costs associated with the shot, but also because clinical evidence—in terms of risk and in terms of efficacy—does not exist for instances when women only receive the first of the series of shots.⁵³ Also, vaccination is recommended for young women before they have had sex. For those women between the ages of eleven to twenty-six who have already been sexually active and have been exposed to the types of HPV that the vaccine protects against, the only reason for vaccination is the fulfillment of an administrative requirement of the U.S. government. This mandate can be understood as one policy in a long line of immigration policies that have utilized health to paint immigrant populations as risky to the American public. This riskiness justified a policy that allowed citizens to choose whether they wanted to receive the HPV vaccine, while immigrant girls and women essentially had no choice.

I will now turn to primary source material from focus groups conducted with women and adolescent girls in communities throughout New Mexico in order to provide a sense of how the HPV vaccination mandates were perceived by people making their own decisions about *Gardasil*. Focus groups were conducted as part of a larger study out of UNM's Department of Family and Community Medicine which examined views about health policy and decision-making for the HPV vaccine in New Mexico. Twelve focus groups were held with caregivers of Hispanic, vaccine-eligible girls (ages twelve to eighteen) and with girls themselves. The groups took place in three communities across

⁵³Krista J. Hachey, Rebecca H. Allen, Melissa Nothnagle, and Lori A. Boardman. "Requiring Human Papillomavirus Vaccine for Immigrant Women." *Obstetrics & Gynecology* 114, no. 5 (November 2009). 1135-1139.

the state of New Mexico including a northern rural Hispano community; a central urban community with participants who identified as Hispana, Latina, Chicana, and Mexicana; and a southern rural community with a large Mexican immigrant population. All focus group transcripts have been de-identified. The names of participants, and the dates and locations of the focus groups are withheld by mutual agreement.

When I spoke with these women and girls about the immigrant mandate it was no longer a legal requirement. Regardless of this fact, the focus group participants were highly critical about the idea of the mandate. They zeroed in on a number of its troubling aspects and clearly articulated the ways in which immigrant women are constructed as risky and at risk in discourses of health.

Many of the themes that came up in the focus groups illustrate the ways in which past public health abuses frame how the HPV vaccine mandate for immigrant women was understood by many of those opposed to its implementation. A number of women in the groups talked about their suspicion of the pharmaceutical industry and of government health programs more generally, invoking Tuskegee and other shameful moments in U.S. history.

It's unethical I feel like, because they're being targeted, you know, and they're probably starting with Mexican nationals. I bet you it wasn't like beautiful Europeans, man, I bet you it's the Mexican nationals. You know, just like 'let's target these poor people that came here for a better life. And let's use them, you know. So that's the clinical trial right there. These people are the clinical trial. Just at looking at it, that's the fact. That's it right there. That's your trial, you know, so in ten years, we're gonna know how many of them died, you know. If it worked, if it didn't work, how many of them came to have babies, can they have babies? Will they have babies? Cause they're not sick and they're just people. That's way unethical. I can't believe . . . no, it's disgusting, not even unethical.

Mothers were uncomfortable with the racialization of certain immigrant women and the apparent determination that immigrant bodies were somehow lesser than those of citizens.

Discourses of health as utilized in immigration legislation have historically worked to define proper citizenship and determine national inclusion and exclusion through the identification of risky populations and individual and community wide “threats” of contagion—often located in immigrant bodies and communities of color. Markel and Stern argue that “[a]nti-immigrant rhetoric and policy have often been framed by an explicitly medical language, one in which the line between perceived and actual threat is slippery and prone to hysteria and hyperbole.”⁵⁴ Girls in the focus groups understood the motivation behind the mandate in these terms. “I think . . . it’s to ensure that—that if you do have one, an STD, and you come to the United States, that you’re not going to go and give it to other U.S. citizens. It’s to protect *us*.” Thus, the mandate was implemented in order to protect Americans from “risky” immigrant women.

Other girls were concerned about protecting women who were coming to the United States from unfair laws and exploitation.

I don’t get what the whole immigrant thing has to do with being a US citizen. It’s like they’re just trying to get money out of them. Also, it’s kind of like judging the person, “Oh this person came from Canada, they’re gonna have like bacon disease”
...
It all comes back to being like racist or something.
That’s kind of true, yeah.

⁵⁴Howard Markel and Alexandra Minna Stern. "The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society." *The Milbank Quarterly* 80, no. 4 (2002). 757.

They saw through the framing of the mandate as a way to protect vulnerable immigrant populations and identified Merck's profit driven utilization of racist tropes.

In his social history of venereal disease, Allan Brandt traces the social construction of sexually transmitted diseases, noting a shift from understanding venereal disease as biological phenomenon to VD as social symbol. He asserts that venereal disease is used as a symbol of corrupt sexuality and contamination of populations which enables understandings of women as sources of moral and biological contagion and shapes health policy responses. The ways that sexually transmitted diseases are framed and addressed through health policy is indicative of the moral leanings of a society and works to regulate bodies and legitimate neoliberal understandings of health.⁵⁵ In the case of HPV, risky immigrants threaten an innocent, at-risk and otherwise uninfected nation.

Such discourses of health have been formally employed as a means to exclude immigrants to the United States since immigration came under the jurisdiction of the federal government in the late nineteenth century.⁵⁶ In many instances, individual bodies

⁵⁵Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880, Expanded Edition*. (New York: Oxford University Press, 1987).

⁵⁶Pascal James Imperato and Gavin H. Imperato, "The Medical Exclusion of an immigrant to the United States of America in the Early Twentieth Century: The Case of Cristina Imperato," *Journal of Community Health* 33 (2008). 225-240; Amy Fairchild and Eileen A. Tynan, "Policies of Containment: Immigration in the Era of AIDS," *American Journal of Public Health* 84 (1994). 2011-2022; Amy Fairchild, "Policies of Inclusion: Immigrants, Disease, Dependency, and American Immigration Policy at the Dawn and Dusk of the 20th Century," *American Journal of Public Health* 94 (2004). In 1891, nine years after the shockingly discriminatory Chinese Exclusion Act's passage, Congress created the Bureau of Immigration and began to require that the U.S. Marine Hospital Service (soon to become the U.S. Public Health Service in 1912) conduct medical examinations of immigrants at U.S. ports of entry. Building on the growing mainstream acceptance of bacteriology, Congress determined that immigrants with "loathsome or dangerous" contagious diseases could be refused entry to the nation. These diseases, designated as class A conditions, included trachoma, favus, venereal diseases, parasitic infections, and tuberculosis, as well as insanity, feeble-mindedness, imbecility, idiocy, and epilepsy. Conditions worthy of exclusion were expanded to identify immigrants who were "likely to become a public charge," when the Public Health Service created class B conditions in 1903, including "hernia, valvular heart disease, pregnancy, poor physique, chronic rheumatism, nervous afflictions, malignant diseases, deformities, senility and debility, varicose veins, and poor eyesight," (Fairchild, 2004, 530). Framing immigrants as "public charges" demonized them and constructed them as parasites feeding off of the state. Immigrant inspections were not

were literally excluded from entering the United States or prevented from joining the ranks of full citizens through a utilization of health policy.⁵⁷ The requirement of HPV vaccination for some immigrant women and girls and not for American citizens is a clear contemporary example of such exclusionary practices.

Many girls that I spoke with thought that a better legislative priority would be to screen women for dangerous types of HPV rather than require them to get vaccinated. The fact that HPV was not communicable in the same way as whooping cough or measles made the mandate seem all the more unjust.

I think everybody should get tested, not just immigrants, because we can be carrying it as well.

Yeah.

Like what if *we* gave it to the immigrant?

Not only were immigrant women being unfairly blamed for the spread of HPV in the U.S., participants noted that they could actually be at risk of catching HPV from citizens who were not required to get vaccinated.

conducted consistently at all ports of entry. Though generally all immigrants were deemed suspicious as carriers of “immigrant diseases,” (Fairchild and Tynan, 1994, 2011), race, class and country of origin impacted just how closely individuals were inspected. Immigrants who attempted entry at Pacific Coast and Mexican border stations were turned away for posing health risks to the nation at higher rates than people entering at northern and eastern stations. The federal government, via the United States Public Health Service’s increasing medical surveillance at the borders, utilized discourses of public health to determine fitness for national inclusion. Health became an intrinsic part of immigration policy.

