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UNIVERSITY OF CALIFORNIA  
SANTA CRUZ

**THE PHARMOCRATICS OF MISOPROSTOL:  
RACE, DRUGS, AND REPRODUCTIVE NEOLIBERALISM**

A dissertation submitted in partial satisfaction  
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

FEMINIST STUDIES

by

**Cecelia Brun Lie-Spahn**

December 2019

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## ABSTRACT

### **The Pharmocratics of Misoprostol: Race, Drugs, and Reproductive Neoliberalism**

**By Cecelia Brun Lie-Spahn**

This dissertation is about underground markets for misoprostol (“miso” or Cytotec), a drug originally created in the 1980s to treat stomach ulcers caused by nonsteroidal anti-inflammatory drugs (NSAIDs), but which is frequently used off-label to treat postpartum hemorrhage, induce labor, and induce abortion. In the cross-hairs of some of the most polarizing debates in mainstream U.S. political discourse—immigration, abortion, and the War on Drugs—depictions of off-label miso-use vacillate from hyper-racialized images of flea markets and drug cartels to hope for a future of unconstrained reproductive health options, a vision in which miso symbolizes the cornerstone of medical, technological, and social progress. However, Pfizer—the mega pharmaceutical company that owns, manufactures, and distributes miso under the brand name “Cytotec”—is overtly absent from these discourses. To bring the pharmaceutical machinery that has so successfully eluded these discourses back into the picture, I resituate discourses about underground misoprostol within the neoliberal structures from which it emerged in the post-World War II period, bringing together two key conceptual frameworks: (1) the reproductive justice movement’s long-held emphasis on women of color organizing and intersectional, radically inclusive, community-based, and comprehensive vision of reproductive freedom; and (2) Kaushik Sunder Rajan’s concept of

“pharmocracy,” wherein pharmaceutical philanthropy acts as a modern form of extractive capitalism. I argue that the pharmocratic scripts of modernity and cultural backwardness reproduced in discourses about underground misoprostol reflect the dangerous proliferation of an updated version of bootstraps individualism I refer to as “reproductive neoliberalism”: the idea that, in lieu of state-provided equitable and holistic reproductive care, women can still achieve reproductive autonomy through entrepreneurial, legal, and pharmaceutical prowess. The individualist language of reproductive neoliberalism in Pfizer’s annual financial reports, mainstream liberal journalism, and family planning research about underground miso invisibly authorizes the uneven transfer of legal and medical liability away from pharmaceutical corporations, such that individuals are made to bear legal, medical, affective, and cultural liabilities—forms of conscripted labor inherent in the act of transgressing federal licensing and malpractice laws, as well as in the fear of accidental injury (bodily, emotional) to oneself or someone else in the process.

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Figure 1: Photo from a flea market in El Salvador, taken by John Poole, published by National Public Radio (NPR). The sign in the image—“SE LEEN LAS CARTAS SE HACEN TRABAJOS Y LIMPIAS”—advertises odd jobs like reading letters and cleaning. NPR’s caption below it reads: “In the markets of San Salvador, El Salvador, you can have your palm read, you can buy plumbing tools... and you can purchase abortion pills.”



## INTRODUCTION

### **Tracking Misoprostol: A Material Approach to Reproductive Neoliberalism**

“In the central market in San Salvador, you can buy just about anything you want: tomatoes by the wheelbarrow full. Fresh goat’s milk straight from the goat. Underwear. Plumbing supplies. Fruit. Hollywood’s latest blockbusters burned straight onto a DVD.

And in the back of the market, in a small stall lined with jars of dried herbs, roots and mushrooms, you can buy an abortion.”<sup>1</sup>

Jason Beaubien  
Investigative Journalist for National Public Radio (NPR)  
*All Things Considered*, 2014

In September 2014, NPR ran a series looking at the health implications of clandestine abortion in developing countries, one of which begins in the San Salvador street market described above. According to Beaubien’s account, the anonymized female herbalist sells these pills mostly to distraught teenagers with “tragic...tales of rape, abuse, betrayal or misguided love” at \$200 per 3-pill course.<sup>2</sup> Pictured through the assortment of farmed, pirated, and pharmaceutical items for sale in her tent, the drug trafficking figure caricatured in the epigraph above mediates a kind of pharma-cultural border within her own street tent: one where bagged roots, dangling jerky, and single-use packets of Tide conceal clandestine abortion methods.

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<sup>1</sup> Jason Beaubien, “Even When Abortion Is Illegal, the Market May Sell Pills for Abortion,” National Public Radio, September 23, 2014.

<sup>2</sup> Beaubien.

The abortion available for purchase is a reference to misoprostol, a drug initially approved in the United States in 1988 for the treatment and prevention of gastrointestinal ulcers. In the early 1980s, long before Beaubien’s story was published, misoprostol (“miso”) garnered attention from U.S.-based news outlets and family planning experts because of its growing use as an off-label abortifacient, as the pregnancy contraindication on its warning label—symbolized by a crossed-out illustration of a pregnant woman, similar to a no-smoking sign—prompted low-income women in areas with restrictive abortion laws in Latin America to buy the drug over the counter or at flea markets and abort pregnancies at home.<sup>3</sup> One can

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<sup>3</sup> Deborah L. Billings, “Misoprostol Alone for Early Medical Abortion in a Latin American Clinic Setting,” *Reproductive Health Matters*, Supplement: Abortion Law, Policy and Practice in Transition, 12, no. 24 (November 2004): 57–64; Deborah L. Billings et al., “Pharmacy Worker Practices Related to Use of Misoprostol for Abortion in One Mexican State,” *Contraception* 79, no. 6 (February 23, 2009): 445–51; Jessica Cohen et al., “Reaching Women with Instructions on Misoprostol Use in a Latin American Country,” *Reproductive Health Matters* 13, no. 26 (2005): 84–92; Maria M. Fernandez et al., “Assessing the Global Availability of Misoprostol,” *International Journal of Gynecology & Obstetrics* 105, no. 2 (5/2009): 180–86; C. C. Harper et al., “Reducing Maternal Mortality due to Elective Abortion: Potential Impact of Misoprostol in Low-Resource Settings,” *International Journal of Gynecology & Obstetrics* 98, no. 1 (7/2007): 66–69; Andrzej Kulczycki, “Abortion in Latin America: Changes in Practice, Growing Conflict, and Recent Policy Developments,” *Studies in Family Planning* 42, no. 3 (September 2011): 199–220; Diana Lara et al., “How Often and Under Which Circumstances Do Mexican Pharmacy Vendors Recommend Misoprostol To Induce an Abortion?,” *International Perspectives on Sexual and Reproductive Health* 37, no. 02 (06/2011): 075–083; Maureen Paul et al., eds., “Medical Abortion in Early Pregnancy,” in *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care* (Chichester, Hoboken: Wiley-Blackwell, 2009), 111–34; J. Sherris et al., “Misoprostol Use in Developing Countries: Results from a Multicountry Study,” *International Journal of Gynecology & Obstetrics* 88, no. 1 (November 14, 2004): 76–81.

understand how, for someone seeking clandestine abortion with limited options, the warning label could read almost like an instructional pamphlet for self-abortion:

CYTOTEC (MISOPROSTOL) ADMINISTRATION TO WOMEN WHO ARE PREGNANT CAN CAUSE BIRTH DEFECTS, ABORTION, OR PREMATURE BIRTH. UTERINE RUPTURE HAS BEEN REPORTED WHEN CYTOTEC WAS ADMINISTERED IN PREGNANT WOMEN TO INDUCE LABOR OR TO INDUCE ABORTION BEYOND THE EIGHTH WEEK OF PREGNANCY (see also PRECAUTIONS and LABOR AND DELIVERY). CYTOTEC SHOULD NOT BE TAKEN BY PREGNANT WOMEN TO REDUCE THE RISK OF ULCERS INDUCED BY NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs) (see CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS).

PATIENTS MUST BE ADVISED OF THE ABORTIFACIENT PROPERTY AND WARNED NOT TO GIVE THE DRUG TO OTHERS.<sup>4</sup>

The language here is careful: while it is informative about the possible physiological effects of miso on pregnant women, it does not specifically direct readers not to use the drug for obstetric purposes, stating that pregnant women should not take miso *if* they are doing so to treat NSAID-induced ulcers. The ending instruction “not to give the drug to others” suggests that the warning’s primary concern is not pregnant women’s physical safety—in fact, the label implies that miso could be taken prior to the eighth week of pregnancy without significant risk of uterine rupture—but rather the threat of underground distribution.

While it is unclear who or what the underground distribution of miso threatens, the language here produces an illusion of informed pharmaceutical choice made by an imagined user-subject, one who rationalizes miso-use according to individually calculated risk. In fact, some family planning experts argue that the risk

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<sup>4</sup> “Label: Cytotec, Misoprostol Tablets,” 2012, 1.

of unsupervised, at-home abortions is minimal compared to the potential gains in cheaper, safer, and significantly less invasive extra-legal options; as one family planning study boldly asserts, “[t]he more widespread misoprostol abortion is, the greater the gains.”<sup>5</sup> Citing this literature, health activists from a variety of professions—public health practitioners, physicians, midwives, peer health advocates—have launched projects explicitly calling for the mass distribution of instructional pamphlets and websites detailing how to self-abort using misoprostol.<sup>6</sup> Some have even trained women to strategically request the drug from pharmacists without revealing their desire to abort.

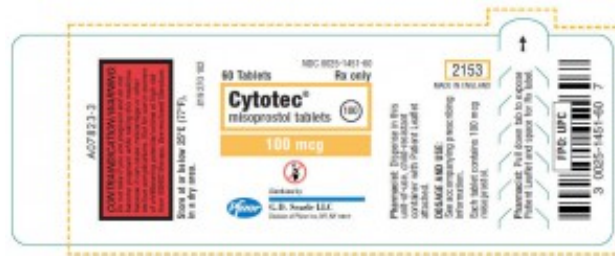


Figure 2: Cytotec packaging.<sup>7</sup>

At the same time, the recurring myth in popular news media and family planning literature that off-label miso use is a phenomenon of the so-called Third World puts the discourse into the crosshairs of some of the most violent and

<sup>5</sup> Harper et al., “Reducing Maternal Mortality due to Elective Abortion,” 68.

<sup>6</sup> Billings, “Misoprostol Alone for Early Medical Abortion in a Latin American Clinic Setting”; Cohen et al., “Reaching Women with Instructions on Misoprostol Use in a Latin American Country”; Fernandez et al., “Assessing the Global Availability of Misoprostol”; Harper et al., “Reducing Maternal Mortality due to Elective Abortion”; Diana Whitten, *Vessel*, DVD, 2014.

<sup>7</sup> “Cytotec (G.D. Searle LLC): FDA Package Insert.” MedLibrary.org, March 1, 2011. <https://medlibrary.org/lib/rx/meds/cytotec-2/page/4/>.

politically divisive debates in the United States: the War on Drugs, immigration, border security, and, of course, abortion. Depictions of off-label miso use thus wildly vacillate from an episode of *Breaking Bad* to hope for a future of unconstrained reproductive health options, a vision in which the abortion pill symbolizes the cornerstone of medical, technological, and social progress. Remarkably, Pfizer—the mega pharmaceutical company that owns, manufactures, and distributes miso under the brand name “Cytotec”—is overtly absent from these discourses, despite extensive critical journalism and scholarship on Pfizer and Big Pharma more broadly. Rather, investigative journalists and family planning experts alike have focused almost exclusively on the entrepreneurial ethics of flea market vendors in the Global South, erasing Pfizer’s role in contributing to the precarious economic conditions, extractive environmental practices, and corporate hegemony from, through, and against which these underground markets emerge. What conditions this refusal to see Pfizer and underground miso in the same conceptual image? How do these partial visibilities shape the pharmaceutical epistemologies expressed and constructed through popular journalism and family planning literature? What do these hierarchies of pharmaceutical knowledge erase?

These questions prompt me to understand misoprostol not only as a pharmaceutical product contingently available for market consumption and thus in need of improved or otherwise reconfigured access, but also as an object through which ideas about race, gender, capital, nation, modernity, and reproduction get (re)constituted. They also make visible the ways in which the “pharmaceutical

imagination”<sup>8</sup> not only shapes everyday notions of the self and the body, but also contributes to the expansion of what Kaushik Sunder Rajan terms “pharmocracy,” or the profit-driven systems by which multinational pharmaceutical corporations become powerful biopolitical forces, transforming techno-scientific knowledge into capital at the expense of the most underserved populations.<sup>9</sup> This dissertation project thus pulls misoprostol under the feminist-postcolonial microscope: it traces the material-discursive circulation of miso as it transgresses and repurposes a variety of state, bodily, disciplinary, and temporal borders.

Joining feminist science and technology studies (STS) scholarship on transnational reproduction and “living drugs”—drugs that “[make] ordinary lives, social relationships and political institutions”<sup>10</sup>—I argue that the pharmocratic scripts of modernity and cultural backwardness reproduced in discourses about underground misoprostol reflect the proliferation of an updated version of bootstraps individualism I will refer to as “reproductive neoliberalism”: the idea that, in lieu of state-provided equitable and holistic reproductive care, women can still achieve reproductive autonomy through entrepreneurial, legal, and pharmaceutical prowess.<sup>11</sup> Reproductive neoliberalism engenders a particular form of racialized

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<sup>8</sup> Barbara L. Marshall, “Sexual Medicine, Sexual Bodies and the ‘Pharmaceutical Imagination,’” *Science as Culture* 18, no. 2 (June 1, 2009): 133–49.

<sup>9</sup> Kaushik Sunder Rajan, *Pharmocracy: Value, Politics, and Knowledge in Global Biomedicine* (Durham: Duke University Press, 2017).

<sup>10</sup> Dr Suzanne Fraser, Kylie Valentine, and Celia Roberts, “Living Drugs,” *Science as Culture* 18, no. 2 (June 1, 2009): 124.

<sup>11</sup> In a radically different context, a similar term, “reproductive libertarianism,” has also been used to support the unobstructed use of assisted reproductive technologies (ARTs), particularly for folks whose sexual orientation and/or sexual anatomy

capital, one that invisibly authorizes the uneven transfer of legal and medical liability away from pharmaceutical corporations. As a consequence, the state becomes complicit in producing a context wherein individuals are made to bear the “hot potato” burdens of legal, medical, and affective/cultural liability—forms of conscripted labor inherent in the act of transgressing federal licensing and malpractice laws, as well as in the very real, embodied fear of accidental injury (bodily, emotional, existential) to oneself or someone else in the process.

### **Reproductive Health and Justice in a Neoliberal Context**

Although working from distinct missions and approaches, health activists have long taken on this labor of liability in an effort to support bodily and reproductive autonomy, whether this has taken the form of community health clinics, reproductive health workshops, published collections of women’s reproductive experiences, zines and pamphlets for self-induced or do-it-yourself (“DIY”) abortions.<sup>12</sup> In the United States, many of these projects were in part motivated not

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necessitates methods of conception other than cisgender heterosexual intercourse. See: Andrew Solomon, “Meet My Real Modern Family,” *Newsweek*, January 30, 2011.

<sup>12</sup> The Barnard College Zine Library has an incredible collection of zines about DIY reproductive health, rights, and justice. For scholarship on DIY activism in the reproductive rights and justice movements, see: Jill E. Adams, Melissa Mikesell, and The SIA Legal Team, “Primer on Self-Induced Abortion” (Berkeley: Center on Reproductive Rights and Justice, 2017); Charles L. Briggs and Daniel C. Hallin, *Making Health Public: How News Coverage Is Remaking Media, Medicine, and Contemporary Life* (Routledge, 2016); Daniel Grossman et al., “Self-Induction of Abortion among Women in the United States,” *Reproductive Health Matters* 18, no. 36 (November 2010): 136–46; Laura Kaplan, *The Story of Jane: The Legendary Underground Feminist Abortion Service* (Chicago: University of Chicago Press, 1997); Kelly Suzanne O’Donnell, “Reproducing Jane: Abortion Stories and Women’s

simply by the liberatory possibilities of taking one's health into one's own hands in the face of systemic injustice, but also by the urgent need to more fully realize the transformative power of grassroots community organizing. For instance, in response to medical malpractice and obstetric violence in municipal hospitals, the Black Panther Party set up its own clinics, known as the People's Free Health Clinics (PFHCs). Part of the PFHCs' mission was to combat violent medical practices against Black people—what they described as institutional genocide—in favor of a “self-health” praxis, which understood patients as experts on their own health.<sup>13</sup> In this sense, self-health aimed to disrupt the hierarchical relationship between medical professional and patient, enabling patients to be more agential participants in their own treatment. Drawing on the medical expertise of their communities, PFHCs offered comprehensive health services out of trailers and old store fronts, not only including preventative health care for men and women, but also birth control access, gynecological exams, mental health services, and drug addiction support. Importantly, this self-health praxis did not mean caring for one's health in isolation, but rather, leveraging community members' medical expertise and DIY solutions through a community-driven, holistic health praxis.

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Political Histories,” *Signs: Journal of Women in Culture and Society* 43, no. 1 (2017): 77–96; Jael Miriam Silliman et al., *Undivided Rights: Women of Color Organize for Reproductive Justice* (Cambridge: South End Press, 2004); Patricia Zavella, “Contesting Structural Vulnerability through Reproductive Justice Activism with Latina Immigrants in California,” *North American Dialogue* 19, no. 1 (April 25, 2016): 36–45.

<sup>13</sup> Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011), 89.



In particular, reproductive justice activism in the United States has been especially crucial for situating community-led, patient-centered healthcare as one among many approaches to achieving reproductive freedom. Centering the experiences and leadership of women of color and indigenous women, the advocacy group Asian Communities for Reproductive Justice (ACRJ) defines reproductive justice as

the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives.<sup>14</sup>

Developed as a corrective to the individualist, choice-based approach of the mainstream (mostly white, middle and upper-class) reproductive rights movement, reproductive justice is intersectional, radically inclusive, and comprehensive. It is as much an activist roadmap as it is an epistemological framework.<sup>15</sup> As Loretta Ross, one of the first to coin the term, puts it:

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<sup>14</sup> Asian Communities for Reproductive Justice (ACRJ), “A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice” (Asian Communities for Reproductive Justice, 2005), I.

<sup>15</sup> See: Rebecca J. Cook and Bernard M. Dickens, “From Reproductive Choice to Reproductive Justice,” *International Journal of Gynecology & Obstetrics* 106, no. 2 (8/2009): 106–9; Barbara Anne Gurr, *Reproductive Justice: The Politics of Health Care for Native American Women* (New Brunswick, New Jersey: Rutgers University Press, 2015); Zakiya Luna, “From Rights to Justice: Women of Color Changing the Face of US Reproductive Rights Organizing,” *Societies Without Borders* 4, no. 3 (October 1, 2009): 343–65; Zakiya Luna and Kristin Luker, “Reproductive Justice,” *Annual Review of Law and Social Science* 9, no. 1 (November 3, 2013): 327–52; Kimala Price, “What Is Reproductive Justice?: How Women of Color Activists Are Redefining the Pro-Choice Paradigm,” *Meridians* 10, no. 2 (April 1, 2010): 42–65; Silliman et al., *Undivided Rights*; Andrea Smith, “Beyond Pro-Choice versus Pro-Life: Women of Color and Reproductive Justice,” *NWSA Journal: A Publication of*

Reproductive justice is a theory for thinking about how to connect the dots in our lives. It is also a strategy for bringing together social justice movements. But also, it is a practice—a way of analyzing our lives through the art of telling our stories to realize our visions and bring fresh passion to our work.<sup>16</sup>

The kind of DIY culture the reproductive justice movement engages is always in service of a much more radically transformative mission: to create the foundational conditions in which total reproductive freedom can be realized, specifically by centering the reproductive experiences of women, trans\*, and gender nonconforming people whom current political, cultural, economic, and healthcare systems most actively reject.

While mainstream liberal investigative journalists are quick to see underground misoprostol as a potentially transformative DIY method, they do so at the cost of recentring abortion as *the* way to achieve reproductive freedom; they also tend to attribute off-label use of miso to the innovative accidents of the pharmaceutical industry, as opposed to the expertise and community mobilization of those using and distributing the drug. In an era in which commodity culture uses the term “DIY” to describe a particular middle- and upper-class aesthetic (e.g. home decor, beauty treatments, IKEA “hacks,” all claiming to “transform” one’s life), stories about misoprostol’s transformative potential merges not only with exclusive abortion access, but also with the individualist language of elite commodity culture:

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*the National Women’s Studies Association* 17, no. 1 (2005): 119–40; Robin West, “From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights,” *Yale LJ* 118 (2008): 1394.

<sup>16</sup> *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change*, n.d., 4.

miso gets read as a magic bullet promising a universalist notion of reproductive autonomy for women everywhere, despite the substantive cultural and institutional transformations such a promise requires. In other words, notions of radically transformative reproductive freedom become conflated with the individualist, race- and class-blind notions of self-help espoused by mainstream, multiculturalist commodity culture, evacuating miso from the broader neoliberal contexts within which the drug first arose and continues to circulate. In this way, one of the central violences of mainstream discourses about underground miso has been to silence the reproductive justice movement's central mission: by misreading underground miso-use as evidence of reproductive freedom, rather than as both a symptom of and response to systemic dysfunction, consumerist forces endow miso with a transformative, cure-all power that, in reality, is far from the kind of systemic change toward which the reproductive justice movement has worked for decades.

Following suit with a reproductive justice framework that understands reproduction as both a material reality and epistemological construction powerfully shaped by interwoven global and local forces, one of my central goals in this project is to correct this violence: to resituate discourses about underground misoprostol within the neoliberal structures from which it emerged in the post-World War II period, and in particular, bring the pharmaceutical machinery that has so successfully eluded these discourses back into the picture. Reproductive neoliberalism provides a name for this particular kind of epistemic violence, helping to rethink the often counterintuitive relationships between biocapital, state

governance, science and technology, and globalization. It also serves as a corrective to previous scholarship that has ignored the exploitative possibilities of reproductive technologies, not only reductively analyzing the development of the pharmaceutical industry itself and erasing the violence of pharmocracy, but also minimizing pharmaceutical corporations' complicity in and perpetuation of systemic inequities. Lastly, reproductive neoliberalism roots these blindspots in the material and ideological conditions following World War II and the Cold War, particularly in the context of what Neda Atanasoski describes as "Euro-America's [postsocialist] humanitarian gaze."<sup>17</sup>

Focusing on misoprostol in particular helps to map how reproductive neoliberalism has developed and shifted, particularly in family planning sciences. Misoprostol came into public discourse at the peak of what many Americanists describe as neoliberal backlash against New Deal-era social infrastructure. In the 1960s and 70s, this backlash manifested in corporate deregulation, free market expansion, increased defense spending, anti-immigrant legislation, and bootstraps individualism. Conservative politicians imposed mass restrictions on social programs (what they renamed "entitlements"), indexing a move away from post-World War II notions of national collectivity and solidarity reflected in the New Deal.<sup>18</sup> In its place was an emphasis on individualistic approaches to health that

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<sup>17</sup> Neda Atanasoski, *Humanitarian Violence: The U.S. Deployment of Diversity* (Minneapolis: University of Minnesota Press, 2013).

<sup>18</sup> Rebecca J. Hester et al., "Bodies in Translation: Health Promotion in Indigenous Mexican Migrant Communities in California," in *Translocalities/Translocalidades:*

minimized state support while channeling funds into both domestic and international population control programs operating under the now controversial name of “family planning.”<sup>19</sup> At the heart of these discourses and major structural changes was the state’s political stake in privileging white heteronormativity modeled by the so-called nuclear family, perpetuating the false assumption that most welfare recipients are poor, single women of color with children. Marked by the provocations of population control rhetoric and paranoia about welfare fraud, the neoliberal ideologies through which discourses about miso circulate are thus deeply invested not only in U.S. notions of the white, heteronormative family unit, but also in the privatization of the health industry, which is, for the most part, owned and controlled by pharmaceutical companies.<sup>20</sup>

One of the hallmarks of reproductive neoliberalism is pharmaceutical companies’ entanglement with research and development projects in the Global South, a form of humanitarian violence that takes a particular form in family planning sciences. Reproductive neoliberalism is both a driver and effect of partnerships between family planning and the pharmaceutical industry; in fact,

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*Feminist Politics of Translation in the Latin/a Americas* (Durham & London: Duke University Press, 2014), 168–89.

<sup>19</sup> Barbara Herr Harthorn and Laury Oaks, eds., *Risk, Culture, and Health Inequality: Shifting Perceptions of Danger and Blame* (Westport & London: Praeger Publishers, 2003); Hester et al., “Bodies in Translation: Health Promotion in Indigenous Mexican Migrant Communities in California”; Dorothy E. Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York: Vintage Books, 1998); Nikolas S. Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*, Information Series (Princeton: Princeton University Press, 2007).

<sup>20</sup> Roberts, *Killing the Black Body*.

pharmaceutical companies have often operated marketing and sales initiatives directly through family planning programs. For instance, in U.S.-funded family planning initiatives in Puerto Rico in the 1960s, pharmaceutical companies tested new forms of birth control on working class Puerto Ricans, subjecting mostly poor women of color to dangerous drugs proposing to empower women via fertility control.<sup>21</sup> Capitalizing on the universalist term “health” to underscore the urgency of providing a variety of pharmaceutical resources—drugs, vaccines, education—to the so-called developing world, this rhetoric understands Third World peoples as lucrative targets for new markets, providing incentives to expand state and pharmaceutical interventions globally. It also sutures the language of humanitarian aid to liberal elite notions of self-empowerment, recasting population-oriented interventions as individualist, choice-based health provisions. As Rebecca Hester explains: “In a reversal from previous health models in which socio-economic status was a primary determinant of health and therefore one needed to be productive to have good health, under neoliberalism, one first needs to have health to be productive.”<sup>22</sup> In this way, the term “health” solidifies an institutional alliance between pharmaceutical companies and family planning organizations that erases the ideological alliance between (race-blind) neoliberal multiculturalism and (class-

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<sup>21</sup> Laura Briggs, *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico*, American Crossroads 11 (Berkeley: University of California Press, 2002).

<sup>22</sup> Hester et al., “Bodies in Translation: Health Promotion in Indigenous Mexican Migrant Communities in California,” 173.

blind) bootstraps individualism, forces that work together to maintain white supremacy.<sup>23</sup>

It is therefore no coincidence that scandalous reports about underground misoprostol emerged right about the same time that family planning practitioners began to push back against their field's name in the late 1980s, ultimately renaming it "reproductive health" at the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt. While the "family" signifier had previously enabled neo-Malthusian population control organizations to dilute what was, in reality, violent, eugenic, coercive medical malpractice, the ICPD institutionalized an ethical and political discomfort, in that "family" could no longer be as visibly embedded in the liberal-progressive language of health, modernity, and (self-)empowerment. This institutional eagerness to bury the family planning terminology may be a well-meaning response to the prolific scholarship on the persistence of eugenic practices exercised via family planning programs; yet, while the shift to reproductive health may not explicitly include the family signifier and may more accurately represent the more comprehensive kind of preventative and treatment-focused work they do within the context of their own field, the proliferation of the

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<sup>23</sup> While one might argue that neoliberal multiculturalism and bootstraps individualism are both race- and class-blind, in the sense that both ideologies are altogether ignorant to the ways that identity formation shapes material realities (and vice-versa), I make the distinction here because neoliberal multiculturalism puts race and class into relationship differently than bootstraps individualism does. While neoliberal multiculturalism commodifies difference, bootstraps individualism rejects difference as a determinant of class (im)mobility. For this reason, when I use the term "white supremacy," I am referring to the whole intersectional machinery of racism, classism, patriarchy, and ableism.

term “health” also marks the success of mega pharmaceutical companies’ espousal of a Western teleology of emancipation via health. Motivated by a secularist, liberal-progressive politics deeply entangled in the growth of the pharmaceutical industry, such language uncritically defines “health” simply as access to pharmaceutical resources, what João Biehl calls the “pharmaceuticalization of public health,” in which public health is “understood less as prevention and clinical care and more as access to medicines.”<sup>24</sup> This universalist definition of health—in which health is a fixed, personal ability measured by proximity to and proper use of pharmaceutical products, rather than a set of conditions for thriving largely determined by intersecting systemic forces—reproduces the individualist ideologies that undergird neoliberal projects carried out by state and corporate actors.

The term “pharmocracy” has been an especially helpful tool with which to conceptualize the impressively cooperative but often destructive partnerships between transnational state and institutional actors. In his work on Novartis’s 2002 drug donation program (the Gleevec International Patient Assistance Program, or GIPAP), which aimed to make Gleevec—a treatment for leukemia—accessible to patients in India who could not afford the drug, Kaushik Sunder Rajan writes:

...corporate philanthropy provides the justification for monopoly even as monopoly provides the conditions of possibility for philanthropy. This is a case of the multinational pharmaceutical industry projecting itself as an agent of humanitarian redemption while emphasizing the necessity of monopoly protections in order to do so.<sup>25</sup>

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<sup>24</sup> João Guilherme Biehl, *Will to Live: AIDS Therapies and the Politics of Survival* (Woodstock: Princeton University Press, c2007), 12.

<sup>25</sup> Sunder Rajan, *Pharmocracy*, 157.



