
Electronic Thesis and Dissertation Repository

10-28-2016 12:00 AM

“In the end, it’s your pleasure that’s on the line”: Postfeminist, healthist, and neoliberal discourses in online sexual health information

Laura Cayen, *The University of Western Ontario*

Supervisor: Dr. Susan Knabe, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Women's Studies and Feminist Research

© Laura Cayen 2016

Follow this and additional works at: <https://ir.lib.uwo.ca/etd>



Part of the [Feminist, Gender, and Sexuality Studies Commons](#)

Recommended Citation

Cayen, Laura, "“In the end, it’s your pleasure that’s on the line”: Postfeminist, healthist, and neoliberal discourses in online sexual health information" (2016). *Electronic Thesis and Dissertation Repository*. 4197.

<https://ir.lib.uwo.ca/etd/4197>

This Dissertation/Thesis is brought to you for free and open access by Scholarship@Western. It has been accepted for inclusion in Electronic Thesis and Dissertation Repository by an authorized administrator of Scholarship@Western. For more information, please contact wlsadmin@uwo.ca.

Abstract

This dissertation expands the critical literature on postfeminism, which is largely discussed in relationship to popular culture, to focus on how postfeminism permeates and shapes contemporary popular understandings of sexual health. A focus on women's sexual health is particularly relevant considering the way in which postfeminist discourse is seen to simultaneously and contradictorily take up and reject the gains and methods of the 'second wave' feminist movement, within which feminist struggles relating to the women's health movement and the sexual revolution were fought. Using a feminist critical discourse analysis methodology, I explore how female sexuality is discursively constructed in five websites offering sexual health information, including non-profit (e.g., government, professional health organization, feminist organization, Aboriginal health organization) and commercial (e.g., condom company) websites. I argue that healthist, neoliberalist, and postfeminist discourses interact to construct a particular form of sexual subjectivity for young women. I identify three themes through my analysis, including the discursive construction of: (i) an imperative of good sexual health; (ii) a choice-making subject; and (iii) the sexually savvy subject. The postfeminist subject is a sexual subject, and the display of an open, free, and active sexuality is a strong source of evidence of feminism's success; however, sex is simultaneously constructed through these websites as integral to overall health and as dangerous for young women in particular. Within cultures characterized by healthism and postfeminism, young women are increasingly expected to be knowing health consumers, consuming both sexual health products and sexual health information. This expectation translates into a moral responsibility to make the right choices in the pursuit of good sexual health: young women are mobilized to manage sexual health risks, including sexually transmitted infections, pregnancy, and sexual assault.

Keywords

Postfeminism, neoliberalism, healthism, women's health, sexual health, discourse analysis, websites

Acknowledgements

There are a number of individuals to whom I owe a great deal of gratitude. First and foremost, I want to thank my supervisor, Dr. Susan Knabe, for her belief in me as a scholar and consistent commitment to my professional development. I left every meeting with her feeling more competent and confident in my abilities than when I entered, an achievement that was easier on some days (and years) than others. Thank you also to Dr. Jessica Polzer, my second reader, for her close readings and always thorough comments. The work I did as a Research Assistant to Susan and Jessica formed the backbone of my methodological and analytical capabilities in this project, and I am so grateful for the intellectual training and guidance they have provided me over the years. Thank you to the members of my examining committee, Drs. Tasha Dubriwny, Carole Farber, Miranda Green-Barteet, and Erica Lawson, as well as to Dr. Nadine Wathen, who served as a dissertation committee member, for the time and care they took with my project. And to Dr. Katherine McKenna, for ushering me in to Women's Studies and Feminist Research not once, but twice; it was the best department in which to conduct my work.

I have had the pleasure of developing relationships with a rich community of people that I have grown to love and admire during my tenure at Western and in London. Thank you to Richard Davila, a forever friend, and to Trevor Almon, Andrea Benoit, Kate Grantham, Marilla McCargar, Tiara Sukhan, Rachel Van Allen, and Giles Whittaker; I am a better thinker and a better friend for having known you all. Special thank you to Jen Chisholm for your open door and open heart. Thank you to Reverend Chris Travers and The Church of the Good Shepherd for giving me access to a room of my own in which to write at the final stage of this process. Ken Ferguson, Denise Fitzsimmons, Colleen Hutchison, Mark Santos, Craig Nelson, Kayte Waters, and Aaron Young were always ready to help me step out of this world whenever I needed it. I am grateful to Benjamin J. Leigh for support during those early years, and to Elma Lekic, whose pride in my successes keeps me from getting too humble.