⁵⁷Roxana Galusca, “From Fictive Ability to National Identity: Disability, Medical Inspection, and Public Health Regulations on Ellis Island,” *Cultural Critique* 72 (2009). 137-163; Abel 2003. Roxana Galusca asserts that the social construction of ability and ablebodiedness historically shaped conceptions of normative citizenship, productivity and who is positioned as an economic burden on the state. On Ellis Island, stigma around disability fed national fears of foreign, imperfect bodies and justified the exclusion of nonnormative bodies. The relative value of immigrant bodies relied on their perceived usefulness as cheap labor. The very health-based policies used to exclude disabled and diseased immigrants from national membership simultaneously consolidated a healthy nation-state in contradistinction to those bodies being denied entry. Framing state exclusion in terms of the perceived risk of becoming a public charge justified the deportation of disabled immigrants (including pregnant women). Similarly, Emily K. Abel explores the rhetoric utilized by public health officials in their treatment of Mexican immigrants in the Southwestern United States at the turn of the 20th century. Discourses of public health utilized racialized rhetoric to construct a nonnormative (sick, weak, unproductive) counter to healthy white citizens.

Alan M. Kraut analyzes the construction of the “immigrant menace” as framed in terms of the fear of germs and genes of foreign bodies.⁵⁸ Priscilla Wald’s analysis of what she terms the “outbreak narrative” in film and fiction illustrates the ways in which the threat of infectious disease, as specifically linked to threats of other, foreign, bodies has been naturalized in popular and scientific culture.⁵⁹ Constructions of the threats emerging from the developing world, threatening U.S. borders and bodies, secure notions of national belonging. These narratives help shape who is seen as risky or as a threat to public health, who is considered at risk, who is stigmatized, and what health related fears are taken up by the U.S. public at large.

Outbreak narratives provide a rationale for xenophobia, isolation and fear. It takes an interconnected, globalized world to make outbreak narratives resonate. Wald explains that through this logic, “[h]uman networks became the conduits of viral destruction.”⁶⁰ This fear is used to justify what Kraut calls medicalized nativism. He notes that “[t]he medicalization of preexisting nativist prejudices occurs when the justification for excluding members of a particular group includes charges that they constitute a health menace and may endanger their hosts . . . Thus, there is a fear of contamination from the foreign-born.”⁶¹ Wald points to the ways in which this stigmatization of immigrants relies

⁵⁸Alan M. Kraut, *Silent Travelers: Germs, Genes, and the “Immigrant Menace”*. (Baltimore: The Johns Hopkins University Press, 1994).

⁵⁹Priscilla Wald, *Contagious: Cultures, Carriers, and the Outbreak Narrative*. (Durham: Duke University Press, 2008). Wald brings an awareness of the story that public health creates to explain disease and the construction of healthy citizens. Through looking at media coverage and language used around communicable disease, she shows the patterns embedded in stories of emerging diseases that rely on a fear of the networks that connect global communities. In discussing the social role of contagions, Wald asserts that “[t]he interactions that make us sick also constitute us as a community. Disease emergence dramatizes the dilemma that inspires the most basic of human narratives: the necessity and danger of human contact” (Wald, 2).

⁶⁰Ibid. 4

on a false understanding of national borders as able to guard against disease.⁶² Girls in the focus groups similarly articulated the ridiculousness of this notion.

It's not fair to separate people from the people [that just came here] you know. We're all at risk here, you know, it's not like one person is completely, you know, protected from that stuff.
We've got the swine flu . . .
There's a lot of diseases that cross the border.
Cause the swine flu's all over. Does that mean that the cervical cancer's just gonna like be in Europe just because they're more out with their sexuality?

Amy L. Fairchild argues that instead of focusing on those bodies who are turned away at the border for health-related reasons, what is important about health policies like immigrant health inspection is the way that they serve to discipline immigrant bodies.⁶³ Where Wald illuminates the use of the outbreak narrative in legitimizing xenophobic ideologies, Fairchild shows the ways that the U.S. Public Health Service historically made use of the outbreak narrative and the discourse of risky subjects to different ends. Fairchild argues that “immigrant medical inspection represented a new technique for discipline in the new social and economic order, signaling a transformation in the nature of discipline and power, from corrective to preventive, from violent to normative. . . The aim of discipline in the industrial era. . . was a normative expression of power intended

⁶¹Kraut, 1994, 2-3.

⁶²Wald, 2008.

⁶³Amy L. Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force*, (Baltimore: The Johns Hopkins University Press, 2003). Fairchild explains how business priorities determined state actions in regards to immigration. In instances when public health practices were used to create and perpetuate racial categories, specifically within immigrant communities, she asserts that the motivations came down to industrial needs for labor. The U.S. Public Health Service medical exam, used to determine which immigrants could enter the United States, served an important role in 1) teaching immigrants that they were suspect and at the whim of the U.S. government and 2) teaching the American public that immigrants were unhealthy risks to public safety. More importantly, according to Fairchild, it taught new laborers where they stood in American society (at the bottom), and stressed the importance of being a good, efficient worker.

not simply to prevent deviant behavior but to promote adoption of core industrial values, to create a cadre of good industrial citizens.”⁶⁴

Both Wald and Fairchild draw on different but connected strands of Foucault’s theory. Wald employs Foucault’s theory of biopolitics and argues that “the concept of public health was formative for modern society, and epidemics were important because they manifested the need for protection in the form of regimented social behavior.”⁶⁵ If people followed bourgeois norms, they would be protected from disease. Fairchild uses Foucault’s understanding of modernity as a moment where norms are more effective disciplinary tools than punishment. She illustrates the ways in which normative expressions of power at work are more effective than restrictive immigration policies. Fairchild asserts that the pressures enacted on laborers to prove their fitness for citizenship performed the disciplinary work of the state without burdening prisons and other overt methods of state control. In both cases, epidemic scares and the promotion of normative behavior work together as means of social control by the state. The HPV vaccine fits squarely into this dynamic wherein immigrant women must utilize pharmaceutical technologies to lessen their riskiness and prove their fitness for citizenship.

⁶⁴Amy L. Fairchild, 2003, 15. Alan M. Kraut, “Immigration, Ethnicity, and the Pandemic,” *Public Health Reports* 125 (2010). 123-133; Fairchild and Tunan, 1994. The threats of epidemics had decreased significantly by the 1920s. With diminished visibility of actual diseases, nativists turned to explicitly eugenicist lines of argument to justify restrictionist immigration politics. Medicalized prejudice broadened from the linkage of particular diseases with specific countries of origin to a more general stigmatization of foreigners as potential contaminators of superior American stock. The Immigration Act of 1924 (known as the Johnson-Reed Act) reflected eugenicist notions of genetic inferiority in its restrictive policies. Fairchild and Tynan assert that “national origin became a marker for degeneration and so a means to justify broad-based exclusion in an ideological environment where strictly ‘public health’ or ‘bacteriological’ arguments for immigration restriction were filtered through the lenses of racism and nativism” (Fairchild and Tynan, 1994, 2012).

⁶⁵Wald, 18.

At times public health discourses have worked to maintain cultural and political hegemony through utilization of the framing of immigrants as risky subjects. With the HPV vaccine mandate, immigrant women are associated with a sexually transmitted infection. A common theme in focus groups included a discomfort with the presumed hyper-sexuality of immigrant women that was implicit in the vaccination requirement.

One girl noted:

What are they saying when they're telling these people that they have to get this vaccine? I mean, is it their way of implying that these people have a lot of sex and are gonna not be protected? I don't understand why they feel the need to protect these people, supposedly, from this particular disease, you know?

Mothers who we spoke with also thought the mandate was unfair, and many saw a link between pharmaceutical interests and public health policy:

I think that's ridiculous, I think, they'll give them a driver's license. . .

. . .

Why not give them a green card, if they are trying to do the right thing? I mean, again, it's their sexual preference. It's what they're, they're choosing to do. If they choose to have unprotected sex, it's on them, and the person they are having it with. Yes, you want to stop the epidemic, but at the same time, you don't want to put all of these children at risk. But I think it's more – I don't even know how much of an epidemic it was. In my mind, it's more on making money for the drug companies.

The concept of choice came up frequently throughout our conversations. Many girls understood that women coming to the U.S. were strong and capable of making their own decisions. “Well, it's wrong, even if they're not from here, they still should have their own choice. They choose to come here. I think they should have their own choosing on whether they want to get a vaccine or not.” It did not seem fair that American citizens did not have to get the vaccine while some immigrant women and girls did.