Rajan's work signals an important shift in manifestations of corporate neoliberalism since the rapid growth of the tech and start-up industries. As pharmaceutical companies figure the Global South as both the recipients of pharmaceutical donations and prime research subjects for clinical trials,<sup>26</sup> pharmaceutical products have come to be understood as both commodities and lifesaving therapeutic agents "increasingly essential in the definition of human rights and projects of humanitarian assistance."<sup>27</sup> Capitalizing on the fashionable nexus of entrepreneurship, humanitarianism, and scientific and technological innovation, major pharmaceutical companies have come to publicly espouse a moral philosophy grounded in "corporate citizenship" while routinely committing marketing fraud, bribing medical professionals to prescribe their products, raising prices on essential medicines, and curating the medical research they submit to the U.S. Food and Drug Administration (FDA) for approval. The joined rhetoric of "corporate responsibility" and "social entrepreneurship" has thus coincided with the increasing privatization of the health industry, suggesting that, under neoliberal multiculturalism, corporations adopt the state's language of official anti-racism as evidence of their ability to self-regulate. As a consequence, the state not only fails to regulate corporate activities, but also

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<sup>26</sup> See: Briggs, *Reproducing Empire*; Melinda Cooper and Catherine Waldby, *Clinical Labor: Tissue Donors and Research Subjects in the Global Bioeconomy* (Durham: Duke University Press, 2014).

<sup>27</sup> Jeremy A. Greene, "Pharmaceutical Geographies: Mapping the Boundaries of the Therapeutic Revolution," in *Therapeutic Revolutions: Pharmaceuticals and Social Change in the Twentieth Century*, ed. Jeremy A. Greene, Flurin Condrau, and Elizabeth Siegel Watkins (Chicago, London: University of Chicago Press, 2016), 152.

actively concentrates and expands corporate power while maintaining a symbolic commitment to official anti-racisms.<sup>28</sup>

Today, Global South women continue to be recruited into clinical trials funded through partnerships between drug companies and state initiatives. For example, Rockefeller University, an offshoot of the Rockefeller Institute that funded and collaborated with eugenics societies pre-WWII, offers programs for students to work directly with pharmaceutical companies, a so-called public-private partnership they advertise on their website:

Pfizer's Centers for Therapeutic Innovation, or CTI, is a unique program that collaborates with leading academic medical centers, the NIH, and foundations to speed the translation of novel targets to the clinic. A partnership with CTI may include collaborative use of Pfizer's technologies, publishing rights, and financial awards in the form of milestone and royalty payments for successful programs, in addition to providing appropriate funds for carrying out the collaborative work.<sup>29</sup>

Often these public-private partnerships are not exactly partnerships. For instance, from 2014-2015, Pfizer funded 100 percent of a USAID project to "improve efficiencies in its sales and medical detailing programs."<sup>30</sup> From 2009-2011, Pfizer West Africa partnered with USAID Senegal "with the goal of increasing the availability of high quality contraceptive products, namely the injectable contraceptive Depo-provera, into the private sector market," again donating 100

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<sup>28</sup> Jodi Melamed, *Represent and Destroy: Rationalizing Violence in the New Racial Capitalism* (University of Minnesota Press, 2011).

<sup>29</sup> "Pfizer CTI Call for Proposals," The Rockefeller University: Science for the Benefit of Humanity.

<sup>30</sup> USAID, "SIFPO," USAID Global Partnerships.

percent of the funding.<sup>31</sup> USAID provided direct access to the target populations, explaining:

Pfizer will be largely available for making the product available at an agreed price, while USAID/Senegal will be responsible for the social marketing of the product. The overall goal is to increase the availability of high quality contraceptive products and services, and meet part of the unmet demand for women wanting to space the births of their children, in order to contribute to improving the health of Senegalese women and children.<sup>32</sup>

Media outlets are also invested in these collaborations. From 2001-2004, USAID's Credit Management System (CMS) partnered with Pfizer, Wyeth, Schering-Plough, and two anonymized categories of donors labeled "pharmaceutical companies" and "host country local media."<sup>33</sup> It was largely a public relations project:

[The goal of the partnership is] to promote the use of generic low-dose oral contraceptives through advertising, public relations and training. The desired outcome is to provide information to women about the benefits of oral contraceptives, to address the fears of side effects, and to raise awareness on the safe use of oral contraceptives.<sup>34</sup>

Over the course of the three-year project, non-USG (United States Government) donors—i.e. the pharmaceutical companies and local media—reportedly made up over 65 percent of the total donations to the project, reflecting the significant owning power pharmaceutical companies and media together hold in these public-private collaborations. These partnerships between pharmaceutical companies, media, and Rockefellerian family planning sciences are consistently framed as cutting-edge research opportunities designed to expedite new drugs into spaces in which they can

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<sup>31</sup> USAID, "Depo Provera Accessibility," USAID Global Partnerships.

<sup>32</sup> USAID.

<sup>33</sup> USAID, "CMS Project," USAID Global Partnerships.

<sup>34</sup> USAID.

be bought and consumed. The benefits of such collaborations—publishing rights and funding—are defined not only in terms of immediate technological and financial resources, but also as patented knowledge that will pay royalties in the future. This raises questions not only about how capitalistic and corporate interests influence the design and delivery of humanitarian aid in these projects, but also vice-versa: how the design and delivery of humanitarian aid supports the growth of the U.S. pharmaceutical industry more broadly.

### **Scholarly Interventions: The Limits of Economic Analysis**

Until recently, historians of the U.S. pharmaceutical industry have attributed its massive growth over the last two centuries to what Charles E. Rosenberg famously termed, in 1977, the “therapeutic revolution.”<sup>35</sup> In “The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America,” Rosenberg argues that the study of pre-nineteenth century medicine had ignored the economic and cultural dimensions of clinical practices, a blindspot he describes as the “increasingly aggressive empiricism of the nineteenth century.”<sup>36</sup> According to Rosenberg’s theory, for most of the nineteenth century in the United States, pharmacists operated out of family-owned retail stores and apothecaries,

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<sup>35</sup> Charles E. Rosenberg, “The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America,” *Perspectives in Biology and Medicine* 20, no. 4 (1977): 485–506. More recent scholarship on the pharmaceutical industry problematizes Rosenberg’s use of the term “revolution.” See: Jeremy A. Greene, Flurin Condrau, and Elizabeth Siegel Watkins, *Therapeutic Revolutions: Pharmaceuticals and Social Change in the Twentieth Century* (Chicago: University of Chicago Press, 2016).

<sup>36</sup> Rosenberg, “The Therapeutic Revolution,” 486.

which primarily sold home supplies like soaps, candy, and other odds-and-ends in addition to drugs and homeopathic remedies. Pharmacists sourced mostly plant-based compounds from wholesaler chemical materials companies and then mixed and sold prescriptions on site, in small batches, and with very limited or no consumer marketing.<sup>37</sup> Although both physicians and pharmacists stocked similar herbal and chemical materials, in this context, drug synthesis was relatively imprecise work, even when mixed by the same person, as compounds were mostly mixed and prescribed on an “as-needed,” per person basis. Rosenberg reasons that pharmaceutical businesses operated this way in part because of physicians’ remarkably holistic approach to the body as an interconnected system of systems: the idea of treatments for an isolated malady—for example, the targeted treatment of a virus—went against the prevailing pathology that illness was always the outcome of a systemic bodily issue. As Rosenberg puts it, “every part of the body was related inevitably and inextricably with every other. A distracted mind could curdle the stomach, a dyspeptic stomach could agitate the mind. Local lesions might reflect imbalances of nutrients in the blood; systemic ills might be caused by fulminating local lesions.”<sup>38</sup> In other words, the body was a systemic unit that necessitated patient-specific treatments; there was no concept of a “miracle drug” that could be produced and distributed en masse.

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<sup>37</sup> Jonathan Liebenau, *Medical Science and Medical Industry: The Formation of the American Pharmaceutical Industry* (Basingstoke, Hampshire: Macmillan Press, 1987).

<sup>38</sup> Rosenberg, “The Therapeutic Revolution,” 487–88.

Rosenberg identifies two major historical events he believed transformed this model into the transnational pharmaceutical giants of today. The first, he argues, was the Civil War, during which military demand for pharmaceutical products prompted pharmacists to create national distribution routes, which in turn required pharmacists to specialize in drug production and distribution.<sup>39</sup> The second was the development of vaccines and antibacterial drugs toward the end of the nineteenth century, which inspired major investments in pharmaceutical research and educational institutions, producing more consistent, thorough pharmacological training and shared sources of knowledge. The assumption among historians of the pharmaceutical industry was that this combination of academic prestige, consumer demand, and available funding created attractive new business prospects. Newly patented technologies—tableting machines, for instance—streamlined drug manufacturing and distribution processes, enabling pharmacists to produce drugs with more precision, consistency, and at a much faster rate than the “handmade” method.<sup>40</sup>

While Rosenberg’s observations help to situate a social analysis of medicine within a broader set of political and economic systems, the therapeutic revolution theory also uncritically transposes a presumed “revolutionary-ness” onto the development of each new drug, reproducing a link between health, modernity, and (neo)liberal notions of freedom that the pharmaceutical industry has long evangelized (a history I take up in Chapter 1). In a scholarly form of tragic irony,

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<sup>39</sup> Liebenau, *Medical Science and Medical Industry*.

<sup>40</sup> For an overview of modern medical manufacturing, see chapter 9 of Liebenau, 125–134.

one of the analytic blindspots the therapeutic revolution theory has thus helped to shield is the very paradigm it sought to crystallize: the material-discursive relationships between pharmaceutical innovation, capital, and liberal-progressive notions of humanitarianism.

Reflecting on his work nearly four decades after his seminal 1977 article was published, Rosenberg admits that “the concept of a twentieth-century therapeutic revolution obscures as well as illuminates... the casual invocation of a ‘therapeutic revolution’ obscures the ways in which clinical practice is necessarily a component in a complex time- and place-specific system of ideas and social practices that cannot be understood outside of that larger context.”<sup>41</sup> Here, Rosenberg points to an epistemological and methodological tension: on the one hand, the therapeutic revolution model helps connect pharmaceutical products to their specific economic contexts, an epistemic intervention in which scientific and technological innovations are always understood as products of the material conditions in which they arise. On the other hand, the therapeutic revolution model also inhibits more nuanced analyses of what specific material conditions are worthy of investigation and, by the same token, what is meant by “therapeutic” and “revolutionary.” He goes on to say:

There has never been a time or place without modes of curing; we have always had therapeutics with us. But it is characteristic of our particular system that we assume that modern therapeutic practices are categorically different—the result of a cumulative understanding of the natural world and a capacity to intervene that somehow removes Western therapeutic practices of

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<sup>41</sup> Charles Rosenberg, “A Therapeutic Revolution Revisited,” in *Therapeutic Revolutions: Pharmaceuticals and Social Change in the Twentieth Century*, ed. Jeremy A. Greene, Flurin Condrau, and Elizabeth Siegel Watkins (Chicago, London: University of Chicago Press, 2016), 302–3.

the past century from the contingency that is culture... This is a powerful and culturally dominant narrative, appealing to our faith in science and the inevitability of progress, to hope that sickness will be vanquished through the inevitable accumulation of “breakthroughs” and “insights.”<sup>42</sup>

Rosenberg echoes Michel Foucault’s foundational concerns about the production of scientific knowledge as empirical truth, suggesting that his (Rosenberg’s) theory of the therapeutic revolution was in part a product of his own internalized “faith in science and the inevitability of progress.” As Foucault puts it in *The Birth of the Clinic*, it was not so much that knowledge itself had accrued, but rather that “the relation between the visible and invisible—which is necessary to all concrete knowledge—changed its structure.”<sup>43</sup>

In connection with my project on discourses about underground misoprostol, I write so much about Rosenberg’s theory here in order to underscore the point that, perhaps more powerful than the technological and educational innovations themselves were the ways in which the *study* of those products—even when put into their cultural contexts—has disciplined pharmacology into an elite professional science, reinforcing the teleological, epistemic authority espoused in pharmaceutical marketing materials. In other words, while I too read material conditions as fundamental to understanding how certain pharmaceutical products became and become marketable, I resist notions of pharmaceutical revolution that imply a radical unleashing of health and medical potential, as opposed to the intensification of

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<sup>42</sup> 305.

<sup>43</sup> Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (London: Routledge, (1973) 2003), xii.



existing liberal-democratic and capitalist forces. Rather than misunderstanding pharmaceutical products as relics of cumulative, progressive knowledge, as the therapeutic revolution theory suggested, we need to think of the intellectual significance assigned to these objects as being in constant states of revision and meaning-making, rippling across time and place, disciplines, and markets.

### **Methodologies: Object Phenomenology**

When I have explained this project to friends and colleagues in the past, some people have asked me whether I will go to El Salvador or the U.S.-Mexico border and ask flea market vendors how they procure misoprostol. Who supplies miso to them? How do the suppliers get it?

While I can understand why people would be curious about this, the subtext of these questions (i.e. are the flea market vendors criminals? If not, who is?) reproduces a juridical gaze, one that seeks to criminalize individuals rather than state and corporate actors who largely control the circumstances under which underground miso circulates. To begin with such questions would be to design my analysis according to colonial logics of ownership and carcerality. Other people are already pursuing these questions—the U.S. Drug Enforcement Administration, for one—and it is not a project in which I wish to participate.

At the same time, this recurrent question has prompted me to think about the most basic methodological, logistical aspects of my project. What does it look like to track an object without reproducing the limitations and violences of surveillant discourses already at work? If I am refusing to seek seemingly basic information—

where flea market vendors get miso from—what am I really asking in this project? What *can* I ask? In other words: what are the analytical possibilities and limits of tracking an object I am not actually looking for, at least not in the most literal sense?

This kind of analysis—one that traces an object I do not intend to find—requires a theory of misoprostol as a particular kind of pharmaceutical object, one that immediately sets in motion a set of critical deceptions. Ironically, one of the reasons misoprostol is said to be such an ideal off-label abortifacient is because of the ways it masquerades as natural physiological processes, refusing its own objectness and therefore its own trackability: unlike a recreational drug like marijuana or cocaine, once swallowed, it dissolves so quickly that it is forensically untraceable within thirty minutes. Depending on the context in which it is consumed, miso is also metamorphic: it returns menstruation when menses goes “missing”; it is a cleansing “wash”; sometimes compared to turmeric, it brings down inflammation.<sup>44</sup> In other words, miso does not only treat; it finds, it cleans, it “brings.”

Recent work in object phenomenology brings some helpful tools with which to conceptualize misoprostol’s objectness, engaging critical race theory, queer theory, and disability theory to understand different kinds of nonhuman matter as animate forces. In the relatively recent wave of “new materialism,” as it has been

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<sup>44</sup> Mizanur Rahman, Julie DaVanzo, and Abdur Razzaque, “Pregnancy Termination in Matlab, Bangladesh: Maternal Mortality Risks Associated with Menstrual Regulation and Abortion,” *International Perspectives on Sexual and Reproductive Health* 40, no. 3 (2014): 108–18.

termed, scholars have experimented with making an object do something, temporarily imbuing various kinds of matter (metals, cells, words) with what they apprehensively describe as life, animacy, agency, willfulness, energy, even vibrance.<sup>45</sup> As Christopher Pinney succinctly puts it, “Clearly things make people, and people who are made by those things go on to make other things. The central question, however, is not whether this does or doesn’t happen, but in what kind of way it happens.”<sup>46</sup> By defamiliarizing the divisions between the human and nonhuman—a “living” thing and another’s “thing-ness”—this scholarship persuasively confirms that matter accumulates and produces meaning in relational processes of cultural, economic, phenomenological intra-action.<sup>47</sup>

Yet as Felicity Amaya Schaeffer points out in her recent work, “Spirit-Matters: Gloria Anzaldúa’s Cosmic Becoming across Human/Nonhuman Borderlands,” the new materialist turn in humanities scholarship silences indigenous epistemologies that do not think according to Western secular dualisms, such as

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<sup>45</sup> Sara Ahmed, *Queer Phenomenology: Orientations, Objects, Others* (Durham: Duke University Press, 2006); Karen Michelle Barad, *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning* (Durham: Duke University Press, 2007); Jane Bennett, *Vibrant Matter: A Political Ecology of Things* (Durham: Duke University Press, 2010); Mel Y. Chen, *Animacies: Biopolitics, Racial Mattering, and Queer Affect*, *Perverse Modernities* (Durham, NC: Duke University Press, 2012); Diana H. Coole and Samantha Frost, eds., *New Materialisms: Ontology, Agency, and Politics* (Durham, London: Duke University Press, 2010).

<sup>46</sup> Christopher Pinney, “Things Happen: Or, From Which Moment Does That Object Come?,” in *Materiality* (Durham: Duke University Press, 2005), 256.

<sup>47</sup> Arjun Appadurai, ed., *The Social Life of Things: Commodities in Cultural Perspective*, 11th ed. (Cambridge: Cambridge Univ. Press, 2013); Maurice Godelier, *The Enigma of the Gift* (Cambridge: Polity Press, 1999); Marilyn Strathern, *The Gender of the Gift: Problems with Women and Problems with Society in Melanesia* (Berkeley: University of California Press, 1988).

human/nonhuman. In other words, indigenous peoples have always understood nonhuman matter to be animate, a part of what Schaeffer describes as Anzaldúa's "cosmic spirit-mattering." Schaeffer urges readers to put Chicana/Latina decolonial "theory in the flesh" and "feminist debates on experiential epistemologies and ontologies" in conversation with one another, explaining:

The importance of questioning the Western split between subject/object in early scholarship—such as Donna Haraway's refusal of the nature/culture divide through her theorization of the cyborg, or the intermingling of human/machine—was a powerful move, yet it had the effect of blurring the lines between elected co-becomings between humans and machines versus the uneven and compulsory ways certain groups were forced into tangled relationality with techno-objects (and animality).<sup>48</sup>

I believe a lot of reproductive politics scholarship has done some of this work in important ways, analyzing how family planning projects and assisted reproductive technologies become powerful biopolitical forces deeply invested in extractive capitalism.<sup>49</sup> In this way, my project follows suit with the state and institutional critiques that this scholarship has already brought forward, demonstrating how Pfizer's research and development practices are, too, part of a modern colonial project that renders certain kinds of bodies and land available for capitalistic

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<sup>48</sup> "Spirit Matters: Gloria Anzaldúa's Cosmic Becoming across Human/Nonhuman Borderlands," *Signs: Journal of Women in Culture and Society* 43, no. 4 (2018): 1009.

<sup>49</sup> By "biopolitical," I am referring to Foucault's formulation of biopower as the ability of state and institutional systems to discipline bodies into particular states of docility, deviance, and redemption that work to maintain hegemonic systems of (neo)colonial power. See: Michel Foucault, *The History of Sexuality*, Vintage Books (New York: Vintage Books, (1978) 1990); Michel Foucault and Collège de France, *The Birth of Biopolitics: Lectures at the Collège de France, 1978-79*, ed. Michel Senellart, François Ewald, and Alessandro Fontana, trans. Graham Burchell (Basingstoke & New York: Palgrave Macmillan, (1978) 2008).

exploitation and the production of biocapital.<sup>50</sup> Working from the premise that pharmaceutical matter is *made* to materialize in order to construct certain kinds of bodies and forms of (de)humanization, my project engages in a form of what Schaeffer describes as “listening to and becoming utterly otherwise.”<sup>51</sup> The conceptual frameworks I employ in this project are thus as much about transgressing and decolonizing pharmaceutical, experiential, bodily knowledge as they are about remaking our orientations to pharmaceutical objects.

Misoprostol is deeply imbedded in the binaristic language of technoscientific modernity and racialized primitivism; it is also somewhat unique in that it needs no help challenging its own object-ness. It already does this across disciplines and epistemologies; quite literally, misoprostol triggers a cascade of physiological processes and disappears from the body at the same time. From this perspective, what I really mean when I say that I am “tracking misoprostol” is that I am tracking misoprostol’s biopolitical footprint: not how it physically gets from one point to the

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<sup>50</sup> See: Briggs, *Reproducing Empire*; Faye D. Ginsburg and Rayna Rapp, eds., *Conceiving the New World Order: The Global Politics of Reproduction* (Berkeley: University of California Press, 1995); Wendy Kline, *Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom* (Berkeley: University of California Press, 2001); Gabriela Soto Laveaga, *Jungle Laboratories: Mexican Peasants, National Projects, and the Making of the Pill* (Durham: Duke University Press, 2009); Roberts, *Killing the Black Body*; Alexandra Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America*, American Crossroads 17 (Berkeley: University of California Press, 2005); Kalindi Vora, *Life Support: Biocapital and the New History of Outsourced Labor*, Difference Incorporated (Minneapolis: University of Minnesota Press, 2015).

<sup>51</sup> “Spirit-Matters: Anzaldúa’s Cosmic Time-Travel Across Human/Nonhuman Borderlands,” *Signs: Journal of Women in Culture and Society* 43, no. 4 (2018): 1008.

next, but rather, how miso gets marked, and what its circulation continually leaves behind. I am looking for its ripples. When does a drug become a drug? When does it exceed the pharmaceutical?

As a kind of metamorphic pharmaceutical object, one of the gains of focusing on misoprostol as opposed to another pharmaceutical object connected to reproduction is thus that I can join systemic and global analyses with local and bodily ones while simultaneously resisting the distinction between seeing “locally” or bodily, and seeing “globally” or transnationally. In other words, allowing misoprostol to be my primary (if elusive) object of analysis epitomizes how meaning and materiality are mutually constitutive. It embodies how history, culture, and politics contingently define objects not by the kind of (secular, molecular) matter of which they may be composed, but rather, as a flexible tool through which hegemonic forces “unevenly and compulsorily” subject people and the planet to the institutional and cultural prisms of techno-scientific rationality and juridical culpability. As a thing that pharmaceutical companies, mainstream liberal media, and family planning sciences have orientated toward and which orients an “us,” misoprostol becomes both the object and the lens through which to bind these material-discursive analytics together.

### **Chapter Summaries**

In the chapters that follow, I analyze three deeply connected and yet discursively severed archives of reproductive neoliberalism enacted via misoprostol’s biopolitical footprint: (1) Pfizer’s corporate marketing, research and

development strategies post-World War II, with a special focus on their annual financial reports; (2) journalistic reports on the underground sale of misoprostol at flea markets in the Global South, which, in addition to regions conventionally read as “Third World” in U.S. political discourse, also includes disparate parts of the United States that are nevertheless linked by discourses about non-white immigrant populations, extreme anti-abortion legislation, or both (e.g. the Texas-Mexico border, or Washington Heights in New York City); and (3) family planning discourses about obstetric uses of misoprostol represented in a variety of scholarly and institutional documents, including case studies, op-eds, mission statements, and correspondence with major health organizations such as the World Health Organization (WHO).<sup>52</sup> Bringing these three key points of engagement together enables me to unpack some critical blindspots: how might tracking misoprostol’s circulation in these discourses help to define and map the emergence of reproductive neoliberalism? How might it make visible the ways that pre and postsocialist trends in technological research and development in the United States have simultaneously corporatized and corporealized reproductive risk and safety? What forms of biocapital does reproductive neoliberalism produce? And how might my analysis here help to inform contemporary scholarship on empire, reproduction, and technoscientific violence in ways that support the reproductive justice mission?

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<sup>52</sup> “Pfizer’s Annual Review, 2016: Bringing Resources to Bear to Improve Global Health,” Pfizer’s Annual Review 2016, accessed October 11, 2017.

As I will show in the chapters that follow, U.S.-based discourses about underground misoprostol reconstruct and export the ideology of reproductive neoliberalism, revealing the ways liberal-democratic ideals of individualism and responsabilization permeate pharmaceutical imaginaries and Global South subjectivities. In a necessarily paradoxical move, reproductive neoliberalism characterizes the Global South as both a barrier to and source of technological, medical, and social progress, rendering Global South subjects as populations and inhabitants of land that must be managed by technoscientific intervention.<sup>53</sup> This is an updated iteration of a very old story in which bilateral tropes of primitivism and technological edge, spirituality and secularity, globalization and individualism mobilize multiculturalist ideologies, which then map onto and emerge from (re)productive bodies.<sup>54</sup> Persistently read as a phenomenon exclusive to the Global South, miso becomes a technology through which to perpetuate reproductive neoliberalism—to erase the historical legacies of extraction and colonial violence that prop up the technoscience of modern medical discoveries.

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<sup>53</sup> Ulrich Beck, *Risk Society: Towards a New Modernity*, Theory, Culture & Society (London; Newbury Park, Calif: Sage Publications, 1992); Isabella Bakker and Stephen Gill, eds., *Power, Production, and Social Reproduction: Human In/security in the Global Political Economy* (Houndmills, Basingstoke, Hampshire ; New York: Palgrave Macmillan, 2003); Harthorn and Oaks, *Risk, Culture, and Health Inequality*.

<sup>54</sup> Kline, *Building a Better Race*; Lisa Nakamura, “Indigenous Circuits: Navajo Women and the Racialization of Early Electronic Manufacture,” *American Quarterly* 66, no. 4 (December 2014): 919–41, 1169; Nancy Stepan, *The Hour of Eugenics: Race, Gender, and Nation in Latin America* (Ithaca: Cornell University Press, 1991); Stern, *Eugenic Nation*; Vora, *Life Support*.



Chapter 1 situates reproductive neoliberalism in the pharmaceutical industry's rapid growth during and following World War II, reading Pfizer's annual financial reports as evidence of the relationship between humanitarian violence and the corporate interests of the pharmaceutical industry more broadly. I argue that the humanitarian rhetoric espoused by the pharmaceutical industry, and the multiculturalist image of U.S. pharmaceutical companies it produces, becomes part of the central infrastructure of reproductive neoliberalism, tying the growth of the pharmaceutical industry first to U.S. militarism abroad, then to humanitarian aid in the Global South, and finally to multiculturalist forms of U.S. official antiracisms. This context is critical to understanding how the development of and discourses about misoprostol in the late 1980s onward come to embody the transition from the United States' anticommunist patriotism to neoliberal multiculturalism, a timeline Jodi Melamed delineates as "a series of successive official or state-recognized U.S. antiracisms: racial liberalism (1940s to 1960s), liberal multiculturalism (1980s to 1990s), and neoliberal multiculturalism (2000s)."<sup>55</sup> Observing these shifts through literary analysis, Melamed defines neoliberal multiculturalism as "the most recent phase of official antiracism, which may have reached its apotheosis in the George W. Bush regimes":

Neoliberal multiculturalism has responded to the reconfiguration of state powers and boundaries under global capitalism by portraying the United States as an ostensibly multicultural democracy and the model for the entire

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<sup>55</sup> Melamed, *Represent and Destroy: Rationalizing Violence in the New Racial Capitalism*.

world, but in a way that has posted neoliberal restructuring across the globe to be the key to a postracist world of freedom and opportunity.<sup>56</sup>

For pharmaceutical companies, we can actually see evidence of neoliberal multiculturalism as early as the 1960s. I explore how Pfizer's annual financial reports narrate an economic and ideological shift from World War II American patriotism to Cold War corporate citizenship, powerfully influencing its research and development pursuits. I argue that this production of pharmocratic knowledge is what enabled pharmaceutical companies to control family planning initiatives in the Global South. In this way, reproductive neoliberalism is a specific (though transnational) manifestation of neoliberal multiculturalism that emerged long before the George W. Bush administration, one that has taken particular forms in family planning circles.

In Chapter 2, I explore how recent mainstream liberal-progressive investigative journalism about underground markets for misoprostol reproduces reproductive neoliberalism, wherein misoprostol becomes the vehicle through which reproductive neoliberalism gets expressed. In this context, reproductive neoliberalism disciplines Global South subjects into a paradoxical subject position in which they are valued according to their ability to successfully perform the always-already racialized markers of techno-scientific and cultural modernity. While the well-intentioned, if implicit, support of women and reproductive rights in these journalistic pieces seems initially promising, it ultimately misappropriates the

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<sup>56</sup> Melamed, xxi.

language of reproductive freedom in service of reproductive neoliberalism, proposing a form of pharmaceutically-enabled reproductive freedom that, in reality, silences the systemic, holistic mission of the reproductive justice movement. In this context, misoprostol takes on the material-discursive weight of reproductive neoliberalism, a recurring pattern in the history of reproductive technologies more broadly. As Laura Briggs puts it, Malthusian concerns about overpopulation in Puerto Rico in the 1960s—and thus the need for birth control—functioned “as an economic theory in drag, which pointed to sex and reproduction to distract from a discussion of the role of North American corporations and the federal government,” demonstrating “how compacted a symbol birth control really was, at once an argument about economics, poverty, nationality, and U.S. political and military intervention.”<sup>57</sup> Just as birth control became a symbol for neoliberal ideologies, misoprostol, too, has become a symbol of and vehicle for reproductive neoliberalism.

Finally, working from reproductive politics scholarship that centers the violence of population control executed by family planning programs, Chapter 3 analyzes how family planning literature on underground misoprostol produces what I call an “ethics of rationality,” a data-centric manifestation of reproductive neoliberalism. In the process, family planning literature produces another kind of Global South subject, one who is morally responsible for the kind of pharmaceutical risk-taking underground misoprostol use requires. As a site of knowledge production

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<sup>57</sup> Briggs, *Reproducing Empire*, 78, 77.

that has historically rendered the relationship between family and nation inextricable, family planning research on underground miso acts as a mechanism through which reproductive neoliberalism gets reproduced. Yet what also draws me to family planning scholarship in this chapter is its complex positionality: straddling public and private sectors, much of the family planning programming that exists today depends on funding from humanitarian organizations like USAID, which are, in turn, frequently funded by pharmaceutical companies. This reality means that the aims and structures of family planning programs are inextricable from the marketing and distribution efforts of pharmaceutical companies, if not unofficial pharmocratic extensions of the technoscientific institutions they serve. At the same time, family planning experts have extensive knowledge of the inner workings of the state, clinics, pharmaceutical companies, widely disparate structures of care, and—though not always reflected in their published work—immense field experience, through which many health professionals build intimate, invested relationships rooted in reproductive justice advocacy and nuanced theories of collectivity and wellbeing. It is this latter set of work that I believe critics of family planning initiatives tend to dismiss, partly because partnership between public health professionals and academics in the humanities is still relatively unusual, but also because this more intimate kind of work in family planning is not usually represented in mainstream public health publications. This chapter complicates the ways that such scholarship characterizes family planning monolithically, such that the family planning field is always-already epistemologically and methodologically violent. While still

unpacking the epistemic violence family planning sciences enact, I also “listen otherwise” to the counterintuitive ways in which family planning research on underground miso both reproduces and disrupts the violence of reproductive neoliberalism.