To my family: Sue and Russ, Lynn and Scott, Dylan and Madeline. You are my home base, and have given me a solid foundation from which to launch and return and launch again that fortifies me through trying times. I am grateful for the way that you model strength, togetherness, and love.

This research was supported by a Social Sciences and Humanities Research Council (SSHRC) Joseph-Armand Bombardier Canada Graduate Scholarship and an Ontario Graduate Scholarship award.

Table of Contents

Abstract.....	i
Acknowledgements.....	ii
Table of Contents.....	iv
List of Figures.....	viii
List of Appendices.....	x
Chapter 1.....	1
1 Introduction.....	1
Chapter 2.....	6
2 Literature Review.....	6
2.1 Women’s Health and Neoliberalism.....	6
2.1.1 Healthism as Self Control in a Risk Society.....	12
2.1.2 Health Information: A Particular Kind of Consumption.....	15
2.2 Postfeminism.....	18
2.2.1 The Norm of Feminist Success: Choosing Conservativism.....	22
2.2.2 Girls as Empowered Choice Makers and Consumers.....	25
2.2.3 Self-Sexualized Subjecthood: Pleasures and Obligations.....	28
2.3 Neoliberal Health and Postfeminism.....	32
2.3.1 Sources of Health Information: Websites as a Focus of Analysis.....	38
Chapter 3.....	41
3 Methodology.....	41
3.1 Foucault and Critical Discourse Analysis.....	41
3.1.1 Discourse.....	41
3.1.2 Images as Discourse.....	43
3.1.3 Power/Knowledge.....	44
3.1.4 Truth.....	45
3.1.5 Trustworthiness.....	48
3.2 Feminist Critical Discourse Analysis.....	48
3.2.1 Postfeminism and Feminist Critical Discourse Analysis.....	50
3.3 Methods.....	52

3.3.1 Research Questions and Objectives.....	52
3.3.2 Data Gathering and Exclusions	53
3.3.3 Objects of Analysis: Sample.....	55
3.3.4 Operationalizing “Sexual Health”	60
3.3.5 Overview of Sexual Health Topics.....	65
3.3.6 Data Analysis and Coding.....	70
3.4 Conclusion	73
Chapter 4.....	74
4 The Discursive Construction of an Imperative of Good Sexual Health.....	74
4.1 Medicalization of Sex: Individual Pursuit of Good (Sexual) Health.....	74
4.2 STIs and Young Women At-Risk: A Call to Action.....	79
4.2.1 Mobilization Through STI Risk: Threats to Physical Well-being	83
4.2.2 Mobilization Through STI Risk: Threats to Emotional Well-being	87
4.3 Monogamy as an Ideal Standard for Sexual Health	89
4.3.1 Serial Monogamy is the New Promiscuity: Assessing Health in a Relationship	91
4.3.2 Communication Required to Preserve Good (Sexual) Health.....	94
4.3.3 Duty to Inform: Disclosing an STI to your Partner.....	97
4.3.4 Accepting and Mitigating Risk: Enjoying a Sex Life with an STI.....	99
4.4 Managing Threats to Sexual Health: Low Sexual Desire.....	101
4.4.1 Sexual Assault as a Threat to Sexual Health	101
4.4.2 Relationship Health through Sexual Activity: Missing Subjective Desire	103
4.5 Conclusion.....	106
Chapter 5.....	108
5 The Discursive Construction of a Choice-Making Subject.....	108
5.1 Feminism, Knowledge, and the Postfeminist Subject.....	108
5.1.1 The Individual Pursuit of Knowledge as the Key to Good Health.....	112
5.2 Mobilizing Choice-Making Potential: Evaluating Sources of (Mis)Information.....	114
5.2.1 Challenging Messages about Sex in Popular Media	115
5.2.2 Undermining the Knowledge of Friends and Peers	117
5.2.3 Framing Sexual Health Education as Inadequate.....	119
5.2.4 Skilled and Supportive: Parents as a Resource for Good Health.....	120