The vaccine is most effective if given to women before they are sexually active. By requiring immigrant women as old as twenty-six to get vaccinated, the policy does

little actual work to protect these women from HPV or to protect Americans from the spread of HPV from those who may already be infected. Rather, following Fairchild's argument, the work that the mandate does is psychological and political. It communicates to immigrant women that they are not capable of making decisions about their own sexual health, and teaches them that in contradistinction to American citizens, they are risky subjects in need of state intervention. The HPV vaccine mandate for immigrant women did more for the construction of proper Americanness than it did for actual HPV prevention.

Merck did not publicly advocate for the immigrant vaccination mandate. According to members of ACIP, the mandate was an accidental result of their general population vaccination recommendations, which, consistent with ACIP procedure, automatically become a rule for immigrants applying for citizenship. Though Merck was not involved in direct lobbying for this rule, their efforts to define HPV as an exigent public health issue more generally, and framing adolescent girls as always already at risk, likely influenced ACIP's recommendation process. When the mandate for immigrant women was challenged, Merck did not push to keep the rule in place. In fact, even representatives from ACIP acknowledged that they had not understood that the process would result in this type of mandate and called for its reversal.⁶⁶ Public resistance from a small but well organized contingent of reproductive justice and immigrants right advocates combined with political confusion about the purpose of the law resulted in the

⁶⁶National Asian Pacific American Women's Forum, "Letter to Richard Besser, MD, Acting Director Centers for Disease Control and Prevention, Re: HPV Vaccination Mandate for Immigrant Women and Girls," January 26, 2009.

removal of the mandate for immigrant girls and women from the books in December 2009.⁶⁷

Unlike the relatively ignored mandate for HPV vaccination of some immigrant women and girls, mandates for HPV vaccination at the state level caused quite a controversy across the country. Once the CDC and Advisory Committee for Immunization Practices (ACIP) recommended HPV vaccination in 2006, twenty-seven states, including New Mexico, and Washington D.C. began to consider mandates of HPV vaccination for school entry. Only Virginia and D.C. successfully implemented them.⁶⁸ While many public health advocates stressed the benefits of the vaccine in terms of eventual cervical cancer prevention, suspicion and resistance to required HPV vaccination came from multiple perspectives. Where only a small group of immigrants' rights and reproductive justice activists objected publicly to the immigrant mandate, resistance to mandates for sixth grade girls came from a broad spectrum of opponents. Cultural conservatives and abstinence-only education proponents worried that any vaccine geared towards an STI would lead to more adolescents having sex; consumer rights activists worried about the safety of the vaccine and were distrustful of Merck after Vioxx, an arthritis drug that they produced, was blamed for over 28,000 deaths before being taken off the market in 2004. Anti-vaccine groups were suspicious of the U.S. government imposing medical decisions on their individual rights; women's health

⁶⁷Miriam Yeung and Amanda Allen, "Eliminating HPV Vaccine Mandate for Immigrant Women: A Victory on the Road to Reproductive Justice," *RH Reality Check: Information and Analysis for Reproductive Health*, December 14, 2009, <http://www.rhrealitycheck.org> (accessed May 6, 2010).

⁶⁸Fernandez, Allen, et al. 2010; Ching Ping Ang, "Federal Law Requires HPV Vaccine for Green Card Applicants: Valid Exercise of State Police Powers?" *Journal of Law, Medicine & Ethics*, 2009. 149-152.

advocates were concerned with potential side effects and future health problems and concern existed in the medical community that the infrastructure necessary to ensure delivery of mandatory adolescent vaccination was not in place.⁶⁹

While by no means representative of the complex HPV policy processes that took place in states across the country, New Mexico provides an example of the ways in which health policy decisions reflect what health means in the current moment and exemplifies the ways in which notions of risky girlhood and of girls at risk were put to work to justify public health action. Importantly, at the state level the vaccine was framed in terms of cervical cancer prevention. It was discussed as a public health strategy to protect vulnerable, at-risk, young girls from cancer. There was not in-depth, public discussion of whether or not HPV was truly an epidemic worthy of a public health mandate. There was also very little discussion of the vaccine as a technology that protected against a sexually transmitted infection. Rather, the discussion focused simply on the presence of a vaccine that was capable of reducing the risk of cervical cancer in innocent, at-risk populations.

During the regular 2007 legislative session in New Mexico, Republican Senator, and MD, Steve Komadina sponsored Senate Bill 1174: HPV Vaccine in School-Based Clinics.⁷⁰ The Senate Education Committee passed the bill seven to zero and sent it to the Senate Public Affairs Committee which amended it (changing the HPV vaccine distribution in school-based clinics for nine to fourteen year-olds to language requiring the vaccine “for school entry” for girls “entering the sixth grade”), and passed it six to zero. Komadina presented the bill on the Senate floor along with an additional

⁶⁹Karen Houppert, "Who's Afraid of Gardasil?" *The Nation*, March 26, 2007.

⁷⁰Bills are only submitted halfway through the legislative session. SB 1174 was introduced on February 15, 2007, near the end of the permissible period.

amendment and it passed thirty to three.⁷¹ The amended bill then passed the House Health and Government Affairs Committee five to zero and was approved by the House at large, forty-nine to sixteen. At this point, the bill was largely supported across party lines. A spokesman for Governor Richardson was even quoted pledging his support for the bill in an article about a controversy related to a similar bill in Texas that ran in the New York Times on March 14, 2007.⁷² It noted that:

In New Mexico, Gov. Bill Richardson, a Democrat who is running for president, has also pledged to sign cancer vaccination legislation. That state's bill, which includes a provision similar to those in Texas and Virginia allowing for parents to opt out of having their daughters vaccinated, has already cleared the Legislature. It is likely to reach Mr. Richardson by tomorrow. "Governor Richardson will sign this bill into law, making New Mexico a leader in protecting girls against cervical cancer," said Gilbert Gallegos, a spokesman for Mr. Richardson. "This is an important public health issue that deserves this type of aggressive action."⁷³

Though the bill had not been signed when the regular New Mexico legislative session closed on March 17, 2007 all signs pointed to an HPV mandate for sixth grade girls in New Mexico.⁷⁴

⁷¹Komadina proposed an amendment adding that "the parent or guardian of" a student entering the sixth grade shall be presented information about the link between HPV and cervical cancer and the availability of the vaccine. Previously the bill stated that students, not their parents or guardians, would be the recipients of the information. The amendment was adopted thirty to three on the Senate floor on March 5, 2007.

⁷²In late January, 2007, Texas Governor Rick Perry issued an executive order requiring HPV vaccination for all sixth grade girls to begin in September 2008. On March 13, 2007 the Texas House of Representatives voted to nullify the executive order. Concerns over donations that Merck had made to Perry's reelection campaign and accusations that his former chief of staff was a Merck lobbyist contributed to suspicion and public criticism of the mandate. Quickly after Perry announced his intentions to run for the Republican presidential nomination in August, 2011 he faced scrutiny for the executive order. For the first time he called it a mistake.

⁷³Dan Frosch, "Texas House Rejects Order by Governor on Vaccines." *The New York Times*, March 14, 2007.

⁷⁴During the legislative session the Governor must sign or veto legislation within three days of transmittal or it becomes law without a signature. Legislation transmitted within the last three days of the session must be acted on by the Governor within twenty days of the session adjournment.

And yet, by April 3rd something had changed. Richardson issued a press release announcing that he would veto the bill because of a lack of time for education and implementation.⁷⁵ He was optimistic about the vaccine's promise to protect girls from cervical cancer. He supported legislation to mandate insurance coverage for the vaccine and approved state funds for uninsured women who chose to get vaccinated. But he was no longer willing to approve a state mandate of HPV vaccination for sixth grade girls.⁷⁶

⁷⁵On April 3, Governor Richardson issued a press release stating his intentions to veto SB 1174 which read: "This vaccine is a promising treatment to prevent certain diseases and cancers," stated Governor Richardson. "I included nearly \$1 million in funding to provide the HPV Vaccine for young women not covered by the federal Vaccines for Children Program and am proud to sign legislation that mandates insurance coverage for the cost of providing this important vaccine." "But, since the end of the session, I have heard from parents, advocates and physicians from all over the state," stated Governor Richardson. "While everyone recognizes the benefits of this vaccine, there is insufficient time to educate parents, schools and health care providers." "For these reasons—a lack of time for public education and the concern expressed by parents and physicians, I will veto legislation mandating a vaccine for all 6th grade girls, even with the ability for parents to opt out. This vaccine will still be available to every young woman in New Mexico and covered by their health insurance." "The Department of Health is developing fact sheets on the vaccine to provide parents enough information so they can make informed decisions about their children's health care. The Department of Health is already working with schools and school nurses across the state to make the HPV vaccine available to girls who are entering the fifth grade this fall. And any future legislation should also contain an opt-out provision for parents." (State of New Mexico: Office of the Governor, 2007).