I have organized these chapters by genre. Despite my analytical alarm bells telling me I ought to resist this way of organizing, I did it anyway in order to mark how and when each genre takes up the project of reproductive neoliberalism. Melamed’s connecting thread between her chapters is literature; mine is misoprostol and its footprints. I also recognize that this structure has inevitably produced its own blindspots. In the Epilogue, I expand on the limitations of the work I’ve done so far, proposing a vision for ethnographic work that I suspect will deeply enrich this project.

# PENICILLIN PFIZER



**BACKING OUR BOYS OVER THERE**



*Chemicals For Those Who Serve Man's Well-Being*

**Chas. Pfizer & Co., Inc.**

MANUFACTURING CHEMISTS · ESTABLISHED 1849

81 MAIDEN LANE, NEW YORK 7, N. Y.  
444 WEST GRAND AVE., CHICAGO 10, ILL.



VOLUME 22, NO. 15 - - AUGUST 10, 1944

1297

Figure 3: Full-page ad for Pfizer published in American Chemical Society (August 10, 1944).

## CHAPTER 1

### **Producing Pharmocratic Knowledge: The Corporate Citizen as American Patriot**

“You are not a manufacturing company. Manufacturing costs are miscellaneous costs. The main costs are the costs of production and distribution of knowledge and information.”<sup>1</sup>

“New knowledge, or new technology, is only potential. Marketing converts that potential into fact.”<sup>2</sup>

Dr. Peter F. Drucker  
Corporate Management Consultant  
Pfizer’s Annual Report, 1981

In a special feature called “The Transfer of Knowledge” included in Pfizer’s 1981 Annual Report, Pfizer reimagines the primary work of pharmaceutical companies for its shareholders. Featuring an interview with Dr. Peter F. Drucker (quoted above), the report frames Pfizer’s increasingly massive investments in research and development, marketing, and product distribution processes in terms of the infinite economic value and exportability of scientific knowledge. As Drucker puts it in another section of the report, the company’s knowledge is “a central economic resource” and “a productive force. It is prime energy.”<sup>3</sup> From this perspective, Pfizer’s most lucrative form of capital is not the pharmaceutical

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<sup>1</sup> “Annual Report, Special Feature: The Transfer of Knowledge” (Ann Arbor: Pfizer, Inc., 1981), 4.

<sup>2</sup> “Annual Report, Special Feature: The Transfer of Knowledge,” 8.

<sup>3</sup> “Annual Report, Special Feature: The Transfer of Knowledge,” 4, 8.

products it creates, but rather its power to shape the channels through which pharmaceutical knowledge is permitted to take shape—to curate who can be said to design, produce, distribute, own, consume, and be knowledgeable about pharmaceuticals. In other words, pharmaceutical products constitute just one aspect of a much grander purpose to transform pharmaceutical knowledge into capital. Marketing is that transformer; as Drucker explains above, it “converts” the potentiality of knowledge into “fact,” instilling ways of thinking and knowing that encode the pharmaceutical imagination.

This chapter tracks Pfizer’s role in producing the pharmocratic narratives that undergird reproductive neoliberalism. Specifically, I identify the cultural and institutional mechanisms through which Pfizer transformed pharmaceutical knowledge into capital during the transition from mid-World War II toward the end of the Cold War (approximately 1942-1988), demonstrating how the U.S. pharmaceutical industry, and Pfizer in particular, sutured humanitarian and philanthropic rhetoric to corporate expansion. As Pfizer grew, the intellectualized altruism of scientific innovation and universal human benefit masked its corporate interests, a key strategy of pharmaceutical neoliberalism more broadly that takes particular form in discourses about reproduction (which I develop in Chapters 2 and 3).

I especially focus on Pfizer’s annual financial reports for a few connected reasons. Although Pfizer and the FDA do not classify annual reports as “marketing,” they index the relationship between institution and audience as a producer-to-



consumer dynamic, in that the reports were specifically designed for audiences whom Pfizer's marketing professionals targeted according to a range of presumed characteristics—from consumer behavior, political orientation, and education level to shareholding authority and medical, scientific, technological, or legal expertise. These materials thus represent a wide variety of forms of consumption and distributed capital, as the “consumers” for whom Pfizer designed these reports encompass everyday shoppers who purchase Pfizer products in stores and pharmacies; health professionals who prescribe Pfizer drugs, implant Pfizer technologies into their patients' bodies, or conduct research using Pfizer products; industrial workers who purchase Pfizer products for the purposes of mass production (for example, farmers who put Pfizer antibiotics into cattle feed to prevent disease and thus maximize milk and meat production); as well as the shareholders on whom Pfizer depends and whose wealth is directly tied to Pfizer's profitability. These annual reports thus not only act as unofficial promotional materials (and are thus not beholden to FDA regulations on official advertisements) but are also poignant illustrations of how products, as objects that signify Pfizer's institutional brand, act as vehicles through which stories of scientific innovation fuse corporate do-gooding and economic pragmatism.

Furthermore, the narrative structure of these reports strikingly models the ways in which culture(s) of science, revolution, and economic capital become narratively inextricable, constituting the pharmocratic logics that set reproductive neoliberalism into motion. Each report contains two parts: a personal letter to

stockholders, written and signed by the company's serving president, followed by the accountant's report, or "raw" financial data. The relationship between these two narrative components radically shifted, seemingly overnight, in 1950. Through 1949, each report was about 10-12 pages; the letter to stockholders was no more than a few paragraphs long, and the rest of each report consisted of tables and numbers (e.g. sales in each department, costs of materials, taxes paid), sometimes with short, two-sentence summaries. In 1950, these legally mandated reports nearly tripled in length. Pfizer began incorporating different kinds of media into its reports, including full-length articles, interviews, photos, illustrations, and biographies of select consumers, all of which provide strikingly detailed stories about Pfizer's history, recent milestones, new or revamped products, business philosophy, mission, and bold speculations about the future of science and the profitability of that future. Some even had their own bylines; in fact, Pfizer actually published its annual reports for 1956 and 1957 in the *New York Times*. By this time, the accountant's statement was by far the shortest part of the document, included at the very end (almost like film credits few people actually read). Once a straightforward document clearly designed to report dollars-and-cents in as few words as possible, the annual report became an important form through which to routinely craft Pfizer's public identity and pharmocratic ideals.

As this chapter will demonstrate, this sudden shift in the form and content of Pfizer's annual reports in 1950 articulates a cultural transition away from the World War II language of American patriotism to the universalist language of corporate

citizenship, constituting new forms of pharmocratic capital. In this way, the reports expose a broader cultural tension between neoliberal logic and the rhetoric of scientific innovation: on the one hand, neoliberal logic rested on the belief that inter-corporate competition would inspire “healthy” innovation, creating conditions in which pharmaceutical companies would, in theory, make more effective drugs, improve the consumer experience, and force the losing company to take their competing product(s) off the market; on the other hand, Pfizer simultaneously claimed to be in collaboration with its competitors worldwide in the name of scientific revolution and even world peace, quoting in its 1957 annual report President Eisenhower’s 1958 State of the Union Address, in which he famously called for a “full-scale cooperative program of Science for Peace.”<sup>4</sup> This rhetoric rendered invisible the contradictions between corporate individualism as it was practiced and the idealism of universal scientific progress. As the multilateral corporate acquisitions at the turn of the twenty-first century illustrate, large-scale, inter-corporate competitions do not result in the global, “cooperative program” Eisenhower proselytized; rather, they set the stage for the consolidation of corporate power, securing Pfizer’s unrecognized monopoly on the entire production and distribution of a huge range of pharmaceutical products worldwide—not only drugs, but also medical equipment, industrial chemical materials, consumer goods like perfume and laundry detergent, health insurance providers, and advertising companies. Under this structure, each subsidiary’s innovative autonomy is always

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<sup>4</sup> “Pfizer Annual Report, 1957: Inside Pfizer by John Gunther” (Pfizer Inc., 1958), 1.

subject to the oversight of the umbrella company it ultimately serves (in this case, Pfizer), exposing the contradictory liberal fantasies of “healthy” capitalist competition or collaboration that undergird neoliberal ideology. This coupling of extreme conservatism and scientific altruism is the hallmark of reproductive neoliberalism enacted via the pharmaceutical industry more broadly.

We can still see this coupling in Pfizer’s more recent marketing initiatives, particularly its “corporate citizenship” project, which aims to ensure “that all individuals everywhere have access to quality medicines, vaccines and health care, and the opportunity to lead healthy lives.”<sup>5</sup> Like those of many of its competitors, Pfizer’s corporate citizenship project grew out of the neoliberal ideologies characteristic of U.S. governance in the latter half of the twentieth century, policies that emboldened major corporations to expand overseas investments through various development projects in the Global South, ranging from philanthropic interventions to the creation of new markets for Pfizer products, new factories and research sites, clinical trials, and the extraction of natural resources to synthesize into chemicals and drug compounds. As recent feminist and postcolonial scholarship illustrate, these corporate philanthropic and humanitarian initiatives are premised on the idea of the Global South as “in need” and the Global North as the best administrator of those “needed” goods and institutions, reconstituting deeply rooted systems of colonial governance in ways that not only homogenize geopolitically disparate

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<sup>5</sup> “Pfizer’s Annual Review, 2016: Bringing Resources to Bear to Improve Global Health.”

contexts, but also erase Euro-America's role in having produced and perpetuated such inequities for centuries.<sup>6</sup> Ironically, this form of modern colonial violence and extractive capitalism necessarily depends on pharmaceutical companies functioning as one of, if not the, source of relief for underserved populations.

Building on this scholarship, I argue that the emergence of the Corporate Citizen<sup>7</sup> subject leading up to the end of the twenty-first century reflects a shift in Cold War-era, neoliberal notions of freedom and health that prompted Pfizer to transform their marketing strategies from the wartime rhetoric of American exceptionalism to that of urgent international scientific cooperation. Under these circumstances, the American patriot figure so prolifically used in just about every form of marketing throughout World War II was remodeled into the multicultural, scientifically progressive Corporate Citizen subject. Couched in the claim that the pharmaceutical knowledge Pfizer was said to generate was not only universally, unequivocally beneficial but urgently life-saving, the beneficent Corporate Citizen subject repackaged WWII notions of U.S. exceptionalism, drawing on colonial-era distortions of identity formation in service of the corporation's epistemic authority and economic power. With this in mind, this chapter marks how parallel stories of scientific, economic, and altruistic "revolutions" so consistently sustained across the

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<sup>6</sup> For example, see: Greene, Condrau, and Watkins, *Therapeutic Revolutions*; Adriana Petryna, Andrew Lakoff, and Arthur Kleinman, eds., *Global Pharmaceuticals: Ethics, Markets, Practices* (Durham: Duke University Press, 2006); Sunder Rajan, *Pharmocracy*.

<sup>7</sup> I capitalize Corporate Citizen here (and not previously) when referring to the Corporate Citizen as a specific kind of subject, as opposed to the corporate citizen as a "project" or broader concept that enables subjecthood but is not itself a subject.

latter half of the twentieth century presented unique challenges to crafting the public discourse around misoprostol when Pfizer acquired G.D. Searle and added the drug to its pharmaceutical repertoire in 2003—challenges that the machinery of reproductive neoliberalism has so successfully masked.

### **Pharmaceutical Patriotism, Inc.**

Although Pfizer’s business pursuits have operated differently across changing economic and cultural conditions over the last two centuries, its annual reports have always articulated a consistently two-pronged approach to their mission: 1) to build a lucrative, expansive business; and 2) to make products that “contribute to man’s needs.”<sup>8</sup> In order to satisfy both their shareholders and everyday consumers, these two goals could not be understood as antithetical; rather, they had to be understood as *necessary* to one another. Pfizer’s annual reports thus suture economic incentives to a scientifically rigorous, universalist vision of human prosperity, defining corporate expansion as the means to a liberated public, free of illness and inefficiency. Furthermore, this rhetoric took a particular form during and after World War II: by espousing the project of attending to human “need” as an act of American patriotism, Pfizer tied their public image to a militant morality of sustaining and healing specific kinds of human life—one that cast industry growth (particularly in research and development) as a universal good, justifying their own

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<sup>8</sup> “Annual Report” (Ann Arbor: Pfizer, Inc., 1977), 4.

corporate control over other forms of life and resources (animal, plant, mineral) to suit this purpose.

Pfizer's annual reports achieve this narrative by conflating the language of business acumen with that of patriotic altruism, explicitly aligning its research and development projects with the war effort. For instance, the 1942 report reads:

Our Company finds itself, as often before, called upon for production of substantial quantities of Chemicals essential to military as well as civilian activities. This is an obligation which we have been glad to assume and which we believe has been carried out with success. More than 150 of our former staff are now enrolled in the Army Forces of our country. The remaining personnel have accepted increased duties and responsibilities and have trained new employees in the tasks at hand.<sup>9</sup>

Above, economic and manufacturing matters—production, sales—are framed not as business choices, but rather as an “obligation” the company was “called upon” to complete. The last sentence reassures stockholders that although a significant number of Pfizer staff left to join the military, the company adapted without negatively impacting its profits; if anything, the war appears to have provided a new market for “military activities.” 1944's annual report shifts particularly abruptly between war and business matters. Immediately after honoring the deaths of six former employees killed in the war, the very next paragraph boasts the company's “success of the operations for the year by the improvement in processes, increased efficiency and reduced costs.”<sup>10</sup> Even the products themselves are oxymoronicall

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<sup>9</sup> “Chas. Pfizer & Co., Inc. Annual Report, 1942” (America's Corporate Foundation; Chas. Pfizer & Co., Inc., March 1, 1943), 3.

<sup>10</sup> “Chas. Pfizer & Co., Inc. Annual Report, 1944” (Chas. Pfizer & Co., Inc., 1945), 2.

described as critical life-saving “weapons.”<sup>11</sup> Pfizer products are said to be “deployed” and to “attack... the armor” of “stubborn,” “malicious” germs, all in the effort to “save Allied lives.”<sup>12</sup> Vacillating between seemingly concurrent revolutions of science, business, and nation, these reports attach a sense of nobility and patriotic sacrifice to Pfizer’s financial success.

As the ad at the beginning of this chapter suggests, Pfizer’s massive investment in penicillin research was especially important for linking pharmaceutical expansion to American patriotism. In 1942, the U.S. government commissioned major pharmaceutical companies to find a way to mass-produce penicillin, an antibiotic that could eliminate most bacterial infections but was difficult to produce in large quantities.<sup>13</sup> Pfizer succeeded one year later, ultimately putting nearly \$3 million toward new facilities to manufacture the drug in the world’s largest fermentation tanks.<sup>14</sup> The letter to stockholders in the annual report presents this enormous investment as evidence of the company’s profound commitment to the war effort. As then Pfizer President George A. Anderson put it, “The management and employees have thus demonstrated their solid determination to support our fighting forces to the utmost in the attainment of ultimate victory,” determination

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<sup>11</sup> “Pfizer Annual Report, 1956: The Chemist and the Whale” (Pfizer Inc., 1957), 4.

<sup>12</sup> “Pfizer Annual Report, 1956: The Chemist and the Whale,” 4–5.

<sup>13</sup> Edmund T. (Jr.) Pratt, *Pfizer: Bringing Science to Life*, Newcomen Publication Number 1247 (1985 National Meeting of the Newcomen Society of the United States, New York: Pfizer, Inc., 1985), 9.

<sup>14</sup> This number is based on Pfizer’s financial reports: “Chas. Pfizer & Co., Inc. Annual Report, 1943” (Ann Arbor: Chas. Pfizer & Co., Inc., 1944); “Chas. Pfizer & Co., Inc. Annual Report, 1944”; “Chas. Pfizer & Co., Inc. Annual Report, 1945” (Ann Arbor: Chas. Pfizer & Co., Inc., 1946).



that also apparently yielded “splendid results” for the company in 1943.<sup>15</sup> By the end of the war, Pfizer was producing half of the world’s supply of penicillin. The company had “captured the public’s imagination and had shown the potential of pharmaceutical research,” as Edmund T. Pratt, Jr. (Pfizer’s president from 1971-1971, CEO from 1972-1991, and Chairman from 1972-1992) later put it in his honorary speech at the Newcomen Society of the United States in 1985.<sup>16</sup>

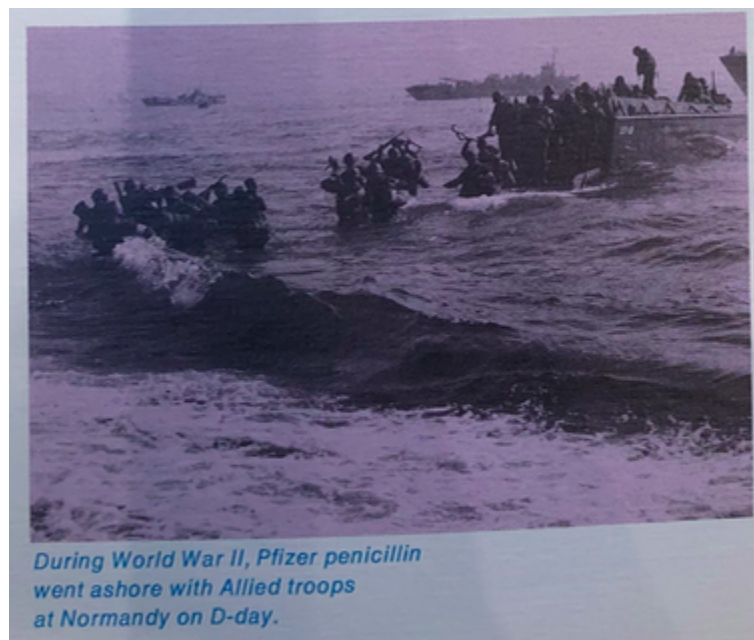


Figure 4: Photo included in Pfizer’s in-house science journal, *Spectrum* (1967).

Yet penicillin also exemplifies what happens when Pfizer’s desire for mass profit motivates its performance of scientific altruism. Although Pfizer gained a

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<sup>15</sup> “Chas. Pfizer & Co., Inc. Annual Report, 1943,” 3.

<sup>16</sup> Pratt, *Pfizer: Bringing Science to Life*, 15.

reliable military market during the war and immense cultural capital for its success, penicillin was not a patentable drug, and as other companies began producing it, Pfizer's penicillin profits fell. As John McKeen, a member of the board at the time, put it, "If you want to go broke in a hurry, go into the penicillin business."<sup>17</sup>

Incentivized to maximize profitability through patents, in 1950, Pfizer patented Terramycin, an antibiotic with the same uses as penicillin, but which was derived from a different type of soil.<sup>18</sup> Pfizer marketed Terramycin in seven different forms: as an oral capsule, oral "elixir," intravenous liquid, ophthalmic (for eyes) solution, ophthalmic ointment, topical ointment, and "troches" (lozenges).<sup>19</sup> While both penicillin and Terramycin radically reduced previously fatal infections that plagued military forces during the war, the strategy here was to slightly alter an existing drug, patent it as a brand new drug, and expand methods of easy-consumption.<sup>20</sup>

During this period, Pfizer's reports mimic the rhetoric of Cold War American foreign policy, only instead of explicitly anti-communist military action, Pfizer packages corporate interests (e.g. patenting untapped drug markets and pursuing cheaper research, development, and manufacturing centers) as acts of service to the

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<sup>17</sup> Pratt, 11.

<sup>18</sup> "Chas. Pfizer & Co., Inc. Annual Report, 1950" (Chas. Pfizer & Co., Inc., 1951).

<sup>19</sup> "Chas. Pfizer & Co., Inc. Annual Report, 1950," 3.

<sup>20</sup> I want to be careful here not to conflate the benefits of the drugs themselves with the practices of the corporations. My point here is that the neoliberal ideologies of revolution, health, and longevity embedded in these discourses become a form of capital that maintains and produces new forms of colonial violence, a self-perpetuating corporate system that gets hidden or at least distorted by the (very possible but unevenly realized) promise of healthy life.

country and, by extension, the world. In the 1950 annual report, McKeen (who had become President and Chairman of Pfizer's board by that time), writes:

As the year 1950 closes it is obvious that the people of the United States are entering an era of uncertainty with the threat of yet another world war constantly before them. Your Company which can point to a record of participation in every emergency since 1849, pledges its resources and its skills to the country's service in this hour of need.<sup>21</sup>

Above, McKeen sees Pfizer as a longstanding extension of the U.S. military, a reserve of skilled laborers who have always been ready to serve the country in the face of potentially volatile political instability. The subtle references to an invisible and yet omnipotent enemy create a sense of fear and an unpredictable future—an enemy that is a “threat” and “emergency” in an “era of uncertainty” and an “hour of need”—a problem to which Pfizer “pledge[s]” its resources and skills.

The 1951 annual report takes this a step further: in addition to its devotion to the U.S. military, the report also espouses a moral obligation to extend their work beyond the United States, encoding corporate imperialism as an expression of patriotic, humanitarian integrity. The cover pictures three objects on a desk: a large, smoking vial; a cage with a live chick inside; and a globe. Inside, it explains that the cover photo is meant to portray the “scope of Pfizer activities, not only of its principal products, but also of the area of its service.”<sup>22</sup> The study of pharmaceuticals is again depicted as a “stimulating and humbling” privilege, one that “aids in the unremitting war against disease and malnutrition” while also

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<sup>21</sup> “Chas. Pfizer & Co., Inc. Annual Report, 1950,” 7.

<sup>22</sup> “Chas. Pfizer & Co., Inc. Annual Report, 1951” (Chas. Pfizer & Co., Inc., 1952).

establishing the “important components for industrial growth.”<sup>23</sup> The report even piggybacks on one of the most central axioms of canonical American political thought, describing Pfizer as uniquely positioned to fully realize the “pursuit of *health* and happiness” (emphasis mine).<sup>24</sup>

Perhaps the most explicit expression of this kind of pharmaceutical patriotism is in the 1957 report, which begins by quoting President Eisenhower:

Mankind’s hope for a better life in a safe and prosperous world “requires more than words of peace. It requires works of peace.” With those words, President Eisenhower urged the nations of the world to unite in a program of “Science for Peace.”

The President called for a co-operative campaign to eradicate malaria, heart disease, cancer... “diseases that are the common enemy of all mortals.” He envisaged the bounty that could flow from waging total peace: “Hunger and disease could increasingly be driven from the earth. The age-old dream of a good life for all could, at long last, be translated into reality.”

This is an account of how one American company, operating for profit under a system of free enterprise, is turning its scientific knowledge and business resources to the task of creating the raw materials of human betterment. It reports some of the meaningful contributions being made by private industry to a world in which all can share in the abundance of scientific and technological progress.<sup>25</sup>

Drawing on Eisenhower’s dream of eradicating disease and hunger, the passage above suggests that U.S. science has the potential to lead nations out of global conflict, asserting that free enterprise is the key to Eisenhower’s presidential vision of “peace” and the “good life.” The letter ends with a thank-you to shareholders: “By their participation in Pfizer’s corporate enterprise—by creating the raw materials of human betterment—employees and shareholders alike are playing an important part

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<sup>23</sup> “Chas. Pfizer & Co., Inc. Annual Report, 1951,” i.

<sup>24</sup> “Chas. Pfizer & Co., Inc. Annual Report, 1951,” i.

<sup>25</sup> “Pfizer Annual Report, 1957: Inside Pfizer by John Gunther,” 1.

in ‘waging total peace.’”<sup>26</sup> Pfizer’s reports not only constitute a fundamental relationship between their own corporate interests and the wellbeing of “mankind,” but also set the stage to secure stockholder support for what the 1951 report describes as an “ever-renewing challenge for the future.”

With romanticized patriotism came performances of transparency and altruism, narratives Pfizer’s 1957 report describes as a “new approach to financial journalism.”<sup>27</sup> Following suit with Pfizer’s previous reports that glorify and militarize the labor of scientific research, John Gunther—a popular journalist at the time, known for a series called the “Inside” books—wrote “Inside Pfizer,” a journalistic article featured in both the annual report and the *New York Times*. Navigating the specters of past and future world wars heightened by the threat of nuclear weapons, Gunther dances between depictions of Pfizer as austere, mysterious, and deeply scientifically rigorous on the one hand, while curiosity-driven, well-meaning, even playful on the other. After noting that Pfizer “rhymes with Kaiser,” a title given to emperors of the German Empire, Gunther writes:

Antibiotics relieve untold human suffering and save millions of lives. We all know that... they [antibiotics] depend on research, on the work of hundreds of virtually anonymous scientists, whose names are unknown to the public, who wage unceasing and relentless war on the depredations of disease. Nobody who visits Pfizer can doubt the value of research in a free society. Research equals science in these troubled days, and science equals survival.<sup>28</sup>

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<sup>26</sup> “Pfizer Annual Report, 1957: Inside Pfizer by John Gunther,” 3.

<sup>27</sup> “Pfizer Annual Report, 1957: Inside Pfizer by John Gunther,” 2.

<sup>28</sup> “Pfizer Annual Report, 1957: Inside Pfizer by John Gunther,” 4.

Gunther imbues the anonymous scientists' labor with a sense of amazement and god-like prestige, qualities their apparent anonymity only seems to magnify. Impressed by their "businesslike" affect and "aseptic way," Gunther writes, "These men are scouts, patrolling the frontiers of the unknown"; yet he is quick to reassure readers that "Pfizer gives a homely atmosphere. This is a friendly company, even if science-minded," playfully referring to Pfizer's microbial antibiotics as "beneficent little miracle workers."<sup>29</sup> In the wake of the United States' use of nuclear weapons and escalating tension with the Soviet Union, this piece applauds the power of pharmaceutical science used for "human betterment." Pfizer reprocessed fears about dangerous science (e.g. nuclear weapons) into excitement about the so-called "life sciences"—pharmaceuticals and technology.

These documents reflect a clear rhetorical strategy: Pfizer was said to be not only an immensely profitable company with the capability to unlock previously unimagined scientific and economic potential all over the world, but an honest, well-meaning company with the United States' (anti-communist) interests at heart. This rhetoric made it impossible to understand economic growth and the healing of human life—or, at least, pharmaceuticalizing of it—as contradictory desires, creating a culture in which rapid and unhindered corporate expansion was understood not only as universally "good," but also as a national security issue.

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<sup>29</sup> "Pfizer Annual Report, 1957: Inside Pfizer by John Gunther," 5.

## **From War to “Concern and Action”**

By the 1960s, Pfizer consistently identified five main sectors of their business: health care, agriculture, specialty chemicals, materials science, and consumer products. Going “international,” as Pfizer’s reports from this era describe it, became a catch-all for the consolidation of lucrative markets and philanthropy targeted at “in need” populations—people lacking basic resources, but also liberation from political and cultural systems that were said to contest their existential freedom. In other words, Pfizer not only asserted that research and development investments were a strategic economic opportunity for the company, but, even more fundamentally, it inculcated investors with the belief that Pfizer’s financial success precipitated a healthier, freer, more democratic world. Pfizer’s annual report from 1963 proclaims: “Our work in the pharmaceutical field, involving as it does creative research, efficient production, progressive marketing and service to those who use our products, represents one of the finest manifestations of competitive economic effort in and for a free society.”<sup>30</sup> Put simply, the narrative was: when Pfizer profits, everyone profits.

At the same time, while Pfizer’s emphasis on freedom (scientific, political, existential) is consistent with the reports during and immediately following World War II, the reports never mention any other U.S. war—surprising, given how central WWII is in the previous reports. Rather, the reports recruit a much broader rhetoric

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<sup>30</sup> “Annual Report for the Year 1963” (Ann Arbor, United States: Chas. Pfizer & Co, Inc., 1963), 4.

of “concern” enacted through various philanthropic projects in the Global South. By 1976, Pfizer was operating in over one hundred different countries in order to take advantage of different “profiles of disease” in developing countries.<sup>31</sup> As Dr. Laubach puts it in a special interview in the 1976 report: “We are everywhere in the world and very frequently we were the first American company in a given country. This presence is a significant commercial, medical and social opportunity.”<sup>32</sup>

As reproductive politics scholars have long observed, these philanthropic projects have historically served as conduits for drug testing, operating under the guise of techno-scientific, humanitarian progress espoused by family planning initiatives, contraceptive research, and environmentalism.<sup>33</sup> In this context, philanthropic projects represent modernized versions of state-sanctioned eugenics that, while often carried out by institutions thought to be techno-scientifically (and therefore socially) progressive, replicate the abuse, incarceration, and pathologization of women of color.<sup>34</sup> By the same token, a major intervention that reproductive politics scholarship has made is to disturb the prevalent assumption that the contraceptive technologies often disseminated in these projects are inherently liberatory, a fantasy in which more technological and medical advancements automatically result in reproductive autonomy for all women. Contrary to discourse that claims the dissemination of reproductive technologies and especially

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<sup>31</sup> “Pfizer Annual Report, 1976” (Pfizer Inc., 1977), 15–16.