5.2.5 Entitled to Care: Responsibilizing Women in the Doctor-Patient Relationship	122
5.3 Constructing Equality and Health Care Access	126
5.4 Responsibilizing Queer Youth in Canada	130
5.4.1 Assuming Acceptance of Queer Identities	130
5.4.2 Forming Community	134
5.5 Responsibilizing Young Women as Potential Victims of Sexual Assault	136
5.5.1 Managing Consent: Sexual Assault as Avoidable	137
5.5.2 Constructing Sexual Assault as Regrettable Sex	140
5.6 Conclusion	142
Chapter 6	144
6 The Discursive Construction of the Sexually Savvy Subject	144
6.1 Girlish Vulnerability: Puberty, Pregnancy, and Responsibility	144
6.1.1 Ready for Pleasure: Communication and Sexual Preparedness	149
6.2 Managing Risk and Pursuing Pleasure: Controlling Contraception	153
6.2.1 Smart Girls Know that Abstinence does not Work	154
6.2.2 A Shared(?) Responsibility: Risk Management and Pleasurable Preparedness	156
6.2.3 Compromising Protection: Men's Pleasure	159
6.2.4 Re-Defining Equality: Women Carry Condoms	161
6.2.5 ...But Men Put Them On	165
6.3 Empowering Women: Negotiating Condom Use	167
6.3.1 Claiming Desire: Sexual Initiation through Condom Use	169
6.3.2 Overcoming Men's Resistance: Deploying Sexual Pleasure	171
6.4 Conclusion	174
Chapter 7	175
7 Discussion	175
7.1 Ideal Sexual Health and the Postfeminist Subject	176
7.2 Sexualized Display: Sex for Health as an Imperative Through Postfeminism	178
7.2.1 Conservative Choices: STI Risk and Healthy Relationships	184
7.2.2 Preserving Future Fertility and Future Motherhood	190

7.3 Sexual Subjectivities and Responsibilities for Sexual Health: Seeking Postfeminist Control in a Risk Society	192
7.3.1 Individualizing Entitlements and Obligations for Health	199
7.3.2 Risk Groups: Capabilities for Health and Responsibilities for ‘Others’	203
7.4 Conclusion	208
Bibliography	214
Appendices.....	226
Curriculum Vitae.....	240

List of Figures

Figure 1: NAHO, Sexual Health Toolkit Part 1	75
Figure 2: NAHO, Sexual Health Toolkit Part 1	77
Figure 3: Trojan, Reducing the Risk: Risk chart	82
Figure 4: Trojan, Reducing the Risk: Risk chart	82
Figure 5: Trojan, Talking About Sex: You need to talk	96
Figure 6: Canadians for Choice, Sexual and Reproductive Health Issues: Abortion - Historical Background	109
Figure 7: Canadians for Choice, Sexual and Reproductive Health Issues: Abortion - Problems in Access	110
Figure 8: Healthy Canadians, Chlamydia	119
Figure 9: Trojan, Intro to STIs: More common than you think	129
Figure 10: NAHO, Sexual Health Toolkit Part 2.....	131
Figure 11: Trojan, Homepage	146
Figure 12: Trojan, Homepage	146
Figure 13: Trojan, Having Sex: Desire	147
Figure 14: Trojan, Condoms: Choosing a condom.....	163
Figure 15: Trojan, Are You Ready: Beyond the first time	164
Figure 16: Trojan, Monogamy and STIs: Am I still at risk	164
Figure 17: Healthy Canadians, Syphilis.....	165

Figure 18: Trojan, Homepage 165

Figure 19: SOGC, Birth Control: Non-Hormonal Methods of Birth Control..... 166

Figure 20: Trojan, Talking About Sex: Negotiating condom use..... 168

List of Appendices

Appendix I: List of Websites Offering Sexual Health Information.....	226
Appendix II: Sexual Health Topics by Website	228
Appendix III: Code Book.....	230

Chapter 1

1 Introduction

“We want to learn about sex”

-Tessa Hill

Lia Valente and Tessa Hill, two grade 8 students in Ontario, Canada, launched a successful petition to have the issue of consent included in the newly released 2015 sexual education curriculum. In an interview with *The Globe and Mail*, Valente and Hill criticize the abstinence- and fear-based discourses that are often characteristic of sexuality education curriculum as being incomplete; Hill states that

We want to learn about sex. One of the reasons that kids are exposed to porn so young is because they want to know about sex. The curriculum needs to be something that's not porn, where it's teaching kids real information. Teaching kids about sex doesn't make them want to have sex. And not teaching kids about sex doesn't make them not want to have sex (quoted in Bielski 2015).