⁷⁶ It is difficult to tell what factored into the shift in Richardson's perspective on the vaccine. The legislative record does not reflect much resistance during the period in which constituents could testify before legislative committees. The Legislative Finance Committee's Fiscal Impact Report notes that it received feedback on the bill from the Department of Health, the Public Education Department and the Health Policy Commission. Though the report notes some concerns with SB 1174, (mainly that there is no appropriation in the bill despite significant costs attached to providing the vaccine for uninsured vaccine-eligible girls, that future vaccines may provide more protection which girls who are vaccinated now may miss out on, and that the vaccine has been proven to prevent HPV infection and cervical dysplasia which are thought to lead to cervical cancer but has not been proven to prevent cervical cancer per se) the report is largely in support of the school mandate. It highlights how effective the rate of protection was in clinical trials, notes the importance of vaccinating girls before they are sexually active and refers to the demonstrated efficacy of school entry requirements for vaccination.

HPC notes that state laws that require immunization as a condition of enrollment in school increase the use of vaccines, reduce disease, lessen racial disparities in vaccine coverage and increase available funding. According to a recent *New England Journal of Medicine* (December 7, 2006) commentary, "Requiring HPV vaccination by law will almost certainly achieve more widespread protection against the disease than will policies that rely exclusively on persuasion and education."

Surveys have generally shown that young women are very interested in getting the HPV vaccine, that parents are willing to have their children vaccinated, and that clinicians are inclined to offer the vaccine in their practices. Both the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics endorse the

There may well have been other players behind the scenes that influenced Richardson's change of heart, or perhaps the backlash from the conservative right against a mandate ordered by Republican Governor Rick Perry in Texas made him rethink his decision. Maybe the increasing scrutiny of Merck's intensive lobbying and the exposure of Merck's financial backing of "Women in Government," a group of women legislators who introduced HPV vaccine mandate bills across the country, made Richardson uncomfortable. Or maybe Richardson's role in the upcoming presidential debates, and the potential vulnerability that support for mandating a vaccine which prevented the spread of a sexually transmitted infection could open him up to had something to do with it. Regardless, Richardson did not feel like he had the public support necessary to pass an HPV vaccination mandate.

The issues of sex and women's control over their own bodies predominated in the discussions I had in focus groups about the possibility of a state mandate. Though these issues seemed to be written out of the legislative discussion completely, they are at the core of the issue of HPV prevention. While some participants supported mandates that would, in their minds, provide more equitable access to a vaccine capable of saving women's lives, others felt like requiring all girls to get vaccinated years before they may even become sexually active was a violation of their individual rights. The absence of sexuality from the discussion of the mandate was a problem for the majority of those women and girls who spoke. Their comments reflect what Jessica L. Gregg identifies as an understanding of women's bodies as risky, further justifying notions of the need for control of women's bodies and female sexuality. She argues that the link between female

use of the vaccine by their members.

Despite this relatively strong endorsement of the mandate, Governor Richardson chose to reverse his initial support and veto the bill.

sexuality and disease reinforces the notion of dangerous female sexuality—of sexuality *as* risk—that limits effective disease prevention work. In the United States, with abstinence education ruling the land during the last decade, and with politicians scared to broach the topic of teen sexuality, Gregg’s assertion that women’s health is reliant on how a woman thinks about and uses her body sexually is especially prescient. When adolescents do not get comprehensive sexual education, or when a vaccine designed to prevent a sexually transmitted infection is couched in terms of cancer prevention rather than STI prevention, young women are deprived of the ability to make informed decisions about their own sexual health.⁷⁷

Many girls I spoke with were supportive of the mandate, understanding the intentions of state actors as in the best interest of girls and women. Many of them knew girls who were sexually active in middle school and so they thought that vaccinating sixth grade girls made sense. Still, they expressed discomfort with the idea of laws mandating decisions about their bodies and sexual health. For some participants there were clear parallels with abortion. “I think that’s something that is a woman’s decision and not the mayor’s decision; ‘Oh, you can’t do it.’ It’s like, ‘Cause I don’t want you to.’ It’s like ‘well, it’s not your decision, it’s not your body, it’s not your life.’” Even when they agreed with the sentiment of the mandate, some girls took issue with the lack of choice for young women when it came to vaccination. “I think that it’s in a way, forcing somebody to get the vaccine is taking away their rights to their bodies, but at the same time, I understand that if the state does pass the law, it’s to ensure a woman’s safety and health.”

⁷⁷Gregg, 2003.

Many girls took issue with the ways in which a mandate precluded their own ability to educate themselves about the vaccine and choose whether it made sense for them.

I think [the mandate is] a great thing to do, but it's a little – it's a bit of a violation for human rights.

So overall, you think it's a good thing but it does kind of violate you?

Yeah . . . but if a doctor explained it to the 11- and 12—year-olds a little better, it wouldn't be as much as taking away their rights.

For many of the focus group participants, a mandate would normalize a vaccine that targets an STI which might make convincing parents to vaccinate their adolescent daughters a bit easier.

How do you think your parents would respond [to the mandate]?

Well, if it's from, like, the nurse and it says, like – I don't think it'd be that bad, like – probably the parents, like, would react more different if you told them about it. You're like, "Yeah. I want to get this." Well, then they're going to think differently. But if it's a requirement for school, and your nurse asks them, it's going to be way different than if you ask your parents.

Girls understood that the vaccine's relationship to adolescent sexuality would alarm some constituencies. Some thought that parents would get offended by the implications that their children were having sex.

And like, wouldn't some parents get offended though? Because, you know how parents overreact over stuff. Like, wouldn't they get offended from a nurse?

They're like, "Well what are you trying to say? My kid's going to have sex or something?"

Yeah. "No, I was trying to say that 80% to 85% of people get this, and *if* your kids have sex, I'd like them to be protected."

One girl who went to a private, Catholic school mentioned that she did not think that Catholic schools would implement an HPV vaccine mandate. "They're all weird about having sex and when you should have sex, and they, in my opinion, are the types of

people who would have the mindset to think if you're getting the HPV vaccine, you are going to have sex.”

While the mandate was not implemented in New Mexico it came very close to becoming law. The strategy of framing young women as perpetually at-risk of developing cervical cancer reflects larger trends in public health and medicine.⁷⁸ Its failure illustrates the ways in which neoliberalism has challenged the acceptance of traditional population-based public health measures. When health is understood in neoliberal terms of personal responsibility, public health issues become individualized. What becomes important is individual risk and individual survival rather than a concern with populations. The population approach of the mandate was its downfall. The issue for most opponents was not whether the vaccine was necessary to protect public health but simply that a mandate impinged on their rights to make autonomous decisions. However, this obsession with anti-state, neoliberal understandings of rights and autonomy is not what motivated the women and girls that I spoke with in their opposition to the mandate. The idea of state efforts to protect their health seemed plausible. What they took issue with was the ways in which young women were framed simply as at-risk and in need of state protection rather than as sexual beings with the ability to understand what an HPV vaccine would actually mean for them. This discomfort with the state dictating what young women should do with their bodies is an important counter to the projected notions of

⁷⁸Natalie Boero, "Bypassing Blame: Bariatric Surgery and the Case of Biomedical Failure." In *Biomedicalization: Technoscience, Health and Illness in the U.S.*, edited by Adele E Clarke, Laura Mamo, Jennifer Ruth Fosket, Jennifer R Fishman and Janet K Shim, (Durham: Duke University Press, 2010). 307-330. Relying on such usages of risk has contributed to the loosening of understandings of what comprises an epidemic which "now extends far beyond the realm of mass contagion and death," (Boero, 327). Natalie Boero calls this the postmodern epidemic wherein everyone is at (varying degrees of) risk, and epidemics do not depend on whether or not they present a highly contagious threat.

empowerment and choice that *Gardasil's* advertising campaign takes up. The girls and women who shared their thoughts in the focus groups demonstrate the failure of neoliberal and contagion discourses to adequately address the concerns of actual girls and women in the U.S. when it comes to their sexual health.