<sup>32</sup> “Pfizer Annual Report, 1976,” 14.

<sup>33</sup> Kline, *Building a Better Race*; Stern, *Eugenic Nation*.

<sup>34</sup> See: Jade S. Sasser, *On Infertile Ground: Population Control and Women’s Rights in the Era of Climate Change* (NYU Press, 2018).



contraception unequivocally allow for reproductive freedom, reproductive politics scholars show how, rather than simply offering new opportunities for women to control their fertility, these technologies also constitute new biopolitical mechanisms through which to surveil and control populations.

Yet less scholarly attention has been given to the ways in which Pfizer turned the concept of corporate philanthropy into a product in and of itself. The 1971 report states the public relations benefits of philanthropy outright, repeatedly reiterating that an “awareness of the role of Pfizer in the community has been stressed.”<sup>35</sup> The report even adds a sixth sector to their business under the heading, “Concern and Action,”<sup>36</sup> claiming that the Concern and Action sector helps to address “three of the most critical questions of our times”: “the environment,” “minority and community action,” and “social health.” Notably, the formatting of this sixth sector is identical to that of the other five, suggesting, at least visually, that “Concern and Action” is itself a kind of pharmaceutical product, one that embodies the affective labor of care and humanitarianism. But what makes these “critical” concerns different from the other five sectors, which also profess the capacity to achieve “human betterment”?

What determined whether a given project fell under Concern and Action or one of the other five sectors was in part the targeted population, but perhaps more importantly, the illness being treated. While Pfizer’s previous sections stress specific

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<sup>35</sup> “Pfizer Annual Report, 1971: Development Technology -- A Complex Link to Product Reality” (Pfizer Inc., 1972), 21.

<sup>36</sup> “Pfizer Annual Report, 1971: Development Technology -- A Complex Link to Product Reality,” 21–22.

product developments to treat cardiovascular disease and diabetes in the Global North, the projects under Concern and Action focus almost exclusively on venereal diseases and drug abuse in the Global South. The latter projects also tend to take an educational approach, as opposed to a product-development approach. For example, the report claims that “Operation Great Concern” distributed “more than three million pamphlets and 300,000 posters explaining the symptoms and consequences of venereal disease.”<sup>37</sup> Descriptions of the results or impacts of these projects are remarkably vague, stating that Pfizer “participated in a number of local programs to alleviate health problems and emergencies,” which consisted of “the contribution of Pfizer pharmaceuticals to the National Health Fund in India and responses to the earthquake in Peru and the polio epidemic in the Dominican Republic.” But what, exactly, was Pfizer’s participation? What was their contribution? What were their responses? According to the reports, Pfizer appears to have reserved the longer-term and more costly product development “response” for the more lucrative consumer market in the Global North, leaving the substantially less costly response—pamphlets and posters—to the Global South. Furthermore, by focusing efforts on so-called “education,” Pfizer implicitly vied for behavior changes in the Global South rather than on immediate physical relief, as it did for consumers in the Global North.

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<sup>37</sup> “Pfizer Annual Report, 1971: Development Technology -- A Complex Link to Product Reality,” 21.

This distinction between education and product development approaches is thus socially stratified: education for the poor, products for the rich.<sup>38</sup>

There are a few tangible consequences that are important to glean from this. The first is the reality that Pfizer is inherently designed to profit from illness, a reality that its claims to survival in the Global South and human betterment in the Global North tend to conceal, but that the reports make explicit. For instance, in summarizing the company's profits for the year, the 1973 report states: "Most encouraging was the continued strong growth of antibiotics sales despite increasing competitive pressures, especially in the important European market... Substantial increases were reported in Japan, and outstanding results were achieved in Africa."<sup>39</sup> The next sentence is almost concessory, stating, "The sharp increase of antibiotic sales in many countries was influenced by some degree by a high incidence of respiratory infections." Ironically, the passage cleaves Pfizer's celebration of increased sales from the reality that those sales result from more incidence of respiratory illness, leaving the reader with the understanding that sales and illness are economically connected, but ignorant to the lived consequences of that reality.

Second, while Pfizer makes claims to universal human betterment, the company only seeks product developments inspired by the most profitable

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<sup>38</sup> There are of course exceptions to this, but in most cases, it's because the purchasing power does not come from the Global South. Even though economically disenfranchised patients receive the treatment a given product provides, they do not constitute the market because the funding for such products comes from U.S.-funded organizations (e.g. USAID) or independently wealthy private donors.

<sup>39</sup> "Pfizer Annual Report, 1973" (Pfizer Inc., 1974), 7–8.

illnesses—those experienced most commonly, in places with the highest concentrations of wealth. Expanding pharmaceutical resources to the Global South—what Pfizer calls “worldwide deployment”<sup>40</sup>—only happens when Pfizer identifies a new potential market. From this perspective, Pfizer’s primary goal is not necessarily to improve health outcomes, but rather, to define new markets of illness that they can then “treat.”

Yet this is not solely a critique of Pfizer’s predictably inequitable distribution of capital invested in the Global North and the Global South; it is also about how Pfizer instrumentalized their philanthropic initiatives in order to shape federal economic policies. As Pfizer expanded these philanthropic projects throughout the 1970s, the annual reports reflect a brewing strain between Pfizer and the state, expressing increasing frustration with the state’s regulation of their pharmaceutical enterprise. The 1975 report ends with a complaint that “society has not fully recognized the impact that public policies and attitudes have on the rates of therapeutic discovery” and advocates for eliminating “cumbersome and often redundant constraints on clinical studies.”<sup>41</sup> Pfizer ultimately proposes a new role of government:

The view that the sole function of drug regulation is the protection of the public from harm should be replaced by a new and broadened conception of the regulators’ mission. The public interest would be best served if the Congress broadened the mandate of FDA to include a positive responsibility to encourage drug innovation and to expedite the development and availability of new drugs.<sup>42</sup>

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<sup>40</sup> “Pfizer Annual Report, 1976,” 5.

<sup>41</sup> “Pfizer Annual Report, 1975” (Pfizer, Inc., 1976), 18–19.

<sup>42</sup> “Pfizer Annual Report, 1975,” 19.

In other words, the report not only argues that people are better served when Pfizer is most profitable—again misleadingly implying that Pfizer’s profitability is evidence of improved health outcomes—but also implies that Pfizer is better suited to serve the “public interest” than the state. The report goes on to explain Pfizer’s unique position:

Pharmaceutical research is unusual as compared with all other kinds of applied chemical research, in that meaningful discovery involves issues of increasing political and social sensitivity. In fact, pharmaceutical innovation is now not only a scientific process, but also a socio-political one. If this delicate process is further complicated, there will certainly be an even greater reduction in the flow of beneficial therapeutic innovations, thereby perpetuating human suffering and economic losses.<sup>43</sup>

While the report’s description of pharmaceutical innovation as a “socio-political” process is, from one perspective, remarkably insightful, the passage is really about chastising the state, asserting that state regulation only over-complicates Pfizer’s ability to save lives and improve health. The section ends with the coded posturing of a high-stakes business negotiation: “We are confident that this dialogue will have an increasing impact on policy. If so, the American pharmaceutical research laboratory can continue to fulfill its important role as the main source of new medicines for better health for people everywhere.”<sup>44</sup> Veiled as a diplomatic “dialogue,” Pfizer warns that their potential to relieve human suffering all over the planet can only be fully realized in a free market.

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<sup>43</sup> “Pfizer Annual Report, 1975,” 19.

<sup>44</sup> “Pfizer Annual Report, 1975,” 19.

## Erasing Pharmocracy, Making Pharmaceutical Subjects

By the early 1980s, each new product took about a decade of research and about \$70 million for it to go on the market.<sup>45</sup> Pfizer justified this massive cost in time and resources to its shareholders by arguing that big investments upfront would generate much bigger profits in the long run. Each annual report is very much a performance of this argument, in part because, each year, shareholders had to recalibrate to an even bigger scale of investment. To reflect the massive range of products it came to manufacture and own, Pfizer rebranded itself as a “life sciences” corporation, developing so many products that it is more difficult to name a product that Pfizer did *not* contribute to in one way or another. In addition to some of the most popular drugs still currently on the market (e.g. Diflucan, Viagra, Zoloft, Zithromax, Celebrex, Lipitor), Pfizer also patented a slew of lesser-known but (at least as) lucrative products in this period. Some examples include: Pferrox, a magnetic oxide whose “unique magnetic properties... and its analog compounds made it possible for the major tape-producing companies to develop premier, high quality audio recording tapes”; Flocon 4800, an “anthem gum fermentation broth for use in enhanced oil recovery (EOR)”; Coxistac, an injection “for use in swine to improve weight gains and enhanced feed efficiency”; Pfinodal, which “utilizes Pfizer powder metallurgy to produce a unique copper-nickel-tin alloy for use as a connector in micro-miniature electronic circuits”; and “Hot Pants,” a fragrance for

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<sup>45</sup> “Annual Report, Special Feature: The Transfer of Knowledge,” 10.

women.<sup>46</sup> While the “life sciences” rebranding is remarkably vague, it befit their mission to develop products in every corner of consumer life, permeating the disciplinary, financial, and geopolitical constraints that previously limited the scope of their business. Today, Pfizer Inc. is the parent company of over 500 subsidiaries, including Monsanto, Warner Lambert, Wyeth, and Pharmacia—some of the biggest pharmaceutical, agricultural, and marketing companies in the world, all of which are parent companies of other subsidiaries.<sup>47</sup>

As Pfizer constructed the narrative that the very expensive pursuit of elite, precise, and curative technologies would, eventually, amass astronomical profits, the reports represent the beneficiaries of Pfizer products strikingly differently. While the reports go to great lengths to illustrate the health benefits for representatives of the Global North through individualized profile stories, representatives of the Global South are predictably depicted as “in need” of Pfizer products. Despite Pfizer’s promise that its products have unprecedented healing potential, consumers in the Global South appear to be not only in a perpetual state of receiving, but also of

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<sup>46</sup> “Annual Report, Special Feature: The Transfer of Knowledge,” 24, 26; “Annual Report 1982, Living with Heart Disease: The Revolution in Cardiovascular Medicine” (Ann Arbor: Pfizer, Inc., 1982).

<sup>47</sup> A “subsidiary” is legally defined as a company that gives fifty percent or more voting stock to its “parent” or “holding” company. There are also subsidiary “tiers,” meaning that a parent company can be a subsidiary of another parent company. Most mega pharmaceutical companies today control all production, marketing, and distribution processes by acquiring subsidiaries that specialize in each industry, a loophole that allows companies to operate as monopolies without violating anti-trust laws. See: Jeffrey L. Harrison, “Business Associations, Economics Of,” in *Encyclopedia of Law & Society: American and Global Perspectives* (Thousand Oaks: Sage Publications, Inc., 2007); “Subsidiaries of the Company (Pfizer)” (U.S. Securities and Exchange Commission, December 31, 2014).

becoming pharmaceutically educated and responsabilized. In this way, Pfizer's pharmaceutical products act as vehicles through which neoliberal ideals of freedom and individualism masquerade as multiculturalism and corporate benevolence.

The 1981 report (highlighted at the very beginning of this chapter in the quote from Dr. Drucker, one of Pfizer's business consultants) illustrates this multiculturalist narrative especially overtly. Dispersed throughout the text of Drucker's interview are full-page photos of Pfizer employees, each specifying a stage in what the report calls the "transfer of knowledge." American manufacturers conduct quality control on a sea of dark, globular hip implants (Figure 5). Pfizer researchers discuss lab results while a topless patient lurks uncomfortably in the background, a spiraled wire connecting his arm to a machine we cannot see, though the caption tells us it tracks heart rate (Figure 6). In an unspecified Latin American village, a crowd of young brown children surround a white male Pfizer employee clothed in a white lab coat, sitting at a desk distributing an antiparasitic drug called Combantrin (Figure 7). In Japan, an ambiguously titled "medical specialist" trains a new sales representative on a Pfizer product, their concentrated faces upstaged by the complex formulas written on a chalkboard behind them (Figure 8). While the images available in the archive are extremely low-quality, the story they tell is clear: those on the receiving end of this "transfer" represent a multicultural, multiracial world eager to be the recipients of Pfizer's pharmaceutical knowledge. This is a *global*, humanitarian revolution predicated on corporate success.



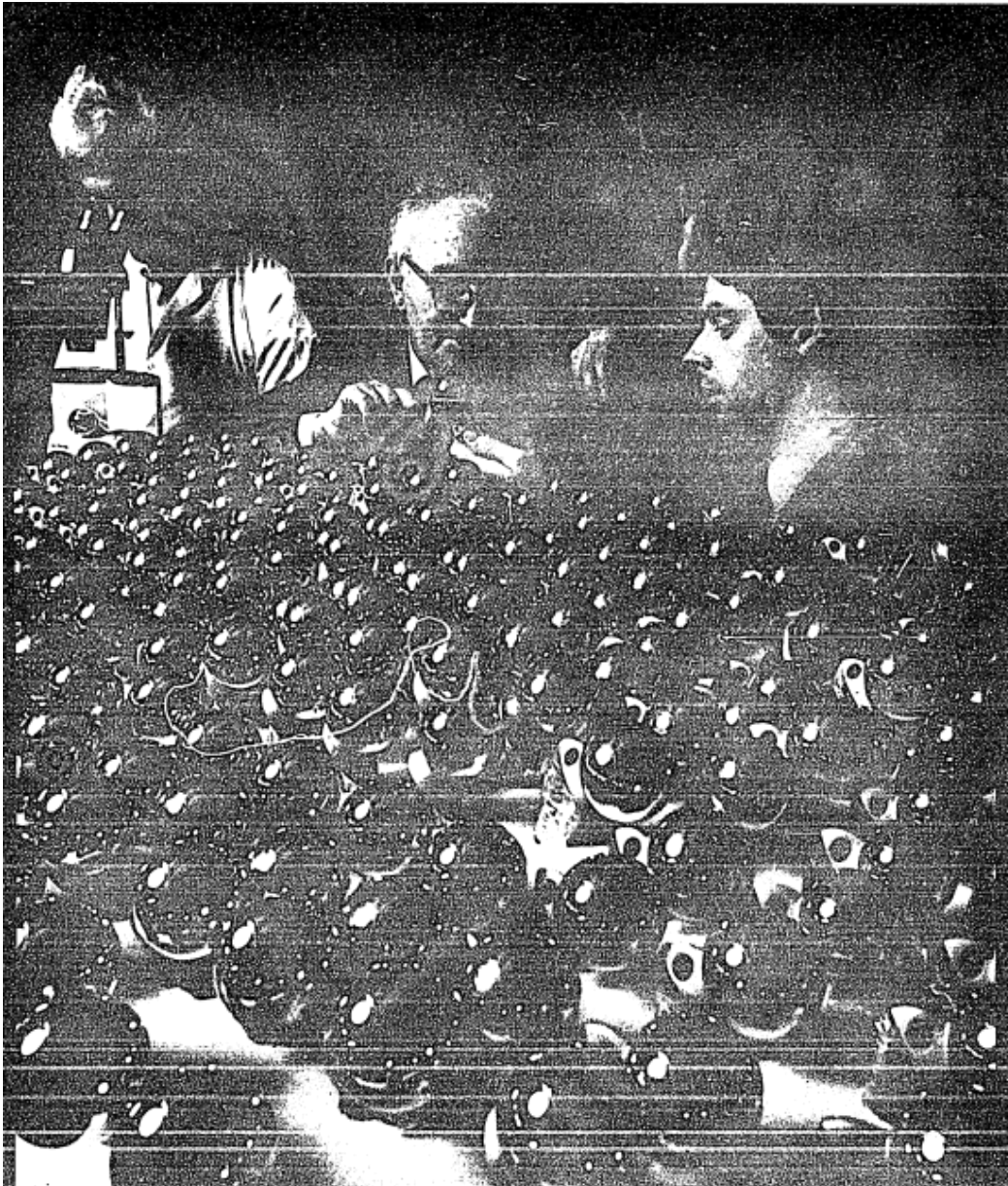


Figure 5: Design engineers and quality control personnel inspecting hip implants at Pfizer's Howmedica plant in Ireland, c. 1981. Under the heading, "The Transfer of Knowledge: Design Engineers and Quality Control," Pfizer's report assures: "The manufacture of products to quality standards is an important aspect of Pfizer's worldwide operations... [D]esign engineers and quality control personnel consult frequently throughout the manufacture of prosthetic devices." ("Annual Report, Special Feature: The Transfer of Knowledge" (Ann Arbor: Pfizer, Inc., 1981), 9.)

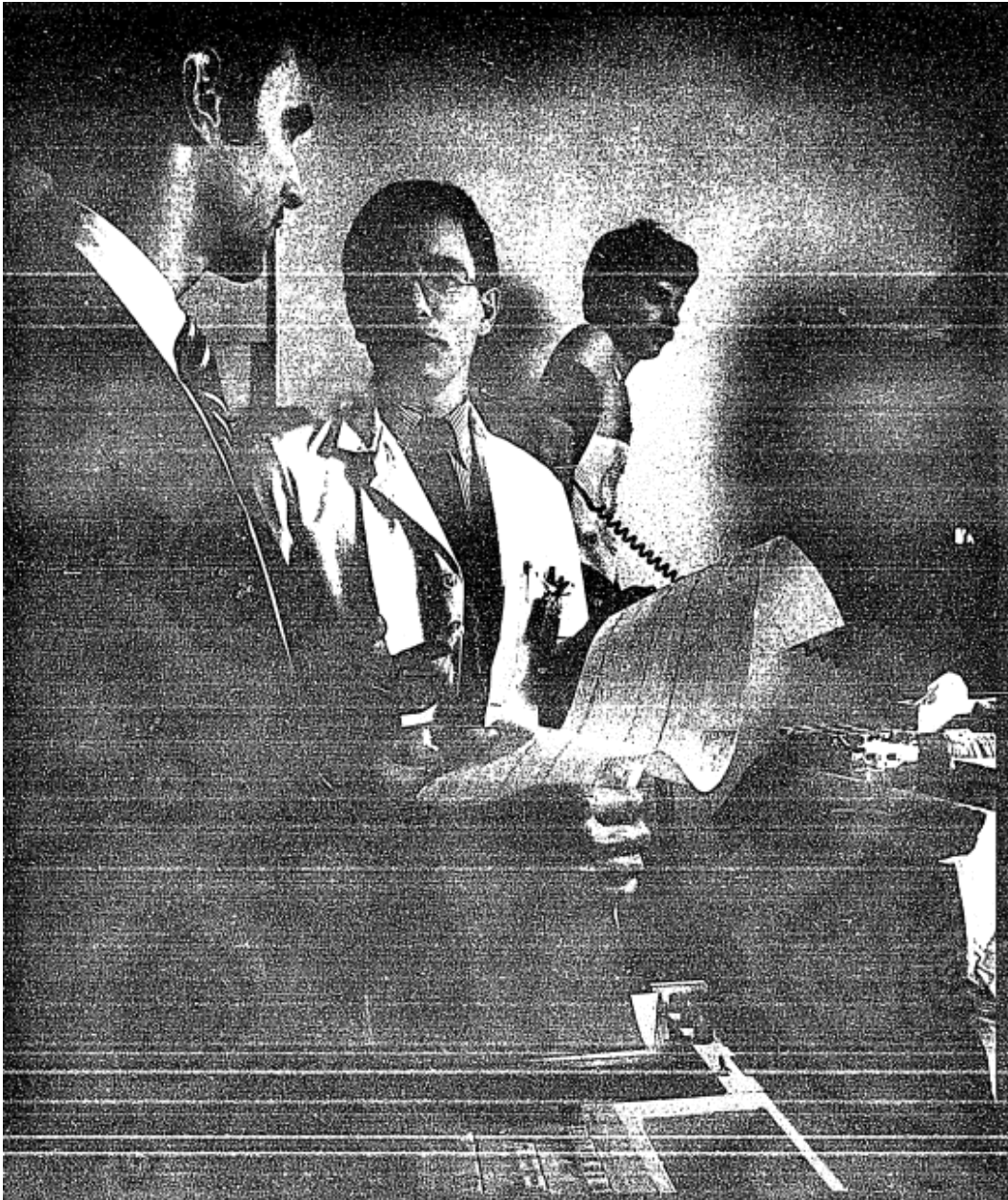


Figure 6: Titled, “The Transfer of Knowledge: The Physician and Clinician.” The description reads: “Extensive clinical studies are needed to evaluate new drugs. Here a member of Pfizer’s medical staff discusses clinical findings with a physician who conducted studies on Procardia, Pfizer’s new cardiovascular drug. Prior to its approval at the end of 1981, Procardia was administered to approximately 18,000 angina patients throughout the U.S. in clinical trials and on an emergency basis.” (“Annual Report, Special Feature: The Transfer of Knowledge,” 7.)



Figure 7: Titled, “The Transfer of Knowledge: Physician and Patients.” The description reads: “In the developing world, where sanitation and medical facilities are limited, drugs offer the most cost-effective form of medical treatment. Here a physician administers Combantrin, a Pfizer antiparasitic drug, to villagers in Latin America. Medical and community health education programs are conducted by the Company in many countries of the Third World.” (“Annual Report, Special Feature: The Transfer of Knowledge,” 15.)



Figure 8: Titled, “The Transfer of Knowledge: Medical Specialist and Sales Representative.” The description reads: “The professional sales representative is a crucial factor in the transfer of knowledge about new products. In Japan, where four new drugs were launched in 1981, the Company has increased its sales force by almost one-third over the past three years. A new representative is seen here receiving training from a medical specialist.” (“Annual Report, Special Feature: The Transfer of Knowledge,” 11.)

Because the reports from the 1980s tend to lump people of color into the same multicultural (i.e. “non-white”) pool of knowledge recipients, it is tempting to presume that the reports maintain the individuality of its white American consumers. To some degree, this is true—the individual profile stories are almost all about white men, and they provide comparatively specific information about each of their lives, including their names, where they live, their jobs, marital statuses, even their personal aspirations. But the biographical form of these stories primarily serves to craft a very generalizing consumer subjecthood: that of a mostly white, productive, heteronormative person with hobbies they are apparently very eager to get back to. For instance, the cover of the 1986 report features Edward Lomanto, a trial lawyer from upstate New York, who controls his angina with Procardia (Figure 9). The description tells readers that “According to his wife, Nancy, Mr. Lomanto has always been a strong, active man,” and that “Golf and gardening are favorite pastimes,” activities he was able to return to after taking Procardia for one month.<sup>48</sup> In the same report, Hans Eberhardt, a bank manager, treats his back pain with Feldene I.M. so he can ski in the Alps, “a pastime he once again enjoys” (Figure 10).<sup>49</sup> Dennis Ballweg, a dairy farmer in Sun Prairie, Wisconsin, gives his cows Rumatel, a deworming treatment that does not interrupt milk production nor require him to discard any milk, allowing him to keep his milk sales on target (Figure 11).<sup>50</sup> Lastly, the “warming power” of Ben-Gay Sports-Gel helps the women’s rowing

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<sup>48</sup> “Pfizer Annual Report, 1986: Bringing Science to Life” (Pfizer, Inc., 1987), 2.

<sup>49</sup> “Pfizer Annual Report, 1986: Bringing Science to Life,” 2, 8.

<sup>50</sup> “Pfizer Annual Report, 1986: Bringing Science to Life,” 16.



team at the Massachusetts Institute of Technology (MIT) “concentrate on work rather than sore muscles” (Figure 12).<sup>51</sup> All of these stories position Pfizer products as the keys to realizing a middle- and upper-class American fantasy in which performing “good” citizenship leads to luxury, longevity, and personal bests.



Figure 9: The cover of Pfizer’s 1986 Annual Report. Unfortunately, this off-center, poorly cropped image is the only version in the archive. Curiously, someone also blacked-out the square-ish patch to the right of the man’s head; I don’t know what it conceals.

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<sup>51</sup> “Pfizer Annual Report, 1986: Bringing Science to Life,” 21.



Figure 10: Hans Eberhardt, 37, gets “back in form” with the help of Feldene I.M., an NSAID designed to relieve pain for longer periods of time than other NSAIDs. (“Pfizer Annual Report, 1986: Bringing Science to Life” (Pfizer, Inc., 1987), 8.)

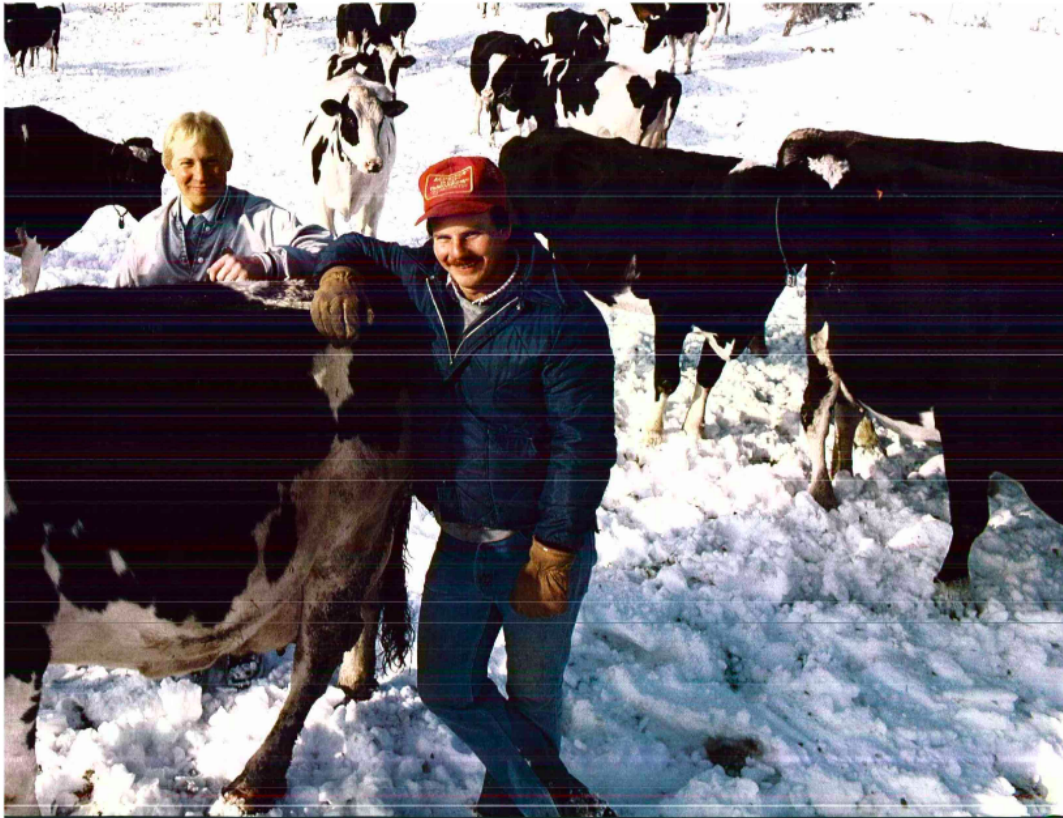


Figure 11: Featured in Pfizer's 1986 report, this photo was taken on Dennis Ballweg's cow farm in Sun Prairie, Wisconsin. Presumably, these cows have been treated with a deworming drug called Rumatel. ("Pfizer Annual Report, 1986: Bringing Science to Life," 17.)





Figure 12: The women's rowing team at Massachusetts Institute of Technology (MIT) celebrating a victory apparently enabled by Ben-Gay Sports Gel. ("Pfizer Annual Report, 1986: Bringing Science to Life," 20.)

One of the featured biographies in the 1986 report stands out from the rest. While other profiles in the report clearly describe those pictured as satisfied consumers of featured Pfizer products, no description was provided for this particular image (figure 9). It is unclear what exactly is going on here—who they are, how they are connected to Pfizer—but we could do some guesswork based on the context. The image separates two pages: 1) a description of Pfizer’s recent developments in the study of calcium channel blockades (CCBs) for the treatment of various cardiovascular issues, and 2) a journalistic piece about the Infusaid Implantable Pump that “helped save Mr. Kreismann’s right foot” (Mr. Kreismann is a construction supervisor for the St. Charles County Highway Department in Missouri but is a different person in another photo).<sup>52</sup> What is striking about the photo is the foregrounding of the two figures. With a downed tree between them, each man poses with a tool: in front, the white man holds a clipboard and a Number 2 pencil, half grinning; a few paces back, a black/brown man rests a chainsaw on the tree, a serious, sobering expression on his face. The literal and symbolic separation between the two figures is uncomfortable in part because, without much information, we are primed to understand that the man in front represents a beneficiary of a Pfizer product; the man in back is an onlooker, a witness, and yet an implicit participant in the overarching narrative.

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<sup>52</sup> “Pfizer Annual Report, 1986: Bringing Science to Life,” 11–13.



Figure 13: Full-page photo (resized for this page) in Pfizer's 1986 Annual Report.

This image points to an important rhetorical ambivalence between pharmocratic, multiculturalist philanthropy and (white) American patriotism, an ambivalence that shields from view the pharmocratic machinery upholding the Corporate Citizen subject. The Corporate Citizen subject is inherently oxymoronic: it is itself a (hypervisible) individual capable of care and duty, *and* an (invisible) corporate body exempt from the punitive aspects of citizenship. Straddling signs of the collective and signs of the individual, the Corporate Citizen enacts a kind of strategic essentialism, producing its own contradictory subjecthood. It is an anthropomorphized, singular figure that is simultaneously pluralized—a visible sign with an invisible body. Where is the body of the Corporate Citizen? What are its contours, its corpse?