In their petition, hosted by change.org, Valente and Hill point specifically to rape culture, porn, and media as pervasive contemporary issues that need to be included in curriculum: “We need curriculum that speaks to our lives and helps to make us safer” (Valente and Hill 2015). Valente and Hill astutely critique discourses of sexuality that rely on fear and repression, and which deny the sexual subjectivities, experiences, and realities of young people. In so doing, these students demonstrate a desire among young women for comprehensive sexual health information and education, while also demonstrating the ability of young women to make demands for this information from their schools.

The limitations of school-based sexuality education have been well documented: Fine (1988) identifies that standard sex education curricula tends to be characterized by “(1) the authorized suppression of a discourse of female sexual desire; (2) the promotion of a discourse of female sexual victimization; and (3) the explicit privileging of married

heterosexuality over other practices of sexuality” (30). Fine and McClelland (2006) later revisit these initial discourses, and claim that their concerns surrounding the privileging of risk and danger-based discourses over considerations of young people’s capacity to experience and express desire have heightened in a U.S.-context where abstinence-only until marriage sexuality education has proliferated in public schools (298). As Fine and McClelland (2006) argue, young women, particularly those “living and desiring at the embodied intersections of gender, sexuality, race, ethnicity, class, and disability”, bear the consequences of limited sexuality education (298). The development of sexual subjectivities is ignored, with the oft-cited fear from parents and conservative policy makers that teaching children about sex will make them want to have sex (a rebuttal for which Valente provides in the passage above).

These fears were articulated leading up to the implementation of the 2015 sexual education curriculum in Ontario; the national pro-life organization Campaign Life Coalition characterized the grade 1 lesson plan that teaches students the name for body parts such as “penis”, “testicles”, “vagina”, and “vulva” as “graphic”, and the grade 3 lesson on the social construction of gender as having the potential to cause “sexual confusion in the minds of children” (Campaign Life Coalition). These concerns were shared by some parents who felt that the curriculum was “too much, too soon” (CBC News 2015). In at least one school board, parents succeeded in getting the curriculum altered: Thorncliffe Park Elementary School in Toronto offered a class “where teachers covered the key issue of inappropriate touching without being specific about body parts”, using the term “private parts” in place of words like “penis” or “vagina” (Rushowy 2016). Religious values are often posited as reasons for resistance.¹

Fine (1988) identifies that “public schools have historically been the site for identifying, civilizing, and containing that which is considered uncontrollable” (31). In this case, it is the sexual bodies of young women and men which are considered uncontrollable, and in

¹ Although the *Toronto Star* article I cite on this issue references the large Muslim population in the community whose children attend Thorncliffe Park Elementary, the Campaign for Life Coalition cites Catholic values on its website. While religion does play a role in some parents’ objections to the new curriculum, it is beyond the scope of my discussion here to explore the extent of this influence.

need of management through sexual education. As Foucault (1978) argues in *The History of Sexuality, Volume I*, the attempt by educators, administrators, or parents to manage or exert power over the unruly sexual bodies of youth cannot simply be described as a repression of sexuality: rather, a multitude of discourses on sexuality are produced and reflected through this negotiation (158). These discourses include the voices of young women who request and seek out sexual health knowledge. Information about sex isn't merely being imposed on (or denied to) young women to regulate their bodies: young women actively desire and seek out that information themselves, from a variety of sources and including educational institutions. Glossy women's magazines routinely include health features and articles offering sex tips, and other forms of popular mass media like TV, films, and music videos regularly feature sexual content. Youth want this information and know that they need it, and they know enough about sex from media and from school to know that they are not getting the full picture.

Within this context, information about sex that can be accessed online through the internet becomes a particularly fruitful area of inquiry for young women and researchers alike: young women have private access to this information in their own homes, in their own bedrooms, and there is an increasing body of literature examining the content of and youth engagement with online sexual health services (see Bay-Cheng, 2001; Simon and Daneback 2013; Shoveller, Knight, Davis, Gilbert, and Ogilvie 2012). Health information is also increasingly accessible through smart phones and apps (