Theories of medicalization and biomedicalization offer an important lens to understand the ways in which individualized medicine is propped up in neoliberal practice, and government-based public health measures have been weakened in the United States. (The failed vaccination mandates attest to this reality.) They also help to explain how *Gardasil*, a vaccine for a health “problem” that was little known until a pharmaceutical fix was discovered for it, has become an accepted, even encouraged, technoscientific health solution. Its vast advertising campaigns to consumers rely on a populace invested in biomedicalization, who seek out health information and choose their own biomedical technological solutions in the name of consumer autonomy and health.

The reality of biomedicalization requires that patients take on the responsibility of being informed health consumers and the process itself relies on players beyond doctor and patient (where the medicalization process largely takes place). The role of the pharmaceutical industry cannot be overstated. Biomedicalization is seen in the growing biopolitical economy of medicine and health which privilege purchasing power and consumer choice in health decision-making. The obsession with obtaining ever better health (rather than avoiding illness) relies on an acceptance of individuals and populations as always at risk and is buffered by the never ending supply of medical technologies that can optimize and enhance bodies. Another key characteristic of

biomedicalization is the production of group technoscientific identities created around the shared risk and experience with medical technologies.⁷⁹

With increasing access to health information via the internet and other technologies, and in following the neoliberal push to deal with health in terms of personal responsibility and consumerism, patients demand outcomes from their doctors in unprecedented ways. The editor of the American Medical Association's Journal of Ethics special issue on Paternalism and Medicine in 2004 notes that much has changed since the early, paternalistic days of "doctor as God." "Patients have taken the reins of health care with both hands. They come to doctor's offices armed with reams of printouts from health Web sites. They specifically request medicines or treatments advertised in popular magazines, on television, and on the Internet. In response to this type of informed (though sometimes misinformed) patient, many physicians have come to grant a greater level of autonomy or shared decision-making to all the patients in their practices."⁸⁰ This "democratization of expertise," core to biomedicalization, creates empowered patients and challenges the paternalistic nature of medical expertise. However, the challenges of knowing what information to trust, the potential for misinformation and the avoidance or dismissal of health information coming from a health professional can have severe results. "[W]hile knowledge sources proliferate and access is streamlined in ways purportedly in the interests of democratizing knowledge, the interests of corporate

⁷⁹Clarke et al, 1-2.

⁸⁰Monya De. "Towards Defining Paternalism in Medicine." *American Medical Association Journal of Ethics: Virtual Mentor*. Edited by Monya De. February 2004. <http://virtualmentor.ama-assn.org/2004/02/fred1-0402.html> (accessed April 29, 2010).

biomedicine predominate.”⁸¹ Mistaking marketing for education has potentially deceptive results. Direct-to-consumer advertising is a case in point.

For decades, the pharmaceutical industry focused its marketing efforts on medical professionals, capitalizing on the paternalistic provider-patient dynamic wherein the recommendation of a medical professional was often all it took to insure use of a specific drug. In 1997, after years of lobbying by the major television networks, advertising agencies and pharmaceutical companies, the FDA lightened the restrictions placed on advertising for prescription drugs, allowing for direct-to-consumer (DTC) advertising. Whereas previous guidelines required pharmaceutical companies to include most of the information from consumer warning labels in any advertisements that named both the product and condition being treated, the new guidelines allowed for drug manufacturers to provide less information about side effects and safety information associated with their products. They now had to list only those risks determined to be “major,” and provide referrals for more information about those risks.⁸²

All at once, the target of pharmaceutical advertisements shifted from health care professionals to the average consumer.⁸³ Print advertisements previously confined to medical journals began appearing in gossip and news magazines. This pharmaceuticalization process brought the larger public into the medicalization process

⁸¹Clarke et al., 74.

⁸²Lisa Belkin, "Prime Time Pushers." *Mother Jones Web Site*. March/April 2001. <http://www.motherjones.com/politics/2001/03/prime-time-pushers> (accessed May 3, 2009).

⁸³Judy Norsigian, "Feminists Challenge Unethical Marketing by Prescription Drug Companies." *Our Bodies Ourselves Web site*. March 2001. <http://www.ourbodiesourselves.org/book/companion.asp?id=30&compID=69&page=2> (accessed February 20, 2010).

through an understanding of all the pharmaceutical opportunities available to them. Pharmaceutical advertising dollars increased by 145 percent in the next four years—for a total of \$2.7 billion in DTC advertising on television and in popular magazines in 2001 alone.⁸⁴ By 2005, this spending rose to \$4.2 billion.⁸⁵ Rather than relying solely on the medical community to promote pharmaceutical technologies, the pharmaceutical industry could now circumnavigate the middleman and reach consumers directly.

Though drug companies hailed DTC advertising as a democratization of health information—providing the education that consumers need to make informed health decisions—the basic motivation for advertising pharmaceuticals is profit. Clearly, drug manufacturers have a vested interest in shaping perceptions of their products and in sharing how “beneficial” their drugs are with the public. Clarke notes that the prevalence of images of “things medical” has increased continuously since the late 1800s. “In turn, such images and objects themselves have become constitutive of medical knowledge and practices.”⁸⁶ DTC advertising is extremely effective in shaping and defining health for the public.

As the marketplace became saturated with advertising offering Americans happier, healthier lives post-1997, the practice of selling health and the neoliberal processes of medicalization, biomedicalization and pharmaceuticalization were increasingly normalized. Consumers learned to recognize “problems” that they had not

⁸⁴Martin T. Gahart, Louise M. Duhamel, Anne Dievler, and Roseanne Price. "Examining the FDA's Oversight of Direct-to Consumer Advertising." *Health Affairs: The Policy Journal of the Health Sphere*. February 26, 2003. <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.120v1/DC1> (accessed May 3, 2009).

⁸⁵Boston Women's Health Book Collective Inc. *Our Bodies Ourselves: Health Resource Center*. <http://www.ourbodiesourselves.org/book/companion.asp?compID=69&id=30> (accessed May 3, 2009).

⁸⁶Clarke et al. 105.

previously understood as problems (depression, erectile dysfunction etc.). They learned about new “solutions” to these problems. And they were taught to ask for those pharmaceutical solutions by name when they went to see their doctors.⁸⁷

In his work on how diseases are marketed, Moynihan states that “[t]he first step in promoting a blockbuster drug is to build the market by raising public awareness about the condition the drug is designed to target.”⁸⁸ Beginning in September 2005, while the FDA was still reviewing *Gardasil* prior to approving its use, Merck was busy promoting HPV awareness campaigns online and on television (called “Make the Connection” and “Tell Someone,” respectively) focused on educating the public about the risks of HPV with no mention of the *Gardasil* vaccine. Advertisements did not mention that the cervical cancer death rate in the United States dropped by seventy-four percent between 1955 and 1992 and has continued to decline.⁸⁹ The drug company was effectively building their market—planting a seed of paranoia, concern and fear of HPV—under the banner of promoting women’s health. Once FDA approval was secured, in June 2006, and Merck could legally promote *Gardasil* by name, they would alleviate the fears of the American public with the new vaccine in their “One Less” and “I Chose” campaigns.⁹⁰

⁸⁷ Gahart et al., 2003.

⁸⁸Ray Moynihan, "The marketing of a disease: female sexual dysfunction." *British Medical Journal* 330 (January 2005). 192.

⁸⁹Beth Herskovitz, "Brand of the Year." *PharmExec.com: for Global Business and Marketing Leaders*. February 1, 2007. <http://pharmexec.findpharma.com/pharmexec/article/articleDetail.jsp?id=401664> (accessed May 3, 2009).

⁹⁰Brittney Lee Buttweiler, "Because We Have the Power to Choose: A Critical Analysis of the Rhetorical Strategies Used in Merck's Gardasil Campaign." Master's Thesis, Communication Studies, The University of Montana, Missoula, 2009.