In some ways, this chapter has attempted to answer these questions—to make the cultural machinery of the pharmaceutical industry visible. Today, Pfizer still casts corporate expansion as both a humanitarian necessity and an act of American patriotism. Echoing the rhetoric of bootstraps individualism, Pfizer frames the shift from local apothecary to transnational, multibillion-dollar industry as a rags-to-(world)-riches story, in which the self-starting owners of a small, family-owned shop seize a business opportunity and—with the right combination of hard work and innovative, entrepreneurial spirit—come to revolutionize the field of biomedicine across time and space for the next century and a half. The “Our Journey” section of Pfizer’s website is emblematic of this teleology, inviting users to “[j]ourney through Pfizer’s history from the first storefront to the beaches at Normandy to the New

York Stock Exchange” via an interactive digital timeline.<sup>53</sup> The first event (1849)

reads:

With \$2,500 borrowed from Charles Pfizer’s father, cousins Charles Pfizer and Charles Erhart, young entrepreneurs from Germany, open Charles Pfizer & Company as a fine-chemicals business. A modest red-brick building in the Williamsburg section of Brooklyn, New York, serves as office, laboratory, factory, and warehouse.

Their first product is a palatable form of santonin—an antiparasitic used to treat intestinal worms, a common affliction in mid-19th century America. Combining their skills, Pfizer, a chemist, and Erhart, a confectioner, blend santonin with almond-toffee flavoring and shape it into a candy cone. The “new” santonin is an immediate success and the company is launched.

The literal and metaphorical sugar-coating here is quite striking: although now widely known among medical professionals as a drug with potentially fatal side effects in malnourished children,<sup>54</sup> here, the “new” santonin not only purged consumers of their intestinal worms—it was also a tasty dessert. Pairing the familial relationship between Pfizer and Erhart with the \$2500 loan (comparable to about \$80,000 today) that pays for the “modest” yet remarkably multi-purpose building, the first paragraph evokes entrepreneurship, familial nostalgia; it is an assimilation success story in which German immigrants nobly perform their American citizenship, an apparent prerequisite to their fulfilment of the American dream. The rest of the timeline goes on to attribute quite a variety of impressively patriotic deeds to Pfizer’s production of tartaric acid and cream of tartar in 1862. According to

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<sup>53</sup> Inc Pfizer, “Our Timeline, 1849 - Present,” Our Journey, accessed February 4, 2018, <https://www.pfizer.com/people/history>.

<sup>54</sup> Santonin has long been replaced by safer drugs, but concern about santonin poisoning has circulated among pharmacologists and physicians since the early 1900s. See: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1658882/?page=1>

Pfizer, these compounds not only “help[ed] meet the needs of the Union Army,” but also made it possible for Mathew B. Brady, elsewhere described as the “father of photojournalism” as well as an “innovator, entrepreneur, and tireless self-promoter,” to photograph the Civil War.<sup>55</sup> The timeline marks another milestone at the year 1880, when Pfizer began selling citric acid to Coca-Cola, Dr. Pepper, and Pepsi-Cola, three iconically American soda companies.<sup>56</sup> Each description cites the soaring economic growth of the company, tying each product innovation not only to fiscal success, but also emblems of American patriotism, whether the product saves lives on the frontlines or brings American families to the dinner table.

Pfizer’s recent marketing projects also double down on this public image. In a recent television ad, Pfizer abandons naming specific drugs altogether, instead tracing the process by which an unnamed drug is made. While maintaining the drug’s anonymity absolves Pfizer of any accountability to laws that restrict them to promoting drugs only for FDA-approved purposes, this approach also allows for a renewed focus on their most reliable selling strategy: philanthropic science. Called

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<sup>55</sup> To emphasize just how bold Pfizer’s assertion here is: after Brady became famous for his series of thirty-five photos of Lincoln, apparently Lincoln said, “Brady and the Cooper Union speech made me President.” See: Mitchel P. Roth, “Brady, Mathew B. (1823-1896),” in *The Encyclopedia of War Journalism, 1807-2015* (Grey House Publishing, 2015).

<sup>56</sup> For more on the strong cultural association between Coca-Cola and U.S. empire, as well as a rich history of boycotting American soda companies, see: Bartow J. Elmore, *Citizen Coke: The Making of Coca-Cola Capitalism* (New York: W. W. Norton & Company, 2015); Maurice Jr M. Labelle, “De-Coca-Colonizing Egypt: Globalization, Decolonization, and the Egyptian Boycott of Coca-Cola, 1966-68,” *Journal of Global History* 9, no. 1 (March 2014): 122–42; Liang Yao, “Nationalism on Their Own Terms: The National Products Movement and the Coca-Cola Protest in Shanghai, 1945–1949,” *Modern Asian Studies* 51, no. 5 (September 2017): 1439–68.

“Before It Became a Medicine,” the sixty-second commercial begins with a fit, white man, presumably in his mid-thirties, brushing his teeth at the bathroom sink in a white undershirt and plaid pajama pants.<sup>57</sup> As he reaches into the medicine cabinet and pops the lid off of an unlabeled prescription container, the narrator—a disembodied, didactic male voice with a youthful, conventionally likeable vocal fry—begins:

Before it became a medicine, it was an idea, an inspiration—a wild, “What if?” So scientists went to work. They examined eighty-seven different protein structures; had twelve years of setbacks and breakthroughs; four thousand, four hundred and twenty-three sleepless nights; and countless trips back to the drawing board. At first they were told, “No.” “Well, maybe.” And finally: “Yes.” Then it was thirty-six clinical trials, eighty-five hundred patient volunteers, [pause] and the hope of millions.

A series of representative clips accompanies each sentence in the process described above. First, lab workers and researchers, each working in isolation at a lamplit desk littered with papers and bubbling vials, look up from their desks, one at a time, all apparently experiencing consecutive “Aha!” moments while the *tick-tock, tick-tock* of an omnipresent clock echoes in the background. Once the scientists “go to work” in the second sentence, the music picks up, and the action propels into fast-forward motion as scientists in Pfizer lab coats skitter from workspace to workspace in fluorescent-lit labs. They order a late-night pizza; they work in bed next to their sleeping spouses; they present charts to corporate representatives in a windowed boardroom. The “thirty-six clinical trials” and “eighty-five hundred patient

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<sup>57</sup> *Before It Became a Medicine* (Pfizer Inc.), accessed December 9, 2017, [https://www.pfizer.com/news/featured\\_stories/featured\\_stories\\_detail/before\\_it\\_became\\_a\\_medicine-0](https://www.pfizer.com/news/featured_stories/featured_stories_detail/before_it_became_a_medicine-0).

volunteers” are represented by three individuals of different races, genders, and ages, each of whom utters a playful “Ouch!” as a nurse injects a needle into each of their arms. Just before the narrator says, “the hope of millions,” the music fades, and the camera shifts to something new: hundreds of multicolored balloons floating up into a vast, bright blue sky, a symbolic expression of freedom, release, conquered limits. After lingering for a moment on the balloons, just long enough to see them begin to scatter in different directions, we return back to the first scene with the man in the bathroom, who has finished brushing his teeth. The narrator recites the final line of the commercial: “And so after it became a medicine, someone who couldn’t be cured, could be: [pause] me.” As the now embodied narrator utters the last word—“me,” with a slight upward inflection, as if surprised that all the work he described was done just for him—a blonde-haired toddler joyfully runs toward the man, who we are now led to assume is the boy’s father. Laughing, he picks up his son and the two embrace. The camera zooms in on their entwined faces, their eyes closed and lips smiling. A white glow emanating from a nearby window enshrines them, and the commercial ends. This is about crafting a multiculturalist image of the corporate citizen; it is corporate altruism commodified.

### **Conclusion: Misoprostol and Abortion**

When G.D. Searle first put Cytotec on the U.S. market in 1989, miso initially modeled this pharmocratic fusion of economic, intellectual, and philanthropic progress in newly profitable ways. First used to treat stomach ulcers caused by non-steroidal anti-inflammatory drugs (NSAIDs) in arthritic patients, it was, essentially,



a drug that treated the side effects of another drug, creating a kind of economic symbiosis between NSAIDs and Cytotec. According to a Chicago Tribune article in 1989, Searle was “sitting on a medical breakthrough and a potential gold mine.”<sup>58</sup> Searle published ads in popular medical journals and launched a six-part television mini-series on Lifetime describing how Cytotec treats NSAID-induced stomach ulcers, funneling millions of dollars into what they billed as an “education effort.”<sup>59</sup> Although a new set of problems emerged when clinicians realized that Cytotec could also prompt the same physiological mechanisms of a medication abortion, presenting a major legal and marketing liability, Searle representatives were confident they would “offset this disadvantage” and “crack this [ulcer] market.”<sup>60</sup>

Unexpectedly, Cytotec came to represent the possibility of revolution for two entangled but fraught sets of interests: those of profit-seeking pharmaceutical companies, for whom Cytotec was expected to bring substantial business; and those of reproductive rights activists, for whom Cytotec could bring radically safer clandestine abortion options. For the latter group in particular, the subversive possibilities seemed almost too good to be true: here was an abortifacient that had

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<sup>58</sup> Steven Morris, “Winner for Searle, Arthritis Sufferers,” *Chicago Tribune* (1963-Current File); *Chicago, Ill.*, April 9, 1989, 8.

<sup>59</sup> Morris, 8. According to an article in the *Detroit Free Press* in 1989, the FDA repeatedly threatened to take the “docu-drama” off the air because, not only was it clearly promoting Cytotec—a form of direct-to-consumer (DTC) advertising that would have required FDA-approval under the Federal Food, Drug, and Cosmetic Act (FDCA)—but it was also promoting off-label uses of Cytotec, which is never legal in DTC advertising. (This is probably why I have been unable to procure a copy of the series.) Apparently all six episodes aired anyway.

<sup>60</sup> Morris, 8.

the resources and institutional bandwidth of Big Pharma, which was eager to make the drug as easily accessible (i.e. buy-able) as possible. Reproductive rights activism appears to buy into Pfizer's pharmocratic rhetoric, once again marrying capital to freedom while erasing the conflicts of interest therein.

This is where the logics of pharmocratic cultural production—a nexus of technological edge, social progress, and business acumen—meet reproduction. The next chapter analyzes how recent journalistic discourses about underground misoprostol take up these mid-century pharmocratic threads, casting miso as a vehicle through which to perpetuate reproductive neoliberalism.



Figure 14



Figure 15



Figure 16

Figures 1-3 (above): Photos of ancient sculptures published in *Spectrum*, Pfizer's in-house science journal, in 1965.

## CHAPTER 2

### Imagining the Global South vis-à-vis Misoprostol

“Whatever the artist’s motive, he had a medical story to tell and he told it in clay.”<sup>1</sup>

The quote above comes from an article in one of the last issues of *Spectrum*, Pfizer’s in-house science journal that ran from 1952-1966. “Like an ancient physician lecturing to modern colleagues,” the article begins, “sculpture and pottery dug from the graves of Mexico and Central and South America tell us of the astonishing medical knowledge of civilizations that vanished long ago.”<sup>2</sup> According to the article, these clay pieces are “specifically medical in their subject matter.”<sup>3</sup> Inspecting a row of six “bowlegged” and “clearly female” figures resting on “primitive hospital beds” (rectangular slabs of clay, about four-by-two inches), the writer concludes that these figures “may therefore represent puerperal osteomalacia (a likely possibility in primitive society), with associated postpartum psychosis.”<sup>4</sup> As

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<sup>1</sup> *Spectrum* (Chas. Pfizer & Co., 1965), 27.

<sup>2</sup> *Spectrum*, 26.

<sup>3</sup> *Spectrum*, 26.

<sup>4</sup> *Spectrum*, 27. Osteomalacia [os"te-o-mah-la'shah], also called “rickets” in children, refers to “softening of the bones, resulting from impaired mineralization, with excess accumulation of osteoid, caused by a vitamin deficiency in adults... The deficiency may be due to lack of exposure to ultraviolet rays, inadequate intake of vitamin D in the diet, or failure to absorb or utilize vitamin D. There is decalcification of the bones, particularly those of the spine, pelvis, and lower extremities.” Puerperal osteomalacia is “exhaustion of skeletal stores of calcium and phosphorus by repeated pregnancies and lactation.” See: “Puerperal Osteomalacia,” in *Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health* (Saunders, an imprint of Elsevier, Inc., 2003), <https://medical-dictionary.thefreedictionary.com/puerperal+osteomalacia>.

though prodding readers to *Look!*, to witness the mid-century medical knowledge the sculptures are made to certify, the article's archaeo-medical fascination demands readers think of these ancient sculptors as performing a kind of medical-pharmaceutical modernity. This form of modernity is measured by the ancient sculptor's (or perhaps sculptors') ability to "capture the visible signs of malnutrition, deformity, physical and mental sickness, the stages of pregnancy and childbirth, the techniques of amputation, trephining and, it is believed, even cesarean section."<sup>5</sup> Apparently, ancient sculptors from the 4th century A.D. spoke the language of 1960s medical experts.

The writer's fascination with these ancient objects obscures critical parts of the story—for example, the fact that these five hundred or so sculptures were dug up from sacred gravesites; collected (as the article terms it) by Dr. Abner I. Weisman, Clinical Professor of Obstetrics and Gynecology of New York Medical College; and displayed at the Pfizer Building in New York from June 21-24, 1968. As humanities scholars writing about archaeological digs have argued, framing these acts of theft as "collecting" normalizes settler colonial violence against indigenous and Latinx peoples, descendants of these ancient sculptors who, according to the *Spectrum* article, simply "vanished" like a magic trick.<sup>6</sup> Yet once these objects are stolen from their ancient tombs, the processes of scientific study to which they become subject also produce a paradoxical indigenous subject: one who embodies hegemonic

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<sup>5</sup> *Spectrum*, 27.

<sup>6</sup> *Spectrum*, 26.

definitions of modernity and primitivism simultaneously, a contradiction that renders indigenous subjects as perpetually trying, working, aspiring to perform modernity, but always imperfectly. In other words, Global South knowledge here is defined as the imperfect *discovery of* Global North knowledge; the ancient artifacts act as evidence of both the primitivity of indigenous cultures and the timeless, static, “factness” of modern science. In this way, as Pfizer’s researchers explain and diagnose these clay sculptures and their sculptors, indigenous subjects become participants in “modern medicine” in a way that further exoticizes them; the ancient “physicians” who molded the sculptures are, by another kind of magic trick, made to posthumously participate in their own objectification. To what extent can indigenous subjects have epistemic agency here? What are the limits of this epistemic agency?

What seems to differentiate the Global North’s knowledge (Fact) and the Global South’s knowledge (imperfect discovery of Fact) is a surveillant gaze, one that wishes to find or recuperate markers of liberal-modern definitions of equality, progress, and (secular) scientific empiricism. For instance, one of the full-page spreads features quite an array of allegedly maladic sculptures: three figures in different stages of pregnancy (Figure 14); a crouched figure with a bubbly, coral-like crust covering their abdomen and face (Figure 15); and two joined, crowned figures, their arms wrapped around one another’s shoulders, each clasping the other’s hand (Figure 16). The captions beneath each set of images shift abruptly between scientific and cultural registers. While the encrusted figure on the bottom left is described as an “[e]dematous male figure with skin and mucocutaneous lesions

identical in pattern” whose “[a]bdominal edema, swollen left arm, and agonized expression suggests that lesions may be terminal metastatic carcinomatosis” or the “gummatous stage of tertiary syphilis,” the joined figures’ “diagnosis” is socio-cultural: though they “may not represent Siamese twins,” the caption nevertheless explains, “In some tribes twins denoted infidelity; the second child, considered evidence of wife’s exposure to another male, would be killed, and the wife severely punished.”<sup>7</sup> This impulse—to both diagnose and pathologize the sculptors and sculpted, even while claiming that the sculptures are specifically, inherently “medical”—reflects a desire not to meaningfully attribute a kind of medical-scientific intellect to ancient peoples, but rather for the writer to perform pharmocratic identity: modern, progressive, scientifically *and* socially advanced. The sculptors can never fully embody modernity because the pharmocratic gaze requires that they be understood as socially and culturally unsophisticated. In other words, the article is not about the sculptors, but about telling a story in medical terms about what *was*, about who *was*, about translating ancient embodied experiences into the language of modern medicine. From this perspective, we might revise the writer’s claim—“Whatever the artist’s motive, he had a medical story to tell and he told it in clay”—to a far more straightforward observation: Whatever the writer’s motive, he had a medical story to tell and he told it in *Spectrum*.

This chapter explores how and why this labor of being *almost* modern—of performing a kind of scientific and medical prowess that normalizes pharmocratic

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<sup>7</sup> *Spectrum*, 29.

logics of social and scientific progressiveness—shows up in much more recent journalism about underground markets for misoprostol. I begin this chapter with *Spectrum* because it so strikingly models the processes of cultural production that I see at work in this journalistic archive: using the affect of fascination and mystery, writers endow Global South subjects with techno-scientific agency, but only to the extent that this agency further entrenches Global South subjects into joined rhetorics of primitivism and self-responsibilization. This discourse—which starts in the late 1980s, goes silent for nearly ten years, and then repeatedly reemerges as “news” from 2000 to the present—reveals the journalists’ liberal-progressive desire to endow Global South subjects with a specific kind of techno-scientific and entrepreneurial agency, one that reflects and upholds the ideology of reproductive neoliberalism.

As I describe in the Introduction, reproductive politics scholars have focused intensively on right-wing rhetoric (marked broadly by xenophobic anti-immigration sentiments, paranoia about tax fraud, and devotion to bootstraps economics) for perpetuating the fiction of overpopulation that has historically enabled systemic obstetric violence. While we might expect the same right-wing thinkers to engage in the discourse about underground misoprostol, perhaps with even more xenophobic gusto, what makes the journalistic discourse about underground miso so unique from other abortion discourses is that it appears almost solely in mainstream liberal journalism, where issues of race, gender, rights, poverty, and women’s health are read through the lens of liberal-progressive humanism. In this way, miso’s



journalistic archive illustrates the sometimes counterintuitive ways that pharmocratic logics take root in liberal-progressive discourses. I ask: How does mainstream liberal-progressive journalism employ the rhetoric of archaeo-medical fascination and modernity/primitivism? What role do these narratives play in the expression and production of reproductive neoliberalism? What cultural imaginaries and pharmaceutical subjects does this kind of journalism encode, and to what ends?

As I will show, strikingly similar to the *Spectrum* piece described at the beginning of this chapter, journalists read miso-users and underground sellers through the lens of reproductive neoliberalism, recruiting representatives of the Global South to perform a kind of *approximate* modernity—performances that are, by design, failed performances. I argue that these journalistic pieces reflect a liberal desire to endow figures of the Global South with a kind of pharmaceutical savvy that comes to define women's agency; yet, ironically, this agency can only be legible through a distorted ethnocultural spectacle, a kind of journalistic violence that gets read and validated as "progressive." In this way, the Global South subjects who are both impacted and produced by the discourses of reproductive neoliberalism occupy an impossible subject position: one in which their agency is contradictorily read as performing, threatening, and being victim to pharmocratic forms of modernity. By reading women's (reproductive) agency specifically as an ability to use pharmaceutical products, journalists implicitly endorse the pharmocratic structures that prop up reproductive neoliberalism.

## **Imagining Brazilian Women: Vigilantes in “Wholesale Defiance”**

The first few journalistic pieces written about miso-induced abortions jumpstart a number of statistical inaccuracies that journalists have repeated to this day—statistics that help to produce an image of Latinx women seeking self-induced abortion as engaged in a kind of mysterious pharmocratic subversion. To some degree, mainstream liberal journalism situates underground miso in the same population-centered, Malthusian logics reproductive politics scholars mostly attribute to right-wing conservatism. Referencing two studies about underground miso published in the *Lancet*, a well-known medical journal, James Brooke writes in the *New York Times* that the studies “shed new light on the shadowy world of abortion in Brazil, Latin America’s most populous nation.”<sup>8</sup> Throughout, the United States serves as the point of comparison for understanding Brazil’s population statistics, distorting the realities of clandestine abortion in both countries. Calculating that, although the number of abortions per year in Brazil is the same in the United States, the latter’s population is “about a hundred million more than that of Brazil,” Brooke’s arithmetic insinuates that Brazilian women (successfully) opt for abortions at a much higher rate than women in the United States do. In another instance, Brooke compares the annual number of women in Brazil treated via curettage (a very unpleasant medical procedure in which tissue vulnerable to

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<sup>8</sup> James Brooke, “Ulcer Drug Tied to Numerous Abortions in Brazil: At \$6 a Dose, Wholesale Defiance of an Abortion Ban,” *New York Times*, May 19, 1993.

infection is preventatively “scraped” out of the womb) to the annual number of women in the United States who are hospitalized for abortion complications:

Curettage was the fourth most frequent medical procedure conducted in Brazilian public hospitals in 1991, where the operation was performed on 342,000 women. About 10,000 American women are hospitalized yearly for abortion complications. The drug, which is available in the United States only by prescription, is not thought to be used there to induce abortion.

While the numbers themselves are striking—342,000 women in Brazil compared to 10,000 women in the United States—they are troublingly misleading, as they are not actually measuring the same phenomenon: curettage *can* be a treatment for abortion complications, but it is also a treatment for miscarriage and retained placenta, as well as to remove abnormal endometrial cells from the vaginal wall, very common conditions (particularly because women are at a significantly higher risk of retained placenta if they have a cesarean section) that have nothing to do with abortion.<sup>9</sup> In the last sentence of the above passage, Brooke not only incorrectly reports that women in the United States do not use miso for abortion, but also implicitly attributes this deceptive statistical comparison to the United States’ tighter regulation of miso, reasoning that “with the world’s largest Roman Catholic population, few

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<sup>9</sup> “Retained placenta” refers to placenta tissue that stays attached to the womb, even after the body expels the placenta following birth. The American College of Obstetricians and Gynecologists (ACOG) notes that incidence of retained placenta has significantly increased in the United States, ranging from a rate of 1 in 2,510-4,017 in the 1970s and 80s to a rate of 1 in 272 in 2016. See: “Placenta Accreta Spectrum,” American College of Obstetricians and Gynecologists, accessed October 9, 2019.

politicians [in Brazil] want to confront the problem posed by 1.5 million clandestine abortions performed each year.”<sup>10</sup>

This language constructs an image of Brazilian women as frugal and resourceful on one hand, while culturally and pathologically inclined to seek clandestine abortions on the other hand, an image that perpetually reemerges in later journalism about underground miso in and beyond Latin America. According to Brooke, Brazilian women go to “[great] lengths” to procure abortions, lengths that the bolded byline—“At \$6 a dose, wholesale defiance of an abortion ban”—puts into economic terms, as though suggesting that miso enables Brazilian women to buy-in-bulk their own rebellion, despite the reality that poor women are most likely to seek self-induced abortion of any kind. It is quite frankly irresponsible to suggest that seeking the most inexpensive abortion methods is evidence of women’s defiance against tight abortion restrictions or bans; rather, it is more likely reflective of the fact that flea markets are often one of the few viable sources of a host of basic essentials—not just medicine, but also healthy food and clothing.<sup>11</sup> Instead, Brooke predicts that underground miso acts as a medium through which Brazilian women can engage in criminal (reproductive, pharmaceutical, entrepreneurial) behavior and deception, warning about the legal loopholes miso-induced abortion presents: “a Brazilian woman *could* claim she had a miscarriage and *could* legally check into a hospital for emergency curettage, or scraping of the womb, which completes the

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<sup>10</sup> Brooke, “Ulcer Drug Tied to Numerous Abortions in Brazil: At \$6 a Dose, Wholesale Defiance of an Abortion Ban.”

<sup>11</sup> Patricia Zavella to Cecelia Lie-Spahn, September 3, 2019.

abortion” (emphasis mine). Although sympathetic to the legal restrictions on abortion in Brazil, Brooke ignores the correlation between poverty and incidence of self-induced abortion, instead reproducing a juridico-surveillant gaze that reads women’s agency and the flea market itself as always-already criminal.

The kind of strategic cunning Brooke associates with miso-induced abortion is at odds with his later report that Brazilian women do not know how to use birth control pills:

Although the Brazilian birthrate has dropped sharply over the last 25 years [with the average dropping from six to three children per family], birth control is still erratic... [O]ne-quarter of Brazilian women who do not want to become pregnant use no birth control. Ninety percent of those who use one method, birth control pills, buy them over the counter at pharmacies, with little or no instruction as to their use.

The message here is that Brazilian women are smart, strategic, self-motivated, even entrepreneurially inspired when it comes to using miso as an off-label abortifacient, but not so when it comes to birth control pills. While it makes sense that women would be knowledgeable about birth control in a different way than about misoprostol, the distinction Brooke makes between knowledge about birth control pills and that of off-label miso here is less about analyzing how pharmaceutical knowledge circulates differently from drug to drug (especially since, if anything, one would expect women to know more about how to use birth control pills than about how to use misoprostol off-label for abortion), and more about constructing an image of Brazilian women as exceptionally adept at using “illegal” underground drugs for clandestine abortion and lawless when it comes to the “legal” pharmaceuticals that help prevent pregnancy. Furthermore, by depicting Brazil as a

simultaneously pharmaceutically unregulated, hyper-religious area ripe for criminal behavior, the Global North becomes the implicit benchmark not only for how to effectively teach women about their contraceptive options, but also for progressive, secular policymaking and responsible pharmaceutical regulation.

Although nearly a decade passed before any journalists wrote about underground miso again, many of these same patterns of Global South subject production reemerged when the story was taken up again in 2000. Journalists repeatedly cite the same legal, cultural, and health barriers to progress in the Global South: restrictive abortion laws; a corrupt government ruled by political greed; religious conservatism; and the World Health Organization's (WHO) statistics on unsafe abortion and maternal mortality and morbidity. The phrase "Up to 70,000 women die a year from complications of abortions" appears in nearly every article, despite a publication span of over fifteen years and the reality that this number only reflects the year 2001.<sup>12</sup> In this way, mainstream liberal journalism depicts the

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<sup>12</sup> For specific examples, see: Amy Allina, "Women Taking Abortion Pills on Their Own," *The Women's Health Activist* 39, no. 4 (July 2014): 4–4,7; "Backtalk," *Mother Jones* 26, no. 2 (March 2001): 12; Emily Bazelon, "'I Retrieved the Medicine from the Post in Nairobi Yesterday. I Kissed the Pills When They Fell Into My Hand.'" *New York Times (1923-Current File)*, 2014; Erik Eckholm, "A Pill Available in Mexico Is a Texas Option for Abortion," *The New York Times*, July 13, 2013; Ann Friedman, "Mail-Order Abortions," *Mother Jones; San Francisco*, Nov/Dec 2006; David Goodman, "Forced Labor," *Mother Jones*, 2001; Nicholas D. Kristof, "Another Pill That Could Cause a Revolution," *New York Times*, August 1, 2010; Jennifer S. Lee and Cara Buckley, "For Privacy's Sake, Risking Do-It-Yourself Abortion," *New York Times (1923-Current File)*, 2009; John Leland, "Abortion Might Outgrow Its Need for Roe v. Wade," *New York Times*, 2005; Sharon Lerner and Christina Cauterucci, "The DIY Abortion," *Slate*, January 18, 2011; Nina Liss-Schultz, "The New Abortion Underground," *Mother Jones* 43, no. 2 (March 2018): 46–51,58; Aaron Nelsen, "Taking Calls On Abortion, And Risks, In Chile," *New*

Global South as having failed to embrace modern juridical and statistical grammars of Progress such as women's rights, fertility decline, and secular governmentality.<sup>13</sup>

At the same time, the journalism continues to cast Global South women as extraordinarily, techno-scientifically savvy, but only when it comes to the extra-legal buying and selling of underground misoprostol. This contradiction epitomizes the fused humanitarian and capitalistic rhetorics that undergird reproductive neoliberalism: racialized primitivism on one hand, economic and techno-scientific individualism on the other.

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*York Times (1923-Current File)*, 2013; Louise Rimmer, "Hard to Swallow: These Pills Were Designed to Treat Ulcers. But to Millions of Latin American Women Denied Legal Abortion, They Have Become a Controversial Symbol of Hope," *The Independent; London (UK)*, September 2, 2003; Thanh Tan, "Looking to Mexico for Alternative to Abortion Clinics," *The Monitor; McAllen, Tex.*, August 13, 2012; Phoebe Zerwick, "The Rise of the DIY Abortion," *Glamour*, accessed March 14, 2017.

<sup>13</sup> This is besides the point, but this depiction is especially unfounded given that fertility has been radically declining in Latin America since the 1950s. Family planning studies frequently describe their work in Latin America as a booming success, citing statistics of declined unmet need for contraception. At the same time, these studies do not account for forced or coercive family planning practices, despite prolific scholarship on coercive sterilizations in the region. See: Martha M. Campbell, Ndola Prata, and Malcolm Potts, "The Impact of Freedom on Fertility Decline," *The Journal of Family Planning and Reproductive Health Care / Faculty of Family Planning & Reproductive Health Care, Royal College of Obstetricians & Gynaecologists* 39, no. 1 (January 1, 2013): 44–50; John Cleland et al., "Family Planning: The Unfinished Agenda," *World Health Organization, Sexual and Reproductive Health*, 3 (n.d.); John Cleland, Sarah Harbison, and Iqbal H. Shah, "Unmet Need for Contraception: Issues and Challenges," *Studies in Family Planning* 45, no. 2 (2014): 105–22.