The resulting direct-to-consumer advertising campaign created a brand that sold a feeling as much as a product. Viewers were induced to feel like they were a part of something important, of making the world a better place for women and girls by preventing cervical cancer. Merck representatives articulated their motivations behind the campaign as a way to focus “on a strong and positive message that is designed to empower [women and girls] to want to become (or help their daughters want to become) ‘one less’ person who will battle cervical cancer.”⁹¹ Merck effectively framed the vaccine as the fulfillment of a pressing need—a need that Merck itself shaped—to end the scourge of cervical cancer. In educating the public about HPV and its relationship to cervical cancer, Merck was in many ways providing a useful public service. On the other hand, in framing their advertising campaign as a “cause”—to protect women from preventable cervical cancer—the company’s hyperbole was misleading. The goal of their “education campaign” was not simply to end cervical cancer but to make money. While the threat of cervical cancer was not completely fabricated and the discovery of the HPV virus was an important scientific finding with major health implications, Merck could just have easily focused efforts on increasing awareness about the importance of screening and Pap smears. Also, the vaccine is offered (at least by implication) as a long-term, even a life-time vaccine, but—though unacknowledged in the marketing—the duration of protection is not known past five years. The company was clearly motivated by more than a commitment to women’s health.

⁹¹Medical News Today. "News: Cancer/Oncology: Merck Launches National Advertising Campaign For GARDASIL®, Merck's New Cervical Cancer Vaccine." *Medical News Today Web site*. November 23, 2006. <http://www.medicalnewstoday.com/articles/57419.php> (accessed May 3, 2009).

When *Pharmaceutical Executive* magazine chose *Gardasil* as its 2006 Brand of the Year, it explained the award by pointing to Merck's ability to "embod[y] the kind of links between science, commercialization, and humanity that typify great pharmaceutical breakthroughs. It turned a medical success story into a campaign of empowerment for a generation of girls and young women. Merck's researchers used visionary science to produce a vaccine with the potential to eradicate the third-most-common cause of cancer worldwide, while marketers taught girls and young women how to talk about sensitive issues in a forthright, unapologetic way."⁹² In their praise, the writers at *Pharmaceutical Executive* acknowledged the difficulty that the makers of *Gardasil* faced—that the market was relatively ignorant about HPV and therefore didn't realize how much they "needed" the vaccine. "[O]nly 60 percent of women had heard of HPV. And even if they knew what it was, only 52 percent knew that it could cause cervical cancer or genital warts."⁹³ The other obstacle was the difficult terrain of teen sex in marketing a vaccine that prevented a sexually transmitted infection. The solution that the marketing team working with Merck came to was to avoid the topic of sexual activity and transmission as much as possible and to focus on empowerment, choice and healthy mother-daughter relationships. In this way Merck chose to co-opt a rhetoric of reproductive justice—albeit one that largely wrote out the issue of sexuality—to neoliberal ends in the marketing of *Gardasil*. In so doing, they also utilized neoliberal discourse that relied on the notion that individuals are responsible for their own health, and persuaded individual health consumers to search out health solutions via the marketplace.

⁹²Herskovitz, 2007.

⁹³Ibid.

Merck very strategically created their audience. Ads did not rely on common medical advertising strategies like images of an “expert” doctor in a lab coat, or scientific charts that would lend authority to the claims being made. Rather they relied on images of female solidarity—a superficial feminism that trumped expertise, and that felt good. Though it could be argued that sexuality is implicit in the *Gardasil* advertising, and that a strong mother-daughter relationship and confident young women are key to good sexual health, writing sexuality out of the discussion limits true health education and empowerment by suppressing the actual context for disease risk.

In effect, the DTC advertisements teach that *Gardasil* is a way for mothers to protect their daughters and to feel empowered and proactive in the face of the threat of cervical cancer.⁹⁴ In many ways they exemplify what Robert Goldman terms “commodity feminism” where advertisements sell the idea of feminism by connecting the concept of feminism to material objects.⁹⁵ Executives at Merck stated that they “learned early on that moms really wanted to protect their daughters—that protective insight is important. For young women, they want to empower themselves to take control of their own destiny.”⁹⁶ The series of advertisements in the “I Chose” campaign do just that. Mothers look directly at the viewer and announce “I chose to get my daughter vaccinated because I want her to be one less woman affected by cervical cancer.” Daughters claim “I chose to get vaccinated after my doctor told me Gardasil does more than help prevent cervical

⁹⁴Judith Siers-Poisson, "The Gardasil HPV Vaccine: Not the Shot in the Arm Merck Hoped for." *Center for Media and democracy: PR Watch.Org*. September 16, 2008. <http://www.prwatch.org/node/7748> (accessed May 3, 2009).

⁹⁵Marita Sturken and Lisa Cartwright. *Practices of Looking: An Introduction to Visual Culture*. (Oxford: Oxford University Press, 2001).

⁹⁶Herskovitz, 2007.

cancer.” *Gardasil* capitalizes on what Inderpal Grewal identifies as the centrality of the concept of “choice” for both feminist and neoliberal movements.⁹⁷

Focus group participants were critical of all the advertisements that we showed them. One mother’s cynicism about *Gardasil* captured the altered landscape resulting from the normalization of pharmaceuticalization and the onslaught of DTC advertising: “It’s just like any other pharmaceutical garbage they’re selling on TV. You know, 20 years ago you never saw them trying to sell a pill for this and a pill for that, now . . . [there’s always a] commercial selling you a pill for something.”

Most of the mothers and teens that we spoke with were aware of the HPV vaccine and were familiar with *Gardasil* advertisements. Those who were not familiar with it by name recognized the “One Less” tag line. In many cases, participants were critical of the advertisements. Girls felt like the attempts to capture normal girlhood were false and hard to relate to:

Like the reason they do the whole stomping the yard and sewing sweaters is, like, to depict an American teenager and, like, so you can relate to them and be like, “Oh, I’m totally them, so I should get [the vaccine] too.” But, like, things like stomping the yard and sewing sweaters aren’t really on the agenda for most teenage girls unless you’re like home-schooled, or Amish.

They noticed that the ads avoided the issue of HPV’s sexual transmission: “I was kind of confused by it. I didn’t know it was like an STD. I just thought it was cancer.”

Each focus group was presented with examples of *Gardasil*’s advertising to enable more in-depth analysis of the advertising strategies and effectiveness (see Appendix A & Appendix B). Both examples were print advertisements for *Gardasil*

⁹⁷Inderpal Grewal, *Transnational America: Feminisms, Diasporas, Neoliberalisms*. Durham: Duke University Press, 2005.

originally published as full page ads in popular magazines. The top half of the first ad (see Appendix A) consists of text designed to look like a handwritten note, surrounded by drawings of a two-story house flanked by clouds (some filled with hearts), stick figures riding bicycles and playing frisbee, and a dog following a cat up a tree (also blooming with hearts). A smiling sun watches down on the scene. The bottom left portion of the page is taken up by fine print explaining briefly what *Gardasil* is, and providing basic safety information, as well as the vaccine's logo, website and hotline number. A woman and a teenage girl stand in the bottom right hand corner of the page. The girl stands with her right hand resting on the woman's shoulder while she smiles directly into the camera. Though she looks straight forward, she leans slightly into the older woman. The older woman stands with both of her hands in her pockets, looking down at the girl with a smile. Her body faces the camera straight on while her face is directed away from the viewer, towards the focal point of the image: the happy, healthy, young woman. Both figures have long, dark, wavy hair that they wear down, both are wearing jeans and both have jewelry on their left wrists. They are linked both through their physicality and their styling.

The image and the text combine to teach the viewer that whatever product is being sold here is both innocent and protective. The "thoughts" scrawled on the top half of the page are written in a mother's voice, but in childlike handwriting, and explain the motivation to use *Gardasil* to protect the daughter assumedly depicted below. The woman's smiling, protective gaze leads the viewer's eye down to the smiling face of the younger woman.

While maternal choice is foregrounded in this advertisement, adolescent sexuality is completely suppressed. The daughter's role in her own health decision making is also glossed over. The text, surrounded by childlike doodles, declares "I chose to get my daughter vaccinated because no matter how old she gets she'll always be my little girl. I'll do everything I can to help protect her. Hey, I'm her mother, that's my job. So when her doctor told me Gardasil helps protect her from cervical cancer and other HPV diseases I thought this is the protection she deserves." The *Gardasil* advertisement uses imagery to construct a viewer who is eager to do something for women, to choose *Gardasil* as part of a larger mainstream feminist project of empowerment and health but who is content to ignore adolescent sexuality and autonomy.