## Centering the Self in Investigative Journalism

What makes the second batch of journalism (starting in 2000) distinct from the few pieces published in the early 90s is that, perhaps in the spirit of investigative journalism, almost all of the journalistic pieces from 2000 and on begin with the writer's own "encounter" with the flea market, spectacularizing the prospect of an underground pharmaceutical abortifacient originating in the Global South and making its way into the United States. Remarkably similar to the archaeo-medical fascination produced in the *Spectrum* article at the beginning of this chapter, journalists take on a kind of prophetic mysticism, marveling at the drug's revolutionary potential while cautioning against the dangers of underground pharmaceutical markets. This rhetoric exoticizes difference, centering the writer's experiences of said difference while claiming to unearth previously unseen truths. This is precisely the form of cultural production at work in the *Spectrum* article at the beginning of this chapter, in the sense that the techno-scientific innovations of Latinx women represented in these stories, however celebratory, only work to further marginalize and exoticize Latinx women via the rubrics of reproductive neoliberalism.

For example, in a 2014 piece for *The Atlantic*, Erica Hellerstein describes her encounter as a personal quest:

Under canopies in the converted parking lot, vendors in dark sunglasses stand behind tables heaped with piles of clothing, barking in Spanish and hawking their wares. The air is hot and muggy, thick with the scent of grilled corn and chili... I'm here to look for a small, white, hexagonal pill called misoprostol... As policies restricting access to abortion roll out in Texas and



elsewhere, the use of miso is quickly becoming a part of this country's story.<sup>14</sup>

The racial tropes here are reminiscent of colonial-era travel writing. Men “bark” and “hawk” like animals, their dark sunglasses masking their identities, while two stereotypically Tex-Mex dishes—grilled corn and chili—cook nearby. This flea market is described as temporary, transient, “converted” from its supposedly intended use (a parking lot) to another (apparently, to grill corn and sell miso), despite the fact that many of these flea markets are permanent. The “small, white, hexagonal pill” Hellerstein is looking for stands out against the image of piles of clothing and food. The final sentence raises alarm about border security: the “use” of miso is transgressive, a seemingly contagious phenomenon infiltrating the “story” of the United States—and fast.

This caricature of abortion-seeking women—women who “[know] exactly what to ask for at the small, family-run pharmacy”<sup>15</sup>—and persistently “shadowy” flea markets in the Global South must be understood in the context of a broader discourse about the supposed “backwardness” of Latinx culture and the gendered carceral logics of the United States’ war on drugs. Right-wing political and journalistic rhetoric on the war on drugs has historically cast Latinx people as the primary producers, traffickers, and consumers of so-called “illicit drugs” such as

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<sup>14</sup> Erica Hellerstein, “The Rise of the DIY Abortion in Texas,” *The Atlantic*, June 27, 2014, <http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/>.

<sup>15</sup> Jennifer 8. Lee and Cara Buckley, “For Privacy’s Sake, Taking Risks to End Pregnancy,” *The New York Times*, January 4, 2009, <https://www.nytimes.com/2009/01/05/nyregion/05abortion.html>.

heroin, marijuana, and cocaine.<sup>16</sup> Mothers have played a particular role in this narrative: while the prevailing rhetoric of the New Right beginning under the Reagan administration accused poor mothers—especially single, Black mothers—of cashing in welfare checks to pay for their supposed drug addictions, Latinx women were, too, painted as excessively reproductive, having so-called “anchor babies” they could not financially support in order to secure their residency and their families’ future citizenship. For Latinx mothers in particular, the New Right’s outrage hinged not only on the question of tax fraud, but also on a belief about Latin American “culture,” one that “highly values the woman’s ability to procreate a family” with “almost a religious significance.”<sup>17</sup> These infantilizing and xenophobic narratives not only worked to legitimize tax-payer resentment, contributing to the fiction that Latinx communities were “stealing” the jobs of hardworking Americans and sapping social programs funded by American taxpayers, but also made borderland communities a nearly exclusive target of the war on drugs. As a result, Latinx women have been disproportionately incarcerated for drug-related crimes in the United States, especially as the United States has continued to privilege funding for Immigration and Customs Enforcement (ICE) and the Drug Enforcement

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<sup>16</sup> Juanita Diaz-Cotto, “Latinas and the War on Drugs in the United States, Latin America, and Europe,” in *Global Lockdown : Race, Gender, and the Prison-Industrial Complex*, ed. Julia Sudbury (New York: Routledge, 2005), 137.

<sup>17</sup> Elena R. Gutiérrez, *Fertile Matters: The Politics of Mexican-Origin Women’s Reproduction*, 1st ed, Chicana Matters Series (Austin: University of Texas Press, 2008), 46; Roberts, *Killing the Black Body*.

Administration (DEA).<sup>18</sup> This context profoundly shapes the U.S. discourse about underground miso specifically and reproductive imaginaries of the Global South more broadly.

It is thus tempting to read these stories about underground miso as re-enacting the fantasy of colonial encounters with the racialized Other “in need” of civilizing. Gayatri Spivak might call these racial tropes acts of “subjective essentialism,” in which a Western gaze re-presents a supposedly authentic or otherwise made to be “real” non-Western subject.<sup>19</sup> As bell hooks puts it, “Within commodity culture, ethnicity becomes spice, seasoning that can liven up the dull dish that is mainstream white culture... In many ways it is a contemporary revival of interest in the ‘primitive,’ with a distinctly postmodern slant.”<sup>20</sup> Masked by the factness or constructed authenticity of detailed physical and spatial descriptions, these investigative journalism pieces only reaffirm this savior-complex reading.

Yet while the New Right reads underground markets as evidence of a kind of innate exploitative greed and dereliction in Latin American people—so-called “breeders” of disease, criminality, primitivism, and economic and environmental destruction<sup>21</sup>—reproductive neoliberalism indexes these underground markets as

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<sup>18</sup> Diaz-Cotto, “Latinas and the War on Drugs in the United States, Latin America, and Europe,” 138.

<sup>19</sup> Gayatri Chakravorty Spivak, *A Critique of Postcolonial Reason: Toward a History of the Vanishing Present* (Cambridge: Harvard University Press, 1999), 264.

<sup>20</sup> bell hooks, *Black Looks: Race and Representation* (Boston: South End Press, 1992), 21.

<sup>21</sup> Briggs, *Reproducing Empire*; Gurr, *Reproductive Justice*; Gutiérrez, *Fertile Matters*; Roberts, *Killing the Black Body*; Silliman et al., *Undivided Rights*; Stern, *Eugenic Nation*.

evidence of Global South women's desire for liberal-modern markers of progress in the Global South—i.e. free markets and rights—rather than as desires for bodily autonomy. This narrative works to justify the dangers these journalists inflict on clandestine abortion providers and seekers, even when they explicitly wrestle with the reality that they could be “ratting out” the revolution:

I talked to dozens of clandestine providers, and our conversations offer a rare glimpse into a world that is shrouded in secrecy and fear. Some urged me not to write about their work. But their efforts reveal a new aspect of how the war on reproductive rights has played out, and how a new generation of activists has come to believe that it's reasonable to handle this aspect of women's health care outside a medical setting. And they are determined to give more women that opportunity, no matter the legal risk.<sup>22</sup>

After dismissing the fears expressed by her informants, the journalist justifies her decision to report on underground miso anyway by citing its epistemic value, even if only offering a “glimpse.” The “efforts” women have taken to survive become models not only of reproductive rights activism, but wartime ideals of determination, reasonability, and risk-taking.

Yet what is most remarkable in this passage is that, rather than depicting subjects of the Global South as overly reproductive bodies to be culturally and physically *remedied*, mainstream liberal journalists refigure subjects of the Global South as reproductive vigilantes whose individual actions need to be existentially *redeemed*. In other words, instead of following suit with conservative anti-immigration rhetoric that renders non-white (over)reproductivity dangerously irresponsible, the mainstream liberal journalism in which these discourses primarily

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<sup>22</sup> Liss-Schultz, “The New Abortion Underground,” 48.

appear turn individual reproductive risk into a kind of social responsibility—a form of civil disobedience necessary to embrace neoliberal definitions of reproductive freedom. In this context, we might understand these journalistic texts as a manifestation of a liberal-progressive fantasy in which the street vendor’s skilled subversion of the state’s social conservatism and undisciplined market forces actually *enable* progressive activism in the Global South. This redemption narrative is consistently premised on a racialized fantasy of necessary criminality; those described as buying and selling miso “underground” can only be read as redeemable against the backdrop of a kind of socially responsible, forgivable form of criminality. In this way, Global South subjects are simultaneously subversively agentic and the non-agentic effect of a backwards legal/cultural context, carrying forth the torch of liberal modernity despite the personal costs.

To be clear, the public health and legal circumstances these journalists perceive here are legitimately concerning. It cannot be overstated that more adequate legal protections—legal work premised on the understanding that the need for self-induced abortion is deeply connected to the political, economic, and cultural structures in which it occurs—would not only help prevent people from being criminally targeted for self-inducing abortion, but also help protect them if prosecuted.<sup>23</sup> The problem is that, rather than pointing to the deeply entrenched systems of violence (i.e. not exclusively juridical) that hurt poor women of color the most, these journalistic discourses (however well-intentioned) contradictorily read

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<sup>23</sup> Adams, Mikesell, and The SIA Legal Team, “Primer on Self-Induced Abortion.”

underground miso as both a conduit through which to speculate about Latinx criminality and a catch-all solution to achieving reproductive freedom. As a consequence, underground miso gets read as evidence of the efficacy of so-called “DIY” or “self-help” strategies said to be newly enabled by liberal and technological modernity, propelling reproductive neoliberalism in the form of a deeply misguided assumption that major economic and institutional change is unnecessary for women to achieve reproductive freedom. In other words, under reproductive neoliberalism, pharmaceutical agency is said to be all that is required to achieve Euro-America’s liberal humanist vision of reproductive freedom, moving the focus away from systemic change and onto individual actions.

This is the central violence this journalism produces: the deeply racialized language in liberal-progressive journalism distorts women’s desire for bodily autonomy as evidence of the dangerous and yet liberatory possibilities of pharmocracy itself. In other words, the journalism misconstrues women’s desire for control over their own bodies—and the powerfully creative and agential ways in which women have historically pursued this—into an impossible Global South subjectivity: one that is only read as agential when her desire for bodily autonomy is characterized as simultaneously a desire for and yet threat to the pharmocratic market structures Pfizer espouses in Chapter 1. This is an updated version of what Saidiya Hartman describes as “benevolent corrections and declarations” of humanity

that, perhaps counterintuitively, act to “teether, bind, and oppress.”<sup>24</sup> In this case, Latinx women’s humanist “agency” gets re-scripted as either criminal or evidence of liberatory techno-science, ignoring the impact of poverty that powerfully shapes the ways women seek reproductive healthcare. It is therefore no coincidence that so much of the investigative journalism focuses almost exclusively on the entrepreneurial ethics of the flea market vendors: under reproductive neoliberalism, pharmocratic individualism masquerades as attention to the systemic (law, poverty, politics), reading women’s creative agency as permission to maintain the structures of neoliberalism more broadly.<sup>25</sup> This form of U.S.-based journalistic violence is important not simply because it is offensive, but because it fulfills the pharmocratic desires described in Chapter 1: it redirects public attention from pharmaceutical companies to its users, reproducing the individualist paradigms of reproductive neoliberalism.

### **Fantastic Markets: Temporalities of Underground Miso**

While quick to point out the juridical and cultural contexts that inhibit reproductive freedom for women in the Global South, journalists almost completely

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<sup>24</sup> Saidiya V. Hartman, *Scenes of Subjection: Terror, Slavery, and Self-Making in Nineteenth-Century America*, Race and American Culture (New York: Oxford University Press, 1997), 5.

<sup>25</sup> This is in spite of the reality that women who have abortions are more likely to be poor; and since 1976, the Hyde Amendment has barred the use of federal funds to pay for abortions except if the pregnancy arises from incest or rape, or when a pregnant woman’s life is endangered. See: Sabrina Tavernise, “Why Women Getting Abortions Now Are More Likely to Be Poor,” *The New York Times*, July 9, 2019, <https://www.nytimes.com/2019/07/09/us/abortion-access-inequality.html>.

ignore the pharmaceutical industry, erasing the material realities within which underground markets for miso emerge, but also basic facts about the drug. For example, none of these U.S.-based journalistic texts explain where miso is manufactured (Connecticut). Rather, they consistently describe underground miso as coming into the United States from the Global South, reflecting liberal anxiety that southern states have become so antithetical to the progressive agenda, so alienated from the political ideologies of iconically progressive states (e.g. Vermont, California, New York), that they have now taken on the “backwards” cultural politics associated with a monolithic image of the developing world. An article published in *Women’s Health Activist*, a journal supported by the National Women’s Health Coalition, begins with this very concern:

When a woman in Idaho, who had taken drugs that she ordered over the Internet to end her unintended pregnancy, told a friend about what she experienced, she ended up under arrest, charged with a felony for having an illegal abortion.

When a woman in Mexico suspects she might be pregnant when she doesn’t want to be, she can buy drugs at a pharmacy or an informal market that she can take at home to bring on her period.<sup>26</sup>

The writer’s observations above literalize her own surprise: how could it be that, in a backwards place with limited legal abortion opportunities, women can apparently so easily procure an abortion? How could it be that they don’t even have to call it abortion?

In this way, discourses about underground miso are deeply entangled with an almost existential curiosity about the flea market itself: what constitutes a market,

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<sup>26</sup> Allina, “Women Taking Abortion Pills on Their Own,” 4.



where markets can exist, what can be sold at them, who can sell at them, even what these markets look like (though still, no questions about the pharmaceutical industry). Detailed descriptions of the flea market position readers at the limits of consumer familiarity and desire, marking the flea market as a kind of consumer wonderland where everything is available in mass quantities and everything is cheap. In a 2014 article about abortion in developing countries (also quoted in the Introduction), Jason Beaubien writes:

In the central market in San Salvador, you can buy just about anything you want: tomatoes by the wheelbarrow full. Fresh goat's milk straight from the goat. Underwear. Plumbing supplies. Fruit. Hollywood's latest blockbusters burned straight onto a DVD.

And in the back of the market, in a small stall lined with jars of dried herbs, roots and mushrooms, you can buy an abortion.

Although purchasing underwear and milk at the same time is pretty routine for most readers, or at least those immersed in superstore culture à la corporate giants like Walmart and Target, journalists tend to indulge the eccentricity of this one-stop-shop experience. In the process, notions of difference solidify into commoditized objects. Racial and cultural fetishisms spill over, extending through and beyond the body: polarized notions of modernity and primitivism, here indiscriminate from the dichotomy of whiteness and blackness/brownness, map not only onto the animate bodies in the scenes, but also onto the inanimate objects. If boxes of Advil represent the technological advances developed by the biotech industries of the Global North, the black and brown, non-Western bodies that sell these drugs act as the Global North's exoticized corollary, a distorted opposite. The flea market becomes a place

of such unprecedented consumptive readiness that abortion itself—a complex, subjective experience *tied* to the body but is not itself neatly discernable as a unified, tangible body or thing—becomes commoditized in the form of a “white, hexagonal pill” (miso).<sup>27</sup> Miso itself becomes a racialized and racializing good one can “buy” in the back of a street tent.

Yet while these dichotomous notions of modernity and primitivism are essential for casting misoprostol as one among many unexpected commodities in the flea market, miso also represents multiple, contradictory forms of essentialism that cannot be neatly classified into unidirectional or bidirectional Subject/Other relationships. For instance, the act of classifying objects that do not belong—culturally, temporally, racially—from those that do ironically produces a kind of double-racialization in which misoprostol is *both* an object of whiteness *and* its exoticized opposite. Recontextualizing the NPR piece below, the breaks between paragraphs quite literally compose this double-racialization:

In the central market in San Salvador, you can buy just about anything you want: tomatoes by the wheelbarrow full. Fresh goat’s milk straight from the goat. Underwear. Plumbing supplies. Fruit. Hollywood’s latest blockbusters burned straight onto a DVD.

And in the back of the market, in a small stall lined with jars of dried herbs, roots and mushrooms, you can buy an abortion.

“I have all types of plants to treat all kinds of diseases,” the woman who runs the shop says through an interpreter. “For example, problems with your liver, your kidneys, stomach problems, nerves, for cancer—for everything.”

She says she also has a bitter tea that can take care of an unwanted pregnancy.

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<sup>27</sup> Hellerstein, “The Rise of the DIY Abortion in Texas.”

Abortion is completely banned in El Salvador and punishable with a prison term of anywhere from two to 50 years in prison. So this woman asks that we not use her name.

Her tea only works, she says, in the first six weeks of pregnancy. If a woman is seeking an abortion later than that, the herbalist arranges to get something far stronger from a local pharmacy: pills used to treat stomach ulcers that are sold generically as misoprostol.<sup>28</sup>

In the excerpt above, each new paragraph categorizes the objects and practices that belong from those that do not. The offset paragraph about “taking care of an unwanted pregnancy” subsumes the previous paragraph, which describes ample stocks of plant-based medicine used to treat ailments as far-ranging as stomach problems and cancer (“I have all types of plants to treat all kinds of diseases”). By contrast, abortion apparently requires a “far stronger,” more effective method that can only come from a pharmacy. In other words, this placing of pharmaceuticals as a *contrast* to plant-based medicine exacerbates the perceived ineffectiveness of the herbalists’ knowledge and relative “strength” of Western pharmaceuticals. It also defines abortion as a trial-and-error process that necessitates pharmaceutical intervention when “primitive” methods fail. This privileging of miso as the more effective option produces a meeting point of racial, economic, and pharmaceutical narratives that marginalizes and exoticizes indigenous medical expertise while marveling at its resourcefulness.

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<sup>28</sup> Beaubien, “Even When Abortion Is Illegal, the Market May Sell Pills for Abortion.”

This contradictory essentializing renders miso itself a metamorphic object, one that comes to signify the scientific achievements of the Global North and the combined economic resourcefulness and criminality of the Global South at the same time. For example, it is only when miso is consumed as an abortifacient that it becomes an import from the Global South. This is best reflected in left-leaning journalism that depicts the underground sale of miso as a workaround solution to anti-abortion legislation in the southern United States, a zone with so much organized resistance to abortion that, in 2017, the Lady Parts Justice League facetiously awarded state representatives for “Best Original Science” and “Best Adaptation of Reality.”<sup>29</sup> For instance, in 2013, mainstream liberal journalism on clandestine abortion was primarily concerned with Texas Senate Bill 5 (Texas SB 5), which would have required all abortion clinics in the state to adhere to the structural requirements of an ambulatory surgical center, shutting down over half of the abortion clinics since 2013 despite the Supreme Court overturning the bill in 2016. Because of this bill, the shape and size of abortion clinics in Texas not only came to determine the legality of the procedure, but also prompted journalists to focus on the aesthetics of over-medicalized spaces the bill threatened to necessitate. One *New York Times* journalist compares the before-and-after aesthetics of a Whole Women’s Health Clinic in McAllen, Texas:

With plush recliners, a Georgia O’Keeffe flower print on the wall and herbal tea, the center’s recovery room resembles a small first-class lounge. Ambulatory surgery centers, in contrast, must have large, hospital-style

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<sup>29</sup> *Texas: Best Original Science*, Film (Lady Parts Justice League), accessed August 3, 2017, <http://www.ladypartsjustice.com/video/texas/>.

recovery rooms, with medical equipment on the walls. Patients must rest on gurneys, separated by ceiling-mounted curtains. The herbal tea would not be allowed.<sup>30</sup>

The excerpt above reflects nostalgia for a physical space that disrupts the affective sterility of hospitals, a place where “patients must rest on gurneys” and where “the herbal tea would not be allowed.” While it makes sense that left-leaning journalists would highlight the administrative absurdity of the legislation, the description above speaks to an anxiety about hitting the right balance of medical expertise and the “natural” (flowers, tea), reinforcing the idea that medical aesthetics are intrinsically in conflict with the latter.

In this context, misoprostol signifies the ability to have an abortion without sacrificing one’s relationship to other “natural” or “organic” signifiers. Rather than emphasizing the strength of pharmaceuticals as a marker of biomedical triumph, miso comes to represent the potential to de-professionalize abortion in the United States, what has been labeled in several contexts as the latest “DIY” abortion method.<sup>31</sup> As various forms of DIY healthcare have long been a part of feminist activism in the United States—DIY speculums of the 1970s, vacuum aspiration abortions, menstrual regulation—the DIY-ness associated with miso abortions prompts the repetition of very old one-liners about women’s reproductive rights. For instance, a *New York Times* article quotes Dr. Jerry Edwards, an abortion provider in Little Rock, Arkansas, stating: “We won’t go back to the days of coat hangers and

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<sup>30</sup> Eckholm, “A Pill Available in Mexico Is a Texas Option for Abortion.”

<sup>31</sup> Hellerstein, “The Rise of the DIY Abortion in Texas”; Lerner and Cauterucci, “The DIY Abortion”; Zerwick, “The Rise of the DIY Abortion.”

knitting needles. Rich women will fly to California; poor women will use Cytotec.”<sup>32</sup> In other words, whether or not medically supervised abortion is available will not prevent women from ending unwanted pregnancies. Ironically, Dr. Edwards’ insistence that we won’t “go back” to the days of coat hangers and knitting needles prompts him to resuscitate the same language of mainstream pro-choice advocacy of the very era he doesn’t want to go back to, right down to the sentence construction: rich women will get a surgical abortion; poor women will go to back alleys. In placing the responsibility for reproductive healthcare into the hands of the patients themselves, the liberal mainstream replicates the right’s notion of pulling up one’s bootstraps in the face of adversity.

Perhaps one of the most revealing public debates about using underground miso as a DIY abortifacient appears in the online comments to an anonymously written *Jezebel* article titled, “I Help Desperate Women, and I Could Go To Jail for It.”<sup>33</sup> After describing women who could not afford an abortion or could not travel to a clinic several hours away—women whom the author “know[s]...most of them so far are immigrants [sic]”—the author discloses that they mail these women a “small, unmarked envelope” containing misoprostol. “I am one of America’s unlicensed, untrained illegal abortionists,” they confess. One commenter, “notso dumbblonde,” writes that they respect the author’s desire to “help people and provide medical care

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<sup>32</sup> Leland, “Abortion Might Outgrow Its Need for *Roe v. Wade*.”

<sup>33</sup> Anonymous, “I Help Desperate Women, and I Could Go To Jail for It,” *Jezebel*, accessed October 8, 2017, <https://jezebel.com/i-help-desperate-women-and-i-could-go-to-jail-for-it-1320076409>.

and opportunity that would otherwise be unobtainable,” but that they are concerned about the medical risk, asking:

But could you elaborate on your medical background a little more?...Especially if you're just (not saying you are) some random regular person who did a little internet search on drug side effects and decided to play pharmacist.

Notsodumbblonde is careful to support the blogger's impulse to “help” while challenging an ethical gray area in which this form of support presumes that anyone, even a self-proclaimed “unlicensed, untrained abortionist,” can take the place of a pharmacist or medical professional. The debate that then ensues revolves around questions of expertise. What constitutes expertise? What training is really necessary to prescribe off-label abortifacients?

yvanehtnioj > notsodumbblonde (9/17/13 12:19pm)

If someone in my house says they have a headache and I tell them I have aspirin, do I need to justify my medical training to do so? It's not like she's using some secret family recipe that she swears works wonders, the pills she's sending are made for this express purpose.

notsodumbblonde > yvanehtnioj (9/17/13 12:22pm):

I understand your point, and you make a good one, but these medications are not aspirin. They induce abortion, which to me sounds like they are a strong enough drug to be cautious of and not throw around. But that's just me, and I'm paranoid when it comes to “quick-fix” pills.

MilkCat > notsodumbblonde (9/17/13 12:27pm):

In most instances, they are, essentially, extra strength birth control pills (with some exceptions). So yes, there is always risk involved, but not nearly as much as some would have you believe.

The commenters here are all working through a few contradictory ideas about misoprostol. On one hand, miso is more powerful than aspirin and thus not something to “throw around.” On the other hand, miso is understood as a “quick-fix”

drug, no more powerful than “extra-strength birth control pills.” Some of these assertions are troublingly misguided—for example, miso is no more an extra strength birth control pill than saran wrap is an extra strength condom—but the conversation is indicative of how underground miso discourses become avenues through which to both redefine expertise and reallocate responsibility according to the paradigms of reproductive neoliberalism.

### **Consequences: Redistributing Pharmaceutical Risk**

One of the repeated assumptions in mainstream liberal media reporting on underground miso markets is that the highly corporatized pharmaceutical industry is, by contrast, “regulated.” In their fixation on the medical risks of taking miso for off-label purposes, journalists implicitly suggest not only that federal and state policies successfully protect consumers from economic and bodily exploitation, but also that underground misoprostol markets somehow evade these protections in more dangerous ways. The irony is that Pfizer’s own off-label marketing strategies over the last few decades have proven to be one of their biggest liabilities, and journalists have not missed the opportunity to broadcast the long list of egregious crimes and handsome settlements they have paid as a result. In 2004, Pfizer paid \$430 million to the federal government for the illegal marketing of Neurontin, a drug the FDA had approved to treat epilepsy, but was also being prescribed to treat bipolar disorder, Lou Gehrig’s disease, attention deficit disorder, restless leg syndrome, and seizures



from drug and alcohol withdrawal, off-label uses that made up ninety percent of their overall sales.<sup>34</sup> According to the *New York Times*, the court concluded that Pfizer

[...] suppressed study results, planted people in medical audiences to ask questions intended to put gabapentin [Neurontin] in a good light, lavished perks on doctors, used ghostwriters, gave generous “consultation fees” to “thought leaders,” and used psychological profiling of doctors in its successful bid to move gabapentin to so called blockbuster status (annual sales in excess of \$1bn).<sup>35</sup>

Using tactics usually associated with the FBI (e.g. psychological profiling, or “a range of techniques [mainly psychology based] for inferring the characteristics of offenders from crime scene behaviours in order to assist in the prioritizing of suspects and lines of inquiry”<sup>36</sup>), Pfizer clearly organized a highly elaborate, surreptitious campaign in order to reach sales goals. In 2009, Pfizer paid another \$2.3 billion settlement—the biggest settlement ever reached in U.S. criminal history—after the company was convicted of marketing off-label uses of Bextra, a painkiller that has since been withdrawn from the market.<sup>37</sup> In 2011, Pfizer paid over \$60 million in fines for violating the Foreign Corrupt Practices Act of 1977 (FCPA), which prohibits making payments to foreign government officials in order to win

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<sup>34</sup> Gardiner Harris, “Pfizer to Pay \$430 Million Over Promoting Drug to Doctors,” *The New York Times*, May 14, 2004, <https://www.nytimes.com/2004/05/14/business/pfizer-to-pay-430-million-over-promoting-drug-to-doctors.html>.

<sup>35</sup> Jeanne Lenzer, “Pfizer Pleads Guilty, but Drug Sales Continue to Soar,” *British Medical Journal* 328, no. 7450 (2004): 1217.

<sup>36</sup> Alison Laurence, “Offender Profiling,” in *Dictionary of Policing*, ed. Tim Newburn and Petere Neyroud (Willan Publishing, 2008).

<sup>37</sup> Gardiner Harris, “Pfizer Pays \$2.3 Billion to Settle Marketing Case,” *The New York Times*, September 2, 2009.

overseas business.<sup>38</sup> In 2014, journalists re-reported the Neurontin scandal when Pfizer paid a second installment of \$325 million toward the case. All told, Pfizer has paid at least \$4 billion to the federal government and individual whistleblowers for illegal marketing practices, most of which stemmed from their promotion of off-label drug use. According to John Kopchinski, a former Pfizer sales representative and one of the whistleblowers in the Bextra case, “The whole culture of Pfizer is driven by sales, and if you didn’t sell drugs illegally, you were not seen as a team player.”<sup>39</sup>

What is misleading about these reports is that, although the settlements do reflect intensified federal action against unethical pharmaceutical marketing practices, in reality, the fines (however impressive) do not discourage pharmaceutical companies from disseminating information about off-label uses of their products. While it is illegal for pharmaceutical companies to market drugs for off-label uses in the United States, physicians are free to prescribe drugs for off-label purposes provided that they are “well-informed about the product, base its use on firm scientific rationale and on sound medical evidence, and maintain records of the product’s use and effects.”<sup>40</sup> On one hand, this exception to federally mandated

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<sup>38</sup> Christopher Matthews and Joe Palazzolo, “Pfizer Near Settlement on Bribery,” *Wall Street Journal (Online)*; *New York, N.Y.*, November 21, 2011.

<sup>39</sup> Harris, “Pfizer Pays \$2.3 Billion to Settle Marketing Case.”

<sup>40</sup> Thomas Szivos, “Recent Developments in the Law of Off-Label Promotion of Prescription Drugs: Litigation and Federal Guidelines,” *American Journal of Law & Medicine* 35, no. 1 (March 2009): 238; FDA, “‘Off-Label’ and Investigational Use of Marketed Drugs, Biologics, and Medical Devices: Info Sheet,” Guidance for Institutional Review Boards and Clinical Investigators, accessed December 8, 2017, <https://www.fda.gov/RegulatoryInformation/Guidances/ucm126486.htm>.

marketing ethics policies allows physicians to treat illnesses that do not yet have a designated cure, providing treatment options to patients who would be otherwise untreatable. On the other hand, physicians' authority to prescribe drugs for off-label purposes presents a conflict between practices understood as "innovative medical care" and regulatory safeguards designed, at least in theory, to protect patients.<sup>41</sup> But perhaps even more troubling is the assumption that information mediated via "non-advertising" forms is inherently neutral—that the principles and formal qualities of an advertisement are distinct from those of scholarly, professional, or journalistic texts—despite overwhelming evidence that Pfizer manipulates these forms through fraudulent scientific studies, bribery, and even hiring ghostwriters in order to meet sales goals. From this perspective, it becomes clear that pharmaceutical companies are still incentivized to produce and distribute information about off-label drug use, just in alternative forms, ones the law cannot characterize as an advertisement. There is thus good reason to assume that, far from eliminating the fraudulent marketing practices for which Pfizer has been known for most of the twentieth century, recent convictions have only ushered in more covert forms of marketing fraud for which Pfizer cannot be held legally accountable.

Despite Pfizer's long criminal record of paying journalists to report on their drug products as a covert form of marketing, there have been no allegations that Pfizer was connected to journalistic texts about underground miso markets, and this

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<sup>41</sup> Szivos, "Recent Developments in the Law of Off-Label Promotion of Prescription Drugs," 238.

chapter has not aimed to make these accusations. Rather, my purpose here has been to show how the mainstream liberal media industry reproduces the underlying pharmocratic narratives Pfizer has deployed throughout the post-World War II period (the subject of Chapter 1). The question of whether or not Pfizer played a direct role in circulating these texts becomes less urgent when faced with the possibility that unethical practices like bribery and ghostwriting may no longer be needed to carry out illicit marketing practices specifically designed to generate corporate profit. From this perspective, mainstream liberal media appears to compensate for Pfizer's marketing limitations, not only creating a no-cost, low-risk form of illicit off-label advertising (from Pfizer's perspective), but also producing an implicit alliance—what Roderick Ferguson and Grace Hong might call a “strange affinity”<sup>42</sup>—between the pharmaceutical industry and mainstream liberal media.

Accordingly, both Chapter 1 and Chapter 2 have been primarily focused on the production and circulation of pharmaceutical knowledge vis-a-vis misoprostol. Chapter 1 historicizes the joint rhetoric of pharmaceutical patriotism and capitalism, while Chapter 2 illustrates how liberal-progressive journalism reproduces this pharmocratic project in new forms, rendering liberal-progressive journalism a critical site of pharmocratic knowledge production. The next chapter moves to another critical site of reproductive neoliberalism: family planning literature about underground miso.

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<sup>42</sup> Grace Kyungwon Hong and Roderick A. Ferguson, “Introduction,” in *Strange Affinities: The Gender and Sexual Politics of Comparative Racialization*, Perverse Modernities (Durham [NC]: Duke University Press, 2011), 2–22.

## CHAPTER 3

### Benevolent Interventions

“I feel like people must have felt when they discovered the nuclear bomb.  
This technology is world-shaking.”<sup>1</sup>

Dr. Beverly Winikoff  
President of Gynuity Health Projects

In 2009, Gynuity Health Projects and Venture Strategies for Health and Development (two reproductive health organizations based in New York City and Berkeley, respectively) submitted an application to the World Health Organization (WHO) to add misoprostol to the Model List of Essential Medicines (EML) for the treatment of postpartum hemorrhage. Of the more than twenty-six letters and studies Gynuity and Venture submitted for the application, all from some of the most elite public health organizations in the world (the American College of Obstetricians and Gynecologists, International Federation of Gynecology and Obstetrics, Marie Stopes International, Stanford School of Public Medicine), as well as one letter from Sigma Pharmaceuticals, all but one document depicts miso as a miracle drug for Third World mothers. According to the application, miso is the perfect drug for this population: it is inexpensive, user-friendly, multi-purpose, and able to withstand hot climates without refrigeration, a combination said to indicate its potential to nearly

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<sup>1</sup> Kristof, “Another Pill That Could Cause a Revolution.”

eradicate maternal death in the so-called developing world. Repeating the same figures and sense of urgency almost verbatim, the many letters and documents read like a chorus of pleas to support institutional recognition and community-based distribution of this “world-shaking” drug.

One of the documents, however, is an outlier:

Name: A Concerned Citizen WHO EML  
Email: zaidi-s@  
country: usa  
sector: health  
suggestion\_type: other\_general

Message: I am concerned about the attempts made by Venture Strategies and it's [sic] partners to include misoprostol in the WHO EML list. They use unethical practices to spread this drug at the community level in the underdeveloped parts of the world. All of us are aware that misoprostol is unsafe for pregnant women. However Venture Strategies is promoting it's [sic] use to cause abortions. We [sic] know that abortion must not be advocated as a means to control population and is not a method of contraception. However if WHO agrees with Venture Strategies and allows misoprostol use for PPH [postpartum hemorrhage] etc, there is a very serious reason for alarm.

Shabina H. Zaidi, MPH  
Electronic message, November 24, 2008

Compared to the other carefully researched and letterhead-ed documents the WHO considered, Zaidi’s hastily written message reads a bit like an alarmed conspiracy theorist. Yet her message does several important things. She rightfully situates family planning initiatives in a long history of covert population control projects, a history that family planning professionals have long tried to relegate to a phenomenon of the past. But even further, Zaidi’s message reveals the irony that

miso pits two of the most well-funded and recognized Safe Motherhood initiatives against each other: clandestine abortion and postpartum hemorrhage. In other words, the drug said to save women's lives from postpartum hemorrhage is the same drug that enables clandestine abortion, a phenomenon thought to be one of the most dangerous and pervasive causes of maternal death. In this way, Zaidi's message is poking a (thought-to-be) sleeping bear—it points to the central ethical tensions plaguing family planning debates about community-based distribution of misoprostol impacting the WHO's decision: should we be worried about miso being used for the “wrong” reasons? What if community-based distribution of miso just further enables clandestine abortion? And what if that is precisely Gynuity's unstated goal here? More fundamentally: for whom is misoprostol really the “ideal” drug?

Building on the last two chapters, which traced the pharmocratic narratives of individualism, responsabilization, racialization, and humanitarianism so central to the proliferation of reproductive neoliberalism, this chapter analyzes what I am calling an “ethics of rationality” in family planning discourses about obstetric uses of misoprostol. By “ethics of rationality,” I am referring to a form of neoliberal knowledge production that derives its moral, ethical, and humanitarian authority from the data-based methodologies characteristic of family planning sciences. In discourses about miso, family planning professionals both rely on and produce data that not only comes to define ethical problems, risks, and solutions, but to empiricize the ideologies of reproductive neoliberalism. I ask: How does this ethics of

rationality shape the moral and statistical paradigms these discourses reflect? Put another way, how does family planning data about underground miso materialize—as in, make material—the ideologies of reproductive neoliberalism? And whom does this particular manifestation of reproductive neoliberalism ultimately serve?

I argue that the ethics of rationality reflected in family planning literature about misoprostol both reproduces and ruptures the pharmocratic forces undergirding reproductive neoliberalism. Family planning debates about misoprostol are fundamentally motivated by a sense of humanitarian benevolence that, as Chapters 1 and 2 have discussed, places reproductive risk onto individuals, subjecting the so-called developing world to continued surveillance via case studies and clinical trials. At the same time, a small but powerful subset of family planning scholarship's performance of the ethics of rationality appears to function as rhetorical capital, an attempt not only to disrupt the Malthusian violence of their own discipline, but also to contribute to a much more expansive project of feminist knowledge production in support of the holistic and inclusive mission of reproductive justice. While this work inconsistently wavers between reproducing and resisting the forces of reproductive neoliberalism, I want to embrace these moments, however fleeting, as opportunities to materialize a form of resistance co-created by unlikely partners.

My goal here is not to suggest that performing an ethics of rationality to secure rhetorical capital is evidence of family planning's subversive relationship to its own discipline. Describing the joined languages of ethics and quantitative



rationalities as simply rhetorical moves would be reductive and overly speculative; frankly, it would let too much family planning scholarship off the hook. However, one of the goals of this chapter is to complicate existing reproductive politics scholarship that critiques the family planning discipline as a whole. This body of scholarship powerfully exposes the violent consequences of Malthusian paranoia about overpopulation; family planning initiatives' use of humanitarian rhetoric to justify state-supported pharmaceutical corporations' presence overseas, as well as disastrous government interventions; and more broadly, the distortive pitfalls of data-based analysis, which have not only racialized and gendered practices of medicine and public health, but also subjected people of color in particular to mass surveillance and abuse of the data collected.<sup>2</sup> As I will show, these forms of epistemic, physical, and identity-based violence are indeed reflected in family planning literature on obstetric uses of misoprostol, and I intend to sustain these critiques, situating each section of this chapter within a reproductive politics framework. At the same time, I also want to challenge the tendency of these critiques to overlook evidence of more radical thinking in the family planning field—not necessarily to redeem the field itself, but rather to embrace the counterintuitive patterns of evidence I see in this particular subset of family planning literature, such as an emphasis on centering local knowledges and the narratives of miso-users. In this way, I hope not only to contribute more complexity to the already profound

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<sup>2</sup> See: Briggs, *Reproducing Empire*; Gutiérrez, *Fertile Matters*; Kline, *Building a Better Race*; Stern, *Eugenic Nation*.

disciplinary and institutional critiques reproductive politics scholars have made, but also to lay the groundwork for visions of disciplinary intervention emerging in family planning discourses.

### **Producing Obstetric Knowledge: Axioms of Legality, Safety, and Risk**

Family planning experts have been publishing research on the popularization of misoprostol as an off-label abortifacient in Latin America for decades.<sup>3</sup> Initially marketed only as a treatment for gastric ulcers, misoprostol circulated widely throughout Latin America until the late 1980s, when the U.S.-based pharmaceutical company, G. D. Searle & Company (now merged with Pfizer), submitted the drug for FDA approval as an abortifacient to be used in conjunction with mifepristone, drawing attention to its off-label uses.<sup>4</sup> As abortion was strictly illegal in the vast majority of Latin America, government officials began restricting access and condemning its use as an abortifacient shortly thereafter.<sup>5</sup>

As described in the Introduction to this dissertation, any analysis of family planning literature must be understood not only in the context of the United States' history of institutionalized eugenics, of which population-focused family planning

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<sup>3</sup> Maria del Carmen Elu, "Between Political Debate and Women's Suffering: Abortion in Mexico," in *Abortion in the Developing World* (World Health Organization, 1999), 245–58; Susan Pick et al., "Pharmacists and Market Herb Vendors: Abortifacient Providers in Mexico City," in *Abortion in the Developing World* (World Health Organization, 1999), 293–310.

<sup>4</sup> Gina Kolata, "U.S. May Allow Anti-Ulcer Drug Tied to Abortion," *The New York Times*, October 29, 1988, <http://www.nytimes.com/1988/10/29/world/us-may-allow-anti-ulcer-drug-tied-to-abortion.html>; Kulczycki, "Abortion in Latin America."

<sup>5</sup> Kulczycki, "Abortion in Latin America."

methodologies play a major role, but also in the field's response to this history. Just as the term "eugenics" was washed out of the titles and mission statements of population-focused organizations following World War II, in the 1980s, the newly taboo title of "family planning" neutralized to "reproductive health"; programs focused on contraceptive access were said to be motivated not by the desire to reduce overpopulation, but rather to empower Third World women; and public health and pharmaceutical companies alike embraced what Jodi Melamed calls the official language of anti-racism and multiculturalism.<sup>6</sup> Yet reproductive politics scholarship has prolifically argued that these rhetorical pivots reflect more about institutional and state concerns about public image rather than a desire to actually transform ideologies and practices, merely producing new language through which to continue eugenic projects. In the case of family planning and reproductive health fields, the intensive focus on maternal mortality and morbidity that emerged in the 1980s merely repackaged population control efforts into a very narrow focus on fertility regulation, solidifying the gendered assumption that maternal mortality is always pregnancy-related. As a result, attributing maternal mortality only to pregnancy-related issues evacuated Third World death from what Soheir A. Morsy calls a "web of mortality-conducive conditions"—poverty, malnutrition, exposure to oil spills, pesticides, and other toxic chemicals, mistreatment or abuse at health centers, overwork, unsanitary drinking water—that directly and indirectly impacts

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<sup>6</sup> Melamed, *Represent and Destroy: Rationalizing Violence in the New Racial Capitalism*.

pregnancy and childbirth experiences, but also many other aspects of life that extend far beyond motherhood.<sup>7</sup> For this reason, Morsy urges family planning researchers to understand maternal mortality as a consequence of systemic inequities that do not only manifest in and through pregnancy. Such an approach, Morsy argues, would prompt public health and family planning professionals to prioritize the root causes of death-conducive conditions (e.g. colonization, privatization of primarily agrarian economies, labor conditions, enormous wealth disparities, state corruption) rather than only treating the symptoms (e.g. antepartum and postpartum hemorrhage, complications from incomplete abortion, toxemia of pregnancy, obstructed labor, anemia, ruptured uterus, and so on). In other words, Morsy is prompting the family planning field to resist the forces of reproductive neoliberalism, forces that maintain the persistent focus on surface solutions vis-à-vis the rhetoric of pharmocratic humanitarianism.

Much of the family planning scholarship on obstetric uses of miso in the Global South falls right into the epistemological traps that reproductive neoliberalism sets up. Nearly every study situates its analysis in alarming statistics on maternal mortality, identifying postpartum hemorrhage and incomplete abortion as the leading causes of maternal death and illness in the developing world. From this perspective, it makes sense that family planning experts would describe

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<sup>7</sup> Soheir A. Morsy, “Deadly Reproduction among Egyptian Women: Maternal Mortality and the Medicalization of Population Control,” in *Conceiving the New World Order: The Global Politics of Reproduction*, ed. Faye D. Ginsburg and Rayna Rapp (Berkeley, Los Angeles: University of California Press, 1995), 164.

misoprostol as ideally suited for a monolithically described environmental and cultural Third World context, emphasizing that miso is a “heat-safe, non-invasive, extremely effective, and inexpensive” drug. Physiologically similar to menstruation, miso’s ability to prompt uterine contractions makes it multi-purpose: it can help the body “expel the products of conception” (as in either abortion or labor induction) or enhance vasoconstriction, slowing excessive bleeding (as in postpartum hemorrhage).<sup>8</sup> Writers are keen to highlight miso’s ease of use, measured by the frequency of doses and number of ways to consume it: abortion requires just a few doses, taken through just about any orifice—swallowed, dissolved in the cheek, or inserted vaginally.<sup>9</sup> Scholars are careful to explain that side effects vary among women, but can include “unpleasant but tolerable” intensities of nausea, vomiting, diarrhea, headache, chills, fever, cramps, and dizziness. While the success rate and risk of complications are said to increase with the age of the pregnancy, family planning experts say miso can be an effective abortifacient throughout the first trimester and even early in the second trimester with the right dosage, and that it has no direct effect on women’s physical abilities to bear future pregnancies. By empiricizing miso’s techno-scientific capabilities, family planning scholarship on miso replicates pharmocratic notions of techno-scientific revolution that, as discussed in previous chapters, reinforce existing neoliberal paradigms.

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<sup>8</sup> A. B. Goldberg, M. B. Greenberg, and P. D. Darney, “Misoprostol and Pregnancy,” *The New England Journal of Medicine* 344, no. 1 (January 4, 2001): 41.

<sup>9</sup> Marge Berer, “Medical Abortion: A Fact Sheet,” *Reproductive Health Matters, The Abortion Pill*, 13, no. 26 (November 2005): 20–24.

Nonetheless, these studies have led a big swathe of family planning experts to praise miso as groundbreaking for safe motherhood worldwide, motivating further investigations of miso's obstetric uses in the poorest regions of Latin America and Africa. Most of these studies aim to measure access to miso. Several studies found that the majority of physicians, obstetric gynecologists, midwives, healers, and pharmacists they consulted about the drug all knew about misoprostol's off-label obstetric uses, and that pharmacists were most likely to provide it to women upon request despite restrictive abortion laws.<sup>10</sup> According to a study on one clinic operating in an anonymized Mexican state with abortion laws characterized as highly restrictive, health professionals openly offered misoprostol as an early abortion option and found that, of the 78 women who evaluated their experience using misoprostol, the vast majority said they would use misoprostol again and "would recommend it to their friends."<sup>11</sup> Another study estimated that if 40 percent of the abortions in Latin America were miso-induced, maternal mortality would be reduced by 26 percent, concluding, "The more widespread misoprostol abortion is, the greater the gains."<sup>12</sup>

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<sup>10</sup> Billings et al., "Pharmacy Worker Practices Related to Use of Misoprostol for Abortion in One Mexican State"; Cohen et al., "Reaching Women with Instructions on Misoprostol Use in a Latin American Country"; Lara et al., "How Often and Under Which Circumstances Do Mexican Pharmacy Vendors Recommend Misoprostol To Induce an Abortion?"; Pick et al., "Pharmacists and Market Herb Vendors: Abortifacient Providers in Mexico City"; Sherris et al., "Misoprostol Use in Developing Countries."

<sup>11</sup> Billings, "Misoprostol Alone for Early Medical Abortion in a Latin American Clinic Setting."

<sup>12</sup> Harper et al., "Reducing Maternal Mortality due to Elective Abortion," 68.

While most agree that miso ought to be on hand to treat postpartum hemorrhage, not all family planning experts are thrilled about its abortifacient capabilities, concerns weighed by their legal and safety risks. Primarily, health professionals fear that more restrictive legal contexts mean women do not have reliable instructions or guidance from trained medical professionals, leading to dangerous health complications if miso is taken incorrectly.<sup>13</sup> Because misoprostol's effects mirror a heavy period, family planning experts say, users might think the drug is working as expected and hemorrhage without realizing they were ever in danger.<sup>14</sup> Researchers explain that, especially in rural areas, many women try other options first, such as teas, coffee, herbal, and lemon mixtures, further delaying the abortion process and increasing the likelihood of incomplete abortion. There are also a slew of treatments practitioners recommend on a case-by-case basis prior to taking misoprostol to reduce the risk of infection, such as treatment of existing sexually transmitted infections.<sup>15</sup> Family planning experts point to studies that anonymously interviewed women in low-resource contexts about their knowledge and/or use of miso-induced abortion; the study results reflect that although most women know of a pill that could induce abortion, they do not feel well-informed enough about how to get it, when and how to use it, and how to confirm whether or not it actually

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<sup>13</sup> Berer, "Medical Abortion: A Fact Sheet"; Cohen et al., "Reaching Women with Instructions on Misoprostol Use in a Latin American Country."

<sup>14</sup> Sherris et al., "Misoprostol Use in Developing Countries."

<sup>15</sup> Berer, "Medical Abortion: A Fact Sheet."

worked.<sup>16</sup> To top it off, there is some disagreement about how often miso-alone abortions<sup>17</sup> result in hospitalization since they are generally done clandestinely, unless performed as part of a study (according to one of the most frequently cited studies, about 1 in 1000 women bleed so heavily after taking miso that they require a blood transfusion).<sup>18</sup>

From a reproductive politics perspective, there are a few big problems with these discourses. First, throughout this literature, family planning experts tend to conflate legality with safety, some arguing that abortion law is in fact the most powerful hindrance to safe abortion of any kind. They support this rationale by connecting two sets of broad-based data: one set that correlates rates of maternal mortality and morbidity with rates of hospital admissions believed to be associated with complications from miso-induced abortions, and a second dataset correlating rates of hospital admissions with comparisons between countries with more restrictive abortion laws and those with less restrictive abortion laws.<sup>19</sup> Whether a country is characterized as having “more” or “less” restrictive abortion laws is typically measured by the circumstances under which abortion is considered legal or

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<sup>16</sup> Cohen et al., “Reaching Women with Instructions on Misoprostol Use in a Latin American Country”; Sherris et al., “Misoprostol Use in Developing Countries.”

<sup>17</sup> A “miso-alone” abortion is one performed without mifepristone. In clinics where medication abortion is regularly practiced, miso is typically taken after a dose of mifepristone, a drug that blocks progesterone, prompting the gestational sac (or embryo or fetus, depending on the stage of the pregnancy) to detach from the uterine lining.

<sup>18</sup> Berer, “Medical Abortion: A Fact Sheet.”

<sup>19</sup> David A. Grimes et al., “Unsafe Abortion: The Preventable Pandemic,” *The Lancet*, Sexual and Reproductive Health Series, October 2006; Harper et al., “Reducing Maternal Mortality due to Elective Abortion.”



illegal (for instance, whether abortion for any reason is allowed, or only in the case of rape or incest; whether the gestational limits are 12 weeks or 20 weeks; etc.). While these concerns about clandestine abortion more broadly (not just miso-alone abortions) are consistent with the priorities of mainstream reproductive rights advocates, which have historically privileged juridical approaches to securing women's bodily autonomy, the conflation of legality and safety underpinning these assessments of underground miso necessarily assumes that licensed physicians operating within legally approved guidelines create "safe" conditions by default, despite prolific scholarship from the public health sector, social sciences, and humanities that thoroughly tracks how licensed physicians have forced women to make reproductive "decisions" under appallingly coercive conditions.<sup>20</sup>

Second, these intertwined axioms of legality, safety, and statisticized risk tend to masquerade as systemic factors of maternal mortality and morbidity when, in practice, these axioms actually further alienate immediate suffering from root causes. For instance, family planning's analyses of law are typically limited to the borders of the nation-state, when in fact one of the reasons underground miso is such a pervasive clandestine drug is because of its ability to cross nation-state borders. This reality changes the definitions and stakes of "safety," and not just because of the

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<sup>20</sup> Briggs, *Reproducing Empire*; Gurr, *Reproductive Justice*; Gutiérrez, *Fertile Matters*; Tamil Kendall and Claire Albert, "Experiences of Coercion to Sterilize and Forced Sterilization among Women Living with HIV in Latin America," *Journal of the International AIDS Society* 18, no. 1 (March 24, 2015), <https://doi.org/10.7448/IAS.18.1.19462>; Roberts, *Killing the Black Body*; Silliman et al., *Undivided Rights*; Stern, *Eugenic Nation*.

possibility for third-party distributors to sell counterfeit or expired drugs, as family planning scholars who are against community-based distribution fear, but also because of the systemic inequities underground markets themselves reflect, whether one is a buyer, seller, or analyst of the market, for that matter.

Ironically, these discourses consequently ignore the fundamental problem motivating their inquiry into obstetric uses of miso in the first place: the statistical reality that miso-alone abortion is simply not as effective as the FDA-approved mifepristone-misoprostol combination drug. For instance, in the study that asks women “if they would recommend miso to a friend” or “use it again,” there is no consideration of the decision context within which women report this. Of course if miso is the only option, they would recommend it to a friend or use it again; this does not necessarily indicate that they would use miso over the significantly more effective miso and mifepristone combination. “Safety” here becomes a calculation of costs and benefits of second-rate treatments, as opposed to an analysis that begins by asking what produces the need for second-rate treatment in the first place.

From this perspective, the data produced and cited in family planning discourses are structured such that they actually produce the ethical quandary they set out to solve. “Safer” than so-called traditional methods or the spectacularized back alley, but “less safe” than the FDA-approved mifepristone-misoprostol combination, family planning discourses on obstetric uses of misoprostol in the Third World is premised on the maintenance of dysfunctional systems that necessitate these compromises.

## Labors of Evidence Production

Perhaps most interesting about the miso debacle is how much energy family planning researchers have put into reflecting on the dynamics of the debacle itself; yet it is in these reflexive moments that the pharmocratic ethics of rationality get even further entrenched. One article published in *Developing World Bioethics* specifically analyzes the narrative patterns of the miso debate, describing the feud as a problem of “entrenched disagreement.”<sup>21</sup> Using the traditional disciplinary methods of qualitative and data analysis (“Morse’s outline of the cognitive basis of qualitative research, and Charmaz’s outline of data analysis in grounded theory”), the authors observe that the two sides of the miso debate reflect conflicting philosophies about public health interventions more broadly.<sup>22</sup> They argue that the miso debate reflects “a strong correlation between epistemic and moral values,” which they represent in a graph (Figure 177):

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<sup>21</sup> Narcyz Ghinea et al., “Overcoming Entrenched Disagreements: The Case of Misoprostol for Post-Partum Hemorrhage,” *Developing World Bioethics* 15, no. 1 (April 2015): 48–54.

<sup>22</sup> Ghinea et al., 50.

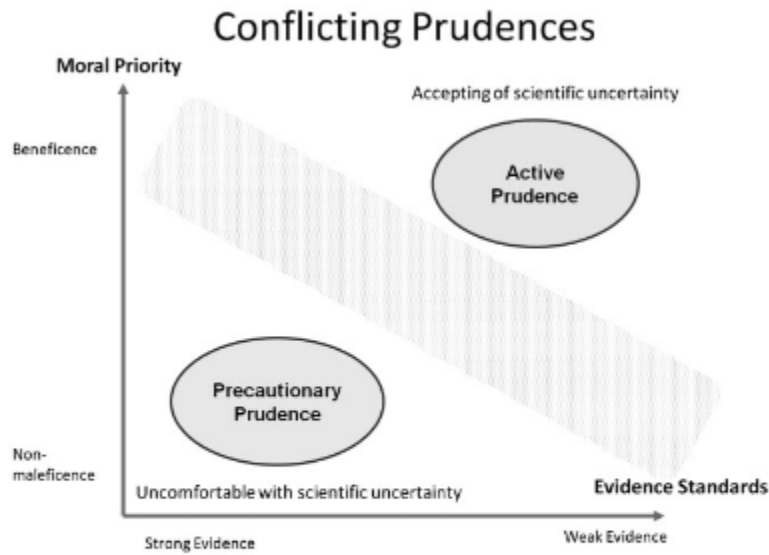


Figure 17: Ghinea et al. describe the above graph as a map of “prudential commitments observed in the misoprostol debate in terms of the correlation between moral priorities and epistemic standards” (ibid.).

Above, the x-axis measures the strength of evidence on a scale from “strong evidence” to “weak evidence.” The y-axis—although misleadingly labeled “moral priority,” suggesting a scale from the least moral or immoral to infinitely more moral—is a scale of “beneficence” (actions taken for the benefit of others) to “non-maleficence” (actions taken in order to avoid harm). Working from Aristotelian moral philosophy summarized as “the application of intuitive reason to scientific knowledge,” the graph represents two moral sensibilities: “precautionary prudence” and “active prudence.” Moral priorities correlate with quality of evidence: those who argue *against* community-based distribution of miso are said to exhibit precautionary prudence—meaning that they are more aligned with a do-no-harm approach to maternal mortality and morbidity—and require *stronger* evidence. Those who argue *in favor* of community-based distribution of miso are said to exhibit “active

prudence”—meaning that they are more inclined to take preventative action against maternal mortality and morbidity—and require *weaker* evidence. The authors ultimately conclude that the precautionary prudence group is more “uncomfortable with scientific uncertainty,” while the active prudence group is more “accepting of scientific uncertainty.”

The immediate implication here is that opponents of community-based distribution of miso are, essentially, better scientists than the supporters; opponents of community-based distribution of miso are found to provide so-called stronger evidence for their position. But the implications here go far beyond the miso debate, raising profound questions about what forms of knowledge production—quantitative, anecdotal, experiential—the field of family planning privileges. After all, what constitutes “weak” and “strong” evidence? Or scientific “certainty” and “uncertainty,” for that matter? The ethics of rationality performed in this study not only renders very subjective, experiential thinking into empirical data, but also uses this performed empiricism as justification for privileging existing data-based methodologies and devaluing experiential knowledge—knowledge that resists being empiricized and disciplined into dichotomous conceptual pairings (e.g. morality/immorality, certainty/uncertainty, benevolence/maleficence).

This failure to value experiential knowledge gives a lot of credence to reproductive politics scholars who frame their central intervention into family planning as an epistemological one, since it appears that the very methodologies family planning experts use to reflect on more foundational epistemological issues in

their field only reinforces the same blindspots. At the same time, this reading assumes that studies like this are published in a vacuum, expected to solve the problems the study raises rather than act as a springboard for further inquiry. From this perspective, while I enthusiastically agree with Morsy and other reproductive politics scholars that defining maternal mortality as only having to do with pregnancy limits the scope of what circumstances can be understood to factor into maternal mortality and health more broadly, I also worry that we miss a whole movement of family planning scholars for whom each study, while initially focused on a specific medical condition, is part of a much larger project of knowledge production that does situate maternal mortality as one among many effects of systemic injustice, including epistemic violence.

In fact, Gynuity Health Projects' mission statement is explicitly responsive to these fundamental disciplinary questions, particularly regarding what constitutes evidence. Their mission is "to develop scientific, clinical and programmatic evidence in reproductive and maternal health and to advocate for its use assuring that each individual benefits from the fruits of medical science and technology," a goal that presumably motivated their initiative to add misoprostol to the EML.<sup>23</sup> While the WHO has no legal authority to regulate which drugs pharmacies and clinics are required to stock, public health professionals generally recognize the EML as the gold standard for policy and clinical practice worldwide. In line with their general

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<sup>23</sup> "Homepage," Gynuity Health Projects, accessed May 23, 2019, <https://gynuity.org/>.

strategy “to use research to fill evidence gaps for new models of care, influence change, and advocate for improvements in policy and practice,”<sup>24</sup> Gynuity’s goal was to produce scientifically and clinically legible evidence to prove miso’s essential-ness. Their vision was to make miso among the most basic pharmaceuticals to stock worldwide—as routinely accepted as amoxicillin, ibuprofen, or emergency treatments for anaphylaxis (e.g. EpiPens), all of which have long been on the EML with virtually no controversy.