Mothers and teens in all three focus group sites were critical of the strategies employed in this particular advertisement. Girls were especially attuned to the representations of the mother-daughter relationship, calling it "too close," and "wack." The exclusion of the sexual transmission of HPV was a continued point of frustration for focus group participants. Girls noted that the portrayal of a close, happy mother-daughter relationship didn't feel realistic in relationship to the sexual activity that the risk of HPV infection, and cervical cancer, implied. The breezy feel of the ad didn't ring true. It was generally agreed upon that the choice not to overtly address sex in the ads was a strategic move to make mothers, the clear target of the advertisement, feel comfortable with the vaccine. As one girl explained: "sex is offensive to older people . . . so maybe this is more comforting towards a parent . . . instead of saying 'sex' they're using like 'little girl' and you know, 'mother'" Caregivers who participated in the focus groups had very similar critiques. Mothers quickly recognized the omission of sex: "I think these are kind

of misleading because if you look at it, it doesn't say anywhere, like 'sexually transmitted'."

In commissioning this advertisement, Merck was working to visually tie the *Gardasil* brand to positive, intimate, mother-daughter relationships and to convince mothers that choosing the vaccine for their daughters was the responsible, even empowering, thing to do. Additionally, the all-smiles, easy feel of the image contributes to a sense that the vaccine is no big deal. Though the campaign was clouded in controversy—with angry parents up in arms that providing a vaccine protecting young girls from an STI would promote early sexual activity—this image attempts to redirect the conversation and focus on maternal choice and empowerment, responsibility and protection. It provides a way for mothers to prove their good parenting and taps in to a desire for a closer relationship with their adolescent daughters. Importantly, it lets mothers overlook the uncomfortable topic of their young daughters as sexual beings.

In addition to the omission of sexual transmission, many of the girls were bothered by the lack of seriousness that they saw in the ad: "My mom had cervical cancer, but um, it's a serious thing so I don't know why they're being . . . nonchalant about it. Like it should be something more dramatic . . . That upsets me because I feel like they're not taking it serious. So then why should we in turn take it serious? Then you wonder why girls get [HPV] in the first place."

Girls felt like the ads were working to manipulate mothers into vaccinating daughters through framing vaccination as the responsible choice. Mothers had similar reactions: "It makes me feel that if I don't do it, I'm a bad mother. That's what it's telling

you. I mean if you're the good mom you're gonna go get the shot, that's what it's telling you on top."

Participants were also shown an advertisement geared towards a different demographic (see Appendix B). This advertisement appears to be a page in a teenager's notebook. The top half has handwritten notes in dark blue ink. The text is surrounded by bright pink drawings of high heels, high top sneakers, flowers, clothing, women's heads with different hairstyles, and one sketch of a woman featured in full carrying a purse. The bottom left hand portion of the page mirrors the fine print in the previous ad. A young woman, in her late teens or early twenties, takes up the bottom right hand corner of the page. She wears a short sleeved t-shirt underneath a black vest with white polka dots. Her hands are casually clasped resting on top of her head. She's relaxed, smiling lightly at the camera. Her hair is up. Her right wrist is encircled by a few bracelets and a necklace hangs over her shirt. A hand-drawn flower blooms in the corner in front of her left hip situating her simultaneously in front of and within the page of the notebook. She is confident, independent, her own woman.

The text, assumedly written in her own hand states: "I chose to get vaccinated after my doctor told me the facts. I mean, FACTS are FACTS, and when it comes to my body and how I can help protect it, I'm all ears. So when I found out that GARDASIL helps protect me from cervical cancer and other HPV diseases. I decided to get vaccinated." The text mirrors her posture: clear, confident, declarative. Like the ad geared towards mothers, sex is not explicitly invoked as an issue related to the transmission of HPV or to the HPV vaccine. A difference lies in the depiction here of a young woman in charge of her own health decision-making. There is no mention of discussing the vaccine

with a parent. No reference to the woman depicted as anyone's "little girl." Instead, the text refers to an interaction with a doctor. The young woman makes her own decisions about her body and her sexual health. She chose to protect herself as an autonomous and responsible woman.

Mothers and girls responded strongly to the colors and sketches in this advertisement. One girl commented: "If I'd know any better I would have said that this was perfume or something, maybe deodorant or something like that. This does not [say] vaccine." Many participants interpreted the drawings as an attempt to draw attention away from the vaccine.

In viewing this ad, mothers noted that the young woman portrayed seemed empowered and in control. The girls agreed: "She looks independent, like she wants to show like, 'I'm independent. I get to do whatever I want.'" Yet many of the girls were confused about whether the woman depicted was supposed to be representative of them as twelve to eighteen year-old girls. They commented that she looked at least twenty in which case the message of the ad was confusing.

I guarantee this woman's had sex before. So . . . even if you have had sex before it could be a possibility that you've already had . . . HPV and if you have, [the vaccine is] probably not going to protect you. Well, for a twenty year old who hasn't had the shot, [and] has been sexually active . . . then does it really make sense for her to be talking to other people about getting the shot and being safe because she still doesn't know if she's protected against HPV if she's already had it?

Some girls thought that having an older girl in the advertisement helped to avoid the discomfort around issues of young girl's sexuality.

Despite the depiction of an older girl, however, the omission of sex was glaring here as well. One girl demanded: "I do not see sex anywhere. I don't see sex in these

drawings. I do not see sex. I see ‘facts, facts,’ but I do not see sex anywhere. I’m just saying. Because this is like sexual stuff. Like, this is a sexually transmitted disease, obviously, so why isn’t there sex being presented?” A mother noted: “My first impression is it doesn’t say anything—you know; is a young girl going to read this and say, ‘Oh, well, it’ll protect me. It’ll protect me from getting cancer, so I’m going to do it.’ Well, it doesn’t say anything about sexually transmitted . . . you have sex, you get this. It just right away reads, to me, ‘Oh, I’ll get this [vaccine] and not get cancer.’”

In some cases, girls who felt like HPV vaccination was an important public health practice thought that the focus on cancer took away from the urgency necessary to effectively convince their peers to get vaccinated.

Maybe we should make ads that are more like, uh, attention-grabbing. . . I know I’ve seen an ad before, but the reason that it didn’t stick in my head was one, because I was not educated. I was just like, “Oh it’s a vaccine for cancer. I don’t have cancer so I don’t need it.” Then also because it’s just like, not that appealing I guess. Like it doesn’t grab your attention. Like maybe they should put some cold hard statistics on it.

Others had a critique of the fear tactics that they already saw employed in *Gardasil* campaigns, leading viewers to believe that vaccination was the only way to protect against cervical cancer.

Another theme in the focus groups was an understanding of the ways in which Merck was working to reach multiple targets with its advertising. In so doing they were sending mixed messages about just who is empowered to “choose” Gardasil. One girl noted, “Well, on this side they’re saying that the girl should choose and on this side they’re saying mothers force your daughters to do it. So it’s like . . . who do you want to choose to do it?”

Through direct-to-consumer print advertisements like these, the makers of *Gardasil* construct a sense that they are committed to, and understand, the needs of real girls and women. They use imagery of mothers and daughters that connote love and protection, and child-like drawings that invoke notions of innocence to show a concern for young women and the need to protect them. Simultaneously, the *Gardasil* vaccine is framed as a choice for young women to make on their own. The implication of this is that women and girls feel as though they are making a free, intelligent choice as a woman rather than a materialist consumer (though the act of choosing vaccination is carried out *through* health consumerism). This allows Merck to tap into feminist discourses of female solidarity, choice and empowerment. What is disturbing here, beyond the condescension and blatant marketing strategy, is the way in which Merck's efforts to pass vaccination mandates completely undercut all that they work to appeal to in the vaccine advertising. Merck takes up the rhetoric of reproductive justice but abstracts it from the context of larger structural inequity and from sexuality. The pharmaceutical giant attempts to link consumer choice to a rhetoric of self-determination and autonomy, melding neoliberal consumerism with a faux feminism, in order to sell more *Gardasil*. The focus groups offer a more complex picture. Participants complicate Merck's strategy and incorrect assumptions about the (in)appropriateness of addressing teenage sexuality in *Gardasil* advertising. They recognize the hypocrisy of the ads placed in contradistinction to the proposed mandates. The manufacturers of *Gardasil*, while appealing to the autonomy of women and girls in their advertising campaigns, simultaneously utilize contamination discourse masked as public health rhetoric to disallow for individual choice related to the vaccine in state and federal mandates.