This is an epistemic project that requires family planning scholarship to not only privilege data that critiques systemic issues, but also to essentially redefine scientific evidence itself, in part because these critiques tend to emerge in the so-called “qualitative data,” i.e. narratives from the study subjects. For instance, in a recent 2018 study on the role of traditional birth attendants (TBAs) in the distribution of miso for postpartum hemorrhage in Mozambique, Hobday et al. center women’s challenges and concerns about the work they do in their communities by quoting TBAs directly:

Unfortunately I am not lucky enough to earn money for the work I do, I have already brought many people into the world by my hands. If it were a case of working for a boss, I think I would be in retirement now and earning money for the time spent in this activity.

Well, they tell me that my job is to get pregnant women to the hospital, but if it happened before I was there, I should get some plastic [from a 1kg sugar bag], and put it on my hands, that’s how I do it, they did not give me gloves, they said they wear the gloves in the hospital.

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<sup>24</sup> “Homepage.”

For example, when a child is born they do not let it be covered with this capulana<sup>25</sup> that I used, in the hospital they say it must be a new capulana ... where will I get money for a new capulana if my only capulana is this one? So we do not know... this price we are paying for our misfortune is very high. The nurses only know to say that we should produce vegetables to be able to sell to get money ... but here who will buy what we produce if we are all farmers and poor people?<sup>26</sup>

All of the above statements speak to the labor conditions within which TBAs operate, demanding a restructuring of capital and labor that not only provides TBAs with pay and baseline materials to do their jobs (soap, gloves, fresh capulanas), but that also recognizes the underlying inequities that create the context for high maternal mortality in the first place. At the same time, they push readers to reimagine the underlying structures of capital one earns through work. While the first quote frames earning a living wage as a privilege one can only fantasize about, in the third quote, the TBA's rhetorical questions resist simplistic (neoliberal capitalist) solutions to systemic issues, asking: where will I get money for a new capulana? Who do they expect will buy my vegetables? There is a circularity to her questions—a persistent “then what?”—that, question by question, reveals not only the almost pathological absurdity of proposing such band-aid solutions to a fundamentally dysfunctional system, but also the urgent need for so far illegible solutions that resist the ruling logics of reproductive neoliberalism.

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<sup>25</sup> A capulana is a kind of sarong popular in southeastern Africa that is often worn as clothing (e.g. skirt, dress) or used as a baby carrier.

<sup>26</sup> Karen Hobday et al., “‘My Job Is to Get Pregnant Women to the Hospital’: A Qualitative Study of the Role of Traditional Birth Attendants in the Distribution of Misoprostol to Prevent Post-Partum Hemorrhage in Two Provinces in Mozambique,” *Reproductive Health* 15, no. 1 (October 16, 2018): 8–9.



What is more concerning to me in these narratives is not whether they situate obstetric issues within broader institutional and systemic critiques (in fact, they do), but that their critiques are inextricable from a kind of self-sacrificial plea for basic resources. On one hand, their statements reflect the success of pharmocratic rhetoric in disciplining Global South subjects into states of need; on the other hand, all of these desires are stated in terms fundamental to the pharmocratic machinery—pay, retirement, supply and demand. From this perspective, we might read these quotes as systemic critiques that family planning researchers interpret and re-encode as demands that can be legible to the institutions that have the power to reshape these systems.

The big caveat here is that Hobday et al. are inconsistently responsive to these critiques, sometimes making meaningful recommendations that speak to systemic issues, other times making disappointingly limited recommendations that reproduce a pharmocratic system in which pharmaceutical responsibility falls on the most burdened populations. At their best, Hobday et al. productively point to the “unintended consequences” of prior interventions:

This study unveiled several unintended consequences of promoting facility deliveries without major investments in transport or communication systems. While some communities did have access to a maternal waiting home, often women were not able to leave their children at home without care and/or husbands did not see it as appropriate for their wife to be away from the home. Giving birth “on the way” to the facility, with no protection from the elements has also been described in Malawi, where women had to give birth on the roadside often due to a delay to seek assistance from a TBA or SBA [Skilled Birth Attendant] at the health facility.<sup>27</sup>

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<sup>27</sup> Hobday et al., 10.

Above, Hobday et al. are identifying the pitfalls of overly simplistic solutions—e.g. tell women to give birth at the hospital—in the context of major infrastructural deficits. It is one thing to encourage women to go to facilities where they and their newborns are less likely to die, and another thing to create structures that enable women to get there without taking even bigger risks (e.g. walking to the hospital and giving birth on the roadside) than they would if they stayed home. In other words, the passage above gives us a glimpse into a potentially transformative, big-picture critique: in their pursuit of governmentally and medically recommended “safe motherhood,” women only entered into newly horrific birthing circumstances.

Given this powerful critique—that public health professionals have failed to see that the physical presence of a health facility does not necessarily make its resources accessible, and that “encouragement” does little to make it accessible—the article’s ending recommendations are perplexing. Hobday et al. list these recommendations in a table at the end of the article (Figure 188). Each recommendation places pharmaceutical responsibility on TBAs: they are to pick up the medicine, store it, and determine when and how to use it. But perhaps most troubling is that these recommendations are framed as though they were direct requests from TBAs. Hobday et al. write in their conclusion: “TBAs request resources such as birth kits, communication and transport options to heighten their efforts to ensure women can access to [sic.] the safest birth possible.”<sup>28</sup> While it is true that one of the TBAs requested a car to transport women to the health clinic, this

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<sup>28</sup> Hobday et al., 11.

<b>Table 1 Recommendations</b>
<p>Operational recommendations for the misoprostol program:</p> <ul style="list-style-type: none"> <li>• Allow TBAs to pick up the medication from the health facility where necessary and appropriate to ensure a stable supply of misoprostol.</li> <li>• Heighten communication of the Strategy for the Prevention of PPH at the Community Level to TBAs. TBAs and MNCH nurses should feel confident distributing and administering misoprostol to women who will have a home birth as part of the National Strategy.</li> <li>• Provide clear information to the community via health facility staff, CHWs and TBAs about misoprostol and how to use it correctly, alongside messages encouraging facility-based birth to dispel fears and myths in the community.</li> <li>• Consider clean birth kits distributed through ANC, APEs, and/or directly to TBAs. This would alleviate concerns TBAs have about infections to themselves, women and newborns while reducing neonatal mortality. This study found no concerns that this might undermine facility deliveries.</li> </ul> <p>Recommendations to increase coverage of births attended by SBAs:</p> <ul style="list-style-type: none"> <li>• Transportation, while costly, is a necessary investment to ensure women have access to health facilities. Women and TBAs both strongly support facility deliveries, but requested assistance with transport and communication.</li> </ul>

Figure 18: A table of recommendations concluding the Hobday et al. study. TBAs are Traditional Birth Attendants; PPH refers to postpartum hemorrhage; MNCH nurses are Maternal Newborn and Child Health nurses; CHWs are Community Health Workers; ANC refers to early antenatal care; APEs are Agentes Polivalentes Elementares; and SBAs are Skilled Birth Attendants. Note: This table is a reproduction of the original, not an exact copy. (Hobday et al., 10)

request was made in the context of a much broader systemic problem—that their work is considered voluntary, and not worthy of pay:

Another problem is transportation, I live far from the health unit, I must pick up two cars and pay 40 meticaïs just to come, so, round trip is 80 meticaïs and no one gives me that money, its personal effort. We are told that this is voluntary work and that we should do it of our own free will, so I do it without gaining anything.

Above, the TBA does articulate a problem transporting women to the hospital, but situates her critique in the reality that, although she is not paid for her work, this

work is still expected of her. Instead of recognizing this deeply inequitable reality, Hobday et al. evacuate the request from its systemic critique and put it into a list of items TBAs need in order to continue bearing the responsibility of reducing maternal mortality.

In this way, family planning scholarship on misoprostol use in the Global South both reaffirms and complicates Morsy's central critique. While the studies do explore miso as a specifically obstetric treatment, perpetuating the definition of maternal mortality as always pregnancy-related, the so-called "qualitative data" presented does critique much broader systemic issues at play. Rather than limiting the scope of action to only pregnancy-related health issues, family planning's focus on obstetric uses of miso, even when put in the limited context of maternal mortality, functions as a threshold concept—one in which the initial object of analysis (obstetric uses of miso) acts as a portal through which to form more complex analyses and make counterintuitive connections.<sup>29</sup> From this perspective, we can understand the focus on maternal mortality in family planning literature about miso not necessarily as a limiting factor, but rather as a starting point for more expansive and possibly transformational scholarly conversations about health more broadly.

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<sup>29</sup> The term "threshold concept" originated in education, but it has been used in a range of fields, such as writing across the curriculum scholarship and psychology/therapy contexts. See: Jan Meyer and Ray Land, "Threshold Concepts and Troublesome Knowledge: Linkages to Ways of Thinking and Practising within the Disciplines," in *Improving Student Learning: Ten Years On*, ed. C. Rust (Oxford U Press, 2003); Jan H. F. Meyer and Ray Land, "Threshold Concepts and Troublesome Knowledge (2): Epistemological Considerations and a Conceptual Framework for Teaching and Learning," *Higher Education* 49, no. 3 (April 1, 2005): 373–88.

The limiting factors I see in family planning conversations have more to do with the ways in which data is translated into recommendations that inconsistently speak to the systemic critiques evidenced in their research. This is clearly a missed opportunity for marrying the concreteness of the traditional “list of recommendations” to systemic critiques that are too often nonspecific, left in the abstract of “heightened communication” and calls for health workers to become more “confident”—hallmarks of reproductive neoliberalism that need more unpacking.

### **Miso as a Surveillant Technology: Tracking Responsibilization**

These calls for more confidence expose the capacity for family planning literature to act as a method of surveillance that “promote[s] abstraction, fetishism, transformation of bodies into commodified information, and perceptions of reduced risk.”<sup>30</sup> In this case, family planning studies on misoprostol tend to interpret data in ways that reconstitute the contradictory pharmocratic values of self-responsibilization and humanitarian self-sacrifice for the Greater Good.

Nearly all of the family planning literature about miso engages with and produces a variety of surveillant data on pregnant women and health workers in a given town or village. As is standard practice in any clinical study, participants are generally required to provide detailed contact information and medical history upon

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<sup>30</sup> Deborah Wilson Lowry, “Understanding Reproductive Technologies as a Surveillant Assemblage: Revisions of Power and Technoscience,” *Sociological Perspectives: SP: Official Publication of the Pacific Sociological Association* 47, no. 4 (2004): 357.

intake at the clinic. Gathering data after this initial meeting, however, requires more elaborate processes. For instance, in a study in eastern Uganda evaluating village health teams' (VHTs) ability to conduct postpartum follow-up after antenatal distribution of misoprostol—part of a project nicknamed “MamaMiso”—researchers instructed VHTs to give each pregnant woman a neck purse containing three items: either misoprostol or a placebo, instructions for its use, and a phone number to call to “report their delivery.”<sup>31</sup> This form of data extraction was easily evaded; in fact, some women provided fake names or phone numbers, and, in a few cases, extensively detailed directions to made-up villages.<sup>32</sup>

What is more troubling is the surveillant “reward” system built into many of these studies, particularly when community health workers act as the surveilling operatives. In the Ugandan study, VHTs were promised 10,000 Ugandan shillings (about 4 USD) for each “timely report of a delivery,” including a test of hemoglobin levels.<sup>33</sup> Timeliness was measured by three categories: “on-time” for reports sent within a week of delivery, “late” for reports sent 8 days or more after delivery, or “lost” if VHTs did not follow up successfully (see Figure 19). Rewards were either prorated or swapped out according to a somewhat arbitrary ratio of timeliness to reporter type (i.e. whether the VHT sent the report or the woman who delivered). The more days that passed after delivery without a report, the less money VHTs

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<sup>31</sup> James Ditai et al., “Achieving Community-Based Postpartum Follow up in Eastern Uganda: The Field Experience from the MamaMiso Study on Antenatal Distribution of Misoprostol,” *BMC Research Notes* 10, no. 1 (October 26, 2017): 2.

<sup>32</sup> Ditai et al., 4.

<sup>33</sup> Ditai et al., 2.

would receive; if VHTs and women both participated in the notification, they would split the earnings. If women reported on their own, researchers gave them an entirely different prize: a bar of soap.

These “measurements” raise some alarm bells. First, the study was structured such that VHTs’ access to lifesaving drugs like miso and compensation for the care they provide pregnant women appear to be contingent on their ability to comply with the study team’s implicit definitions of responsibility and accountability; in order to be a “good” VHT deserving of a reward, they must participate in their own pharmaceutical self-responsibilization. In other words, the information gathered is not simply an accumulation of “raw” data (it never is), but rather an evaluation of Global South subjects’ ability to perform the medical, pharmaceutical, and humanitarian responsibilities the study bestowed on them.

Second, the stakes here go well beyond the more immediate injustice of withholding “rewards” on terms defined by those in charge of distributing resources. If VHTs do not participate in the surveillance processes outlined and measured by the study team, not only do they not get compensated for their work nor get basic hygienic materials like soap (items that are readily available for study teams to distribute anyway), but VHTs also get a paper published in *BMC Research Notes* concluding whether or not they can be trusted to do follow-up work. The production of Global South knowledges and labors of care, precarity, and survival are at risk of being completely dismissed far beyond the parameters of the study, abstracted and

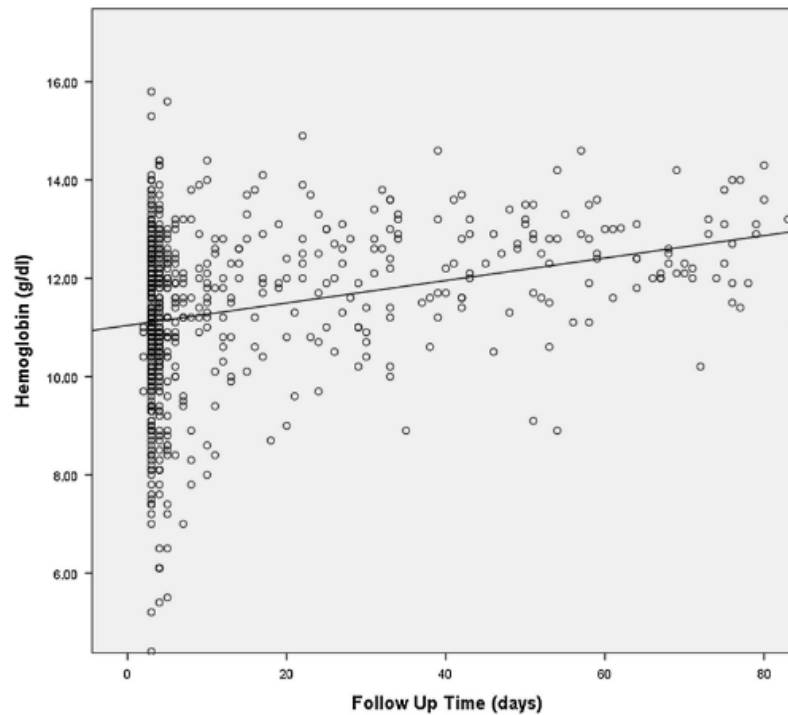


Figure 19: “Postpartum hemoglobin values for all women followed up irrespective of place of delivery and use of study medication. This figure depicts a scatter plot with the follow up time in days on the x-axis and the hemoglobin value in g/dL along the y-axis and incorporates a linear best fit line.” (Ditai et al., 7)

represented to a Global North audience as cultural deficiency and even delinquency. This is embedded at the most basic levels of language, evidenced in descriptions of study subjects as either “compliant with the study protocol” or “non-compliant” because of “user-choice failure.”<sup>34</sup>

That said, the studies do provide some insight into the study subjects’ experiences of being surveilled, exposing the blurry line between surveillance that misrepresents lived

<sup>34</sup> B. Elul et al., “Can Women in Less-Developed Countries Use a Simplified Medical Abortion Regimen?,” *The Lancet* 357, no. 9266 (May 5, 2001): 1403.



experiences and surveillance that lays the groundwork for those experiences to be made legible in meaningful ways. For example, the study team asked women who were categorized as having followed up “late” why they did not report their deliveries sooner, producing a table of “illustrative quotations” organized by theme (

Figure 20). Some women’s statements reflect almost comical resistance to being surveilled in the critical days of postpartum recovery and life adjustment immediately following delivery (“I was very sick and confused so I could not remember to report to *you people* that I had delivered” [emphasis mine]). Even so, the “evidence” this particular study produced, however simplistic, was overwhelmingly positive for VHTs. Like Gynuity Health Projects aims to do, they produced evidence legible to the public health world that VHTs are important, knowledgeable, and trusted actors in their community’s systems of care. To some degree, their conclusions reflect this:

In the MamaMiso study, follow up in the immediate postpartum period was feasible and a high follow-up rate (93.6%) was achieved... [S]imilar rates of follow up were achieved irrespective of birth and the presence of a skilled birth attendant. This finding may suggest that even women who are disconnected from the health system at the time of delivery by giving birth at home and without a skilled birth attendant are still amenable to postpartum follow-up.<sup>35</sup>

This passage is particularly striking because it seems to identify two different objects of study: how well VHTs completed their jobs, and how “amenable” women were to being surveilled by VHTs. It is tempting to say that measuring how amenable

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<sup>35</sup> Ditai et al., “Achieving Community-Based Postpartum Follow up in Eastern Uganda: The Field Experience from the MamaMiso Study on Antenatal Distribution of Misoprostol,” 5–6.

women are to participate in the surveillance process—to provide their data—is evidence yet again of the study structure pushing women to have to perform responsibility. At the same time, we could also see this language as an attempt to produce evidence that VHTs are knowledgeable, trusted members of their communities—a way of solidifying the importance of community trust and belonging into family planning knowledges. Their findings support the idea that care need not come from hospitals, but rather from their own communities, and that, if anything, institutional attended deliveries just complicate the process:

The MamaMiso study showed that women who delivered at home and without a skilled birth attendant were equally likely to be followed up on time as those with institutional attended deliveries. Women who enrolled during antenatal care at an urban hospital were especially difficult to follow up on time. In their own words, women explain that phone difficulties, misperceptions, postpartum travel, and condition of the mother or neonate also interfere with postpartum visits.<sup>36</sup>

This passage suggests a pretty radical idea: that proximity to hospitals is also proximity to institutional violence that further estranges women from the resources they may or may not want to use. The problem here is not one of “access,” but rather the way the hospitals conduct (or do not conduct) care. In other words, this is specifically an epistemic problem; to attend to the “systemic” does not translate into proximity to institutions, but rather to fundamentally change the cultural assumptions upon which these institutions operate.

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<sup>36</sup> Ditai et al., 6.

<b>Table 3 Illustrative Quotations</b>	
THEME: phone difficulties	<p>“My phone was faulty, the battery was spoiled so I was off air” (<i>Quotation from woman</i>)</p> <p>“I delivered at home and did not report because I did not have the phone because my husband had gone for a safari and had not come back...” (<i>Quotation from woman</i>)</p> <p>“I left the book which had your telephone number in the hospital. I did not remember about the telephone number on the participant information sheet.” (<i>Quotation from woman</i>)</p>
THEME: inaccurate baseline information	<p>“I followed up the participant at the given address but failed to get her because the villages given don’t exist.” (<i>Quotation from study staff</i>)</p> <p>“The [name of contact person provided] had died some time back, [the neighbors] told me that they had never come across the name of the participant in their village.” (<i>Quotation from study staff</i>)</p>
THEME: misperceptions	<p>“I thought [reporting my delivery] was not important since I was fine after delivery.” (<i>Quotation from woman</i>)</p> <p>“I delivered and forgot to call until a nurse called me and asked if I had delivered.” (<i>Quotation from woman</i>)</p> <p>“Participant followed up late because she feared calling us due to the fact that she swallowed only two tablets and missed one... She thought we would blame her for not swallowing the third tablet.” (<i>Quotation from study staff</i>)</p> <p>“[The husband] answered the phone ... He wondered whether it was necessary to follow [the wife] up... He said he will need us to follow her up in his presence... He also asked me why a man called to find out whether she had delivered.” (<i>Quotation from study staff</i>)</p>
THEME: travel/events	<p>“On my third day after delivery I lost someone and travelled... for a burial. That’s why the MamaMiso staff were not able to find me.” (<i>Quotation from woman</i>)</p> <p>“When my baby died, I lost my marriage, that’s why you were not able to get me at my home. I had come here to stay with my mother.” (<i>Quotation from woman</i>)</p> <p>“When I reached the home, I did not get the participant because she had lost her one twin and they had taken the twin to another village for burial.” (<i>Quotation from study staff</i>)</p> <p>“I was told by the neighbor that she left for their village... after delivery. She went with her mother because they had a misunderstanding with her husband.” (<i>Quotation from study staff</i>)</p>
THEME: condition of mother/neonate	<p>“I was very sick and confused so I could not remember to report to you people that I had delivered.” (<i>Quotation from woman</i>)</p> <p>“After the death of the baby I was disturbed in the mind so I could not even remember to notify you that I had delivered.” (<i>Quotation from woman</i>)</p> <p>“I called the participant today... she said she was operated on and the baby passed on... she went to a relatives place for more support.” (<i>Quotation from study staff</i>)</p>

Figure 20: Quotations from study subjects in the MamaMiso study. The authors note the following: “Participant numbers and locations have been redacted from quotations. Quotations from women were typically provided in one of the three local languages (Ateso, Lugisu, Lugwere) and translated by study staff into English for recording. The English grammar of some quotations has been amended to facilitate comprehension” (Ditai et al., 5). Note: This table is a reproduction of the original, not an exact copy.

## **Conclusion: Rereading Possibilities**

This analysis pulls me in a few different directions. On one hand, family planning literature on obstetric uses of miso reproduces pharmocratic forces that discipline Global South subjects into performing self-responsibilization. It does this by encoding data as evaluations of whether Global South women are “compliant” with miso-use, characterizing women’s non-use of the drug as “user-choice failure.” Being non-compliant with drug use is thus read as a failure to choose the pharmaceutical solution—an act of cultural deficiency, of defective knowledge, evidence of women’s poor decision-making—rather than due to any of the infinite reasons, willful or not, that women may not use miso, whether non-use indicates some kind of desire, resistance, fear, stoicism, perhaps relationships to the body that the family planning literature is simply not set up to see.

This reality tempts me to conclude that, even when the studies present Global South knowledges positively—as in, “compliant” with miso-use—the dualistic framework of compliance/non-compliance only reinforces pharmocratic narratives of responsabilization and (neo)liberalization, delegating reproductive risk-taking to individuals rather than the pharmaceutical corporations, public health organizations, and policymakers (for example) that have historically created conditions of risk-taking in the first place. Regardless of whether women are evaluated as compliant or non-compliant, the dichotomy itself reproduces the neoliberal, neocolonial rationale for their continued institutional management—management that is clearly dysfunctional. From this perspective, family planning sciences are fundamentally

built to align with reproductive neoliberalism, the very same ideologies from which family planning took off in the 1950s.

At the same time, I want to at least partly resist this reading because, while this argument is in some ways the logical corollary to the analysis I do in this chapter, it creates what (I believe to be) an illusion of epistemological entrapment.

As Deborah Lowry puts it:

... the general rejection of all or certain contemporary reproductive technologies that is promoted by some critical scholars will fail to change the embedded power relations and interests permeating the surveillant assemblage of reproductive technologies. Cutting off information networks, banning sonograms and reproductive testing, and attempting to end surveillance of pregnant women are not viable solutions to the question of how power, autonomy, and the status of pregnant women and others might be altered.<sup>37</sup>

By the same token, it would be reductive to say that all family planning studies on misoprostol should be ended or ignored because they are doomed to be violent tools. In other words, rejecting an entire field of study on the premise that it is inevitably bound to reproduce epistemic violence is itself a kind of epistemic violence—it erases the complexity of family planning scholars' varying positionalities and motivations, a kind of epistemological essentialism. For example, there is clearly an opportunity for family planning experts to center existing reproductive care networks and local knowledges, an opportunity that many family planning professionals already actively pursue. At the risk of naivety, I want to leave open the possibility that while performing responsabilization conscripts women into neocolonial systems,

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<sup>37</sup> Lowry, "Understanding Reproductive Technologies as a Surveillant Assemblage: Revisions of Power and Technoscience," 366.

it may also position unexpected actors to rupture the gendered and racialized epistemologies undergirding modern forms of reproductive neoliberalism. Holding family planning scholarship accountable is not mutually exclusive with reading for its possibilities; I think we can do both.

## EPILOGUE

### Elephants in the Room

This dissertation project has attempted to trace the biopolitical footprints of misoprostol, linking key sites in miso's material-discursive circulation. Contrary to pharmocratic narratives that endow misoprostol with previously unseen techno-scientific potential, discourses about miso represent the concentration of reproductive neoliberalism, a force that joins the rhetorics of pharmaceutical revolution, humanitarianism, and reproductive vigilantism. The universalist language of empiricism and unity via techno-science masks the individualistic and nationalistic ideologies from which misoprostol emerged.

While underground markets for misoprostol open up the possibility that reproductive autonomy may emerge not from state legitimation, but rather, through possibly disorganized networks operating both with and outside of juridical and health frameworks, the discourses surrounding the drug also idealize these possibilities, ignoring the pharmaceutical production and distribution processes that precede its circulation. Discourses about underground miso also reproduce colonial-era notions of race, exoticizing miso users, sellers, and the Global South spaces from which miso is (incorrectly) said to originate. These discourses thus tend to reveal less about the ways miso-users claim (and miso-sellers enable) reproductive autonomy, and more about how liberal-progressive desire for universal reproductive

freedom persistently privileges individual action over systemic change, silencing the reproductive justice mission.

Resisting the desire to romanticize or otherwise flatten the complexities of underground misoprostol markets as we might other forms of resistance, what draws me to study them is that they are not necessarily cohesive or organized, even while they produce traceable patterns of exchange and capital. Unlike more traditional stories of resistance or subversion, these networks do not necessarily work in direct opposition to the state, nor do they ascribe to a specific, uniting ideology as we might imagine a social justice movement would. Rather, my research has shown me that these underground networks could be so complex and heterogeneous that not all participants participate knowingly or intentionally.

This reality raises more questions for me: How do we reconcile agential, subversive readings of resistance with the systemic analyses reproductive politics scholars rightfully urge? What does it look like to attend to the agential while also reading for the whole?

While a more complex theory of agency and resistance that does not re-enable existing paradigms would be helpful here, I call this Epilogue “Elephants in the Room” because I think the complexity I am craving may only come from ethnographic work (this is one of my elephants). When I presented my dissertation prospectus in January 2017, my project included plans for an ethnography at the midwifery practice at Bellevue Hospital, a free clinic whose clients are mostly low-income women of color who have immigrated or are in the process of immigrating to



the United States. I believed that Bellevue would be the ideal site to begin to explore the ways the Global North/Global South dichotomy haunts reproductive health discourses, in part because of its unique partnership with the Doula Project, a New York City-based reproductive health and justice organization that trains volunteer doulas to support low-income women across the spectrum of pregnancy, including birth, abortion, miscarriage, stillbirth, and fetal anomaly. The Doula Project's extensive advocacy in and outside the hospital, grounded in a reproductive justice praxis, not only directly impacts Bellevue's patient demography by drawing under-resourced clients who otherwise would give birth in the emergency room or not receive reproductive care at all, but also generatively complicates what social scientists call "the clinical encounter."<sup>1</sup> Unlike a more traditional hospital setting—one that does not employ midwives, does not make volunteer doulas available on-site, and requires payment regardless of whether the patient has health insurance—the clinical and pharmaceutical culture at Bellevue prompts questions about how linguistic, racial, ethnic, and bodily borders structure reproductive experiences and grammars of health. Anecdotally, it also just so happened that the midwives at Bellevue were in the midst of their own passionate debates with Bellevue about misoprostol vs. oxytocin (another drug that treats postpartum hemorrhage and tends to be more effective, but is more expensive).

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<sup>1</sup> Judith Farquhar, *Knowing Practice: The Clinical Encounter of Chinese Medicine*, Studies in the Ethnographic Imagination (Boulder: Westview Press, 1994); Earl E. Shelp, *The Clinical Encounter: The Moral Fabric of the Patient-Physician Relationship* (Dordrecht: Springer Netherlands, 1983).

While I did volunteer as a doula for several months at Bellevue, my volunteership was cut short when Bellevue cut funding to the midwifery practice, putting a freeze on all new hires in the practice. Morale was at an all-time low, and midwives began leaving, many for higher-paying jobs at private clinics. It is only in retrospect that I see this funding cut and its consequences as yet another public-private embrace of reproductive neoliberalism. Reproductive neoliberalism is more than an ideology; it is a material force that siloes full-spectrum reproductive care meant to center the needs and desires of the most marginalized.

Part of my desire to do ethnographic work was to be in closer proximity to this materialization of reproductive neoliberalism (though I did not call it that at the time)—to see if the clinical culture of Bellevue would help me rupture the discourses about misoprostol that I was reading. As João Biehl succinctly puts it, “Ethnography complicates. It is a way of grounding and dissecting such abstractions, illuminating the contingency, multiple interests, and unevenness of the political game that is under way.”<sup>2</sup> When I look at the striking photographs and poignant stories he pairs together in his work, I am reminded of my project’s incompleteness—how ethnographic work would complicate and enrich my analysis of underground markets for miso.

While my archival research has given me valuable ways of reading the hegemonic forces driving the circulation of discourses about misoprostol, it has also provided glimpses into the kind of complication and enrichment ethnography could

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<sup>2</sup> Biehl, *Will to Live*, 11.

enable—specifically, how reproductive neoliberalism manifests in the everyday lived experiences of people whose lives have intersected with misoprostol in one way or another. In the next phases of this project, I would like to pry open those glimpses.

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