Conclusion

The story of public health in the United States, as recounted in traditional historical narratives, is one of progress and uplift: the development of an American public health infrastructure saved the health of the nation. Though important to acknowledge public health's tremendous impact on real people's lives in this country, the history of public health encompasses more than simply the eradication of disease and the extension of life expectancy. The exposure of state interests distinct from a concern for the health of its populace, and often working in tandem with the needs of big business and/or invested in maintenance of racial, economic and gendered hierarchies, allows for an alternative understanding. The contemporary moment in public health is characterized by neoliberal policies that have weakened the institution and redirected the focus to individual health and market solutions.

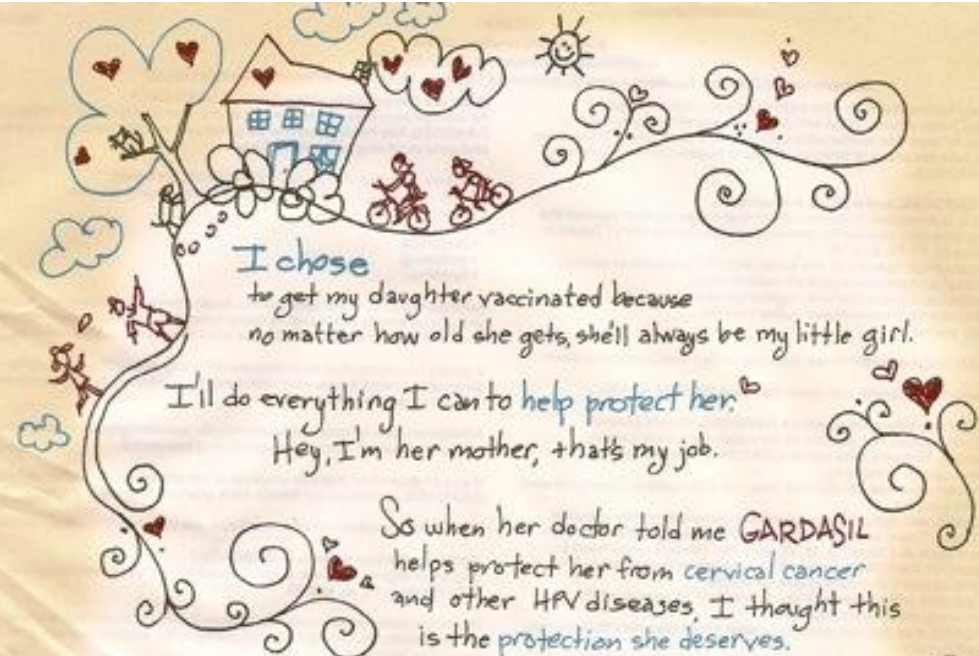
The example of *Gardasil* captures the normalization of individual medical solutions for everyday life. The neoliberal turn in public health emphasizes individual rights and consumerism. This ideological work is strengthened by the process of biomedicalization which stresses the personal responsibility for health and the morality implicit in health decision-making. Pharmaceuticalization foregrounds the importance of the pharmaceutical industry in providing options for health consumers, in strengthening reliance on pharmaceutical solutions to health issues, and in altering how public health is understood. *Gardasil* allows for a deeper understanding of the ways in which neoliberal and contamination discourses are utilized through all of these processes to justify particular public health practices.

The HPV vaccination mandate for immigrants effectively characterized immigrant women and girls as excludable based on their status as potential sources of contagion. If they refused to be vaccinated, their chance for national inclusion was rejected. The policy had little to do with actual HPV infection rates of immigrant women and offered very little actual protection for the women being vaccinated or the public that they supposedly threatened with infection. School mandates avoided the issue of adolescent sexuality and overestimated the general population's commitment to population health. Policies taught immigrant women that they were risky, suspect and at the whim of the U.S. government when it came to decisions related to sexual health. They reaffirmed notions of immigrants as unhealthy risks to public health nationally and taught adolescent girls that they were perpetually at-risk and powerless to protect themselves. However seemingly incongruent, the same company that pushed for these mandates strategically worked to "educate" consumers about health issues and pharmaceutical solutions, and framed health consumers as empowered health decision-makers, ready to choose the best health solutions for themselves.

It is important to understand the multiple strategies at work in the consumer and legislative marketing of *Gardasil* and to view the efforts of a powerful pharmaceutical industry, however seemingly well-intentioned, with a critical eye. *Gardasil* provides an opportunity to better understand how pharmaceutical interests can work to shape discourses of health via the state, and how, through a strategic targeting of health consumers (through advertising) and government (through policy), they can contribute to the neoliberalization of public health that works to sexualize, racialize, and at times literally exclude those it purports to protect.

We see, through the use of neoliberal and contamination discourse in the promotion of *Gardasil*, that age-old tropes of women as risky subjects and subjects at risk and of immigrants as sources of contagion are unfortunately alive and well. The danger illustrated by the case of *Gardasil* is of a neoliberal public health that focuses on individual pharmaceutical solutions rather than prevention and health equity. As girls in the focus groups in New Mexico pointed out, a more rational policy on both the state and federal fronts may be one focused on screening and education rather than pharmaceutical technologies.

APPENDIX A



I chose
to get my daughter vaccinated because
no matter how old she gets, she'll always be my little girl.

I'll do everything I can to help protect her.
Hey, I'm her mother, that's my job.


So when her doctor told me GARDASIL
helps protect her from cervical cancer
and other HPV diseases, I thought this
is the protection she deserves.

GARDASIL is the only cervical cancer vaccine that helps protect against 4 types of human papillomavirus (HPV): 2 types that cause 70% of cervical cancer cases and 2 more types that cause 90% of genital warts cases. GARDASIL is for girls and young women ages 9 to 26.

SELECT SAFETY INFORMATION:
Anyone who is allergic to the ingredients of GARDASIL should not receive the vaccine. GARDASIL may not fully protect everyone, and does not prevent all types of cervical cancer, so future cervical cancer screenings will be important for your daughter.


GARDASIL is not for women who are pregnant. GARDASIL does not treat cervical cancer or genital warts. The side effects include pain, swelling, itching, and redness at the injection site, fever, nausea, dizziness, vomiting, and fainting. GARDASIL is given as 3 injections over 6 months. Only a doctor or health care professional can decide if GARDASIL is right for your daughter.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088. Please see the Patient Information on the next page to discuss it with your daughter's doctor or health care professional.



GARDASIL.
[Human Papillomavirus Quadrivalent
(Types 6, 11, 16, and 18) Vaccine, Recombinant]


gardasil.com 1-800-GARDASIL

 For more information on the availability of GARDASIL through the Merck Vaccine Patient Assistance Program, visit gardasil.com/freevaccines or call 1-800-GARDASIL.

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http://www.worldofdtcmarketing.com/files/page0_blog_entry437-gard1.jpg

APPENDIX B



I chose to get vaccinated after my doctor told me the facts.


I mean, FACTS are FACTS. And when it comes to my body and how I can help protect it, I'm all ears.

So when I found out that GARDASIL helps protect me from cervical cancer and other HPV diseases, I decided to get vaccinated.


GARDASIL is the only cervical cancer vaccine that helps protect against 4 types of human papillomavirus (HPV): 2 types that cause 70% of cervical cancer cases and 2 more types that cause 90% of genital warts cases. GARDASIL is for girls and young women ages 9 to 26.

SELECT SAFETY INFORMATION:
Anyone who is allergic to the ingredients of GARDASIL should not receive the vaccine. GARDASIL may not fully protect everyone, and does not prevent all types of cervical cancer, so it's important to continue routine cervical cancer screenings. GARDASIL is not for women who are pregnant. GARDASIL does not treat cervical cancer or genital warts. The side effects include pain, swelling, itching, and redness at the injection site, fever, nausea, dizziness, vomiting, and fainting. GARDASIL is given as 3 injections over 6 months. Only a doctor or health care professional can decide if GARDASIL is right for you.


You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088. Please see the Patient Information on the next page to discuss it with your doctor or health care professional.


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gardasil.com 1-800-GARDASIL

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http://www.magnetreps.com/wp/wp-content/uploads/2008/06/gardasil_scan.jpg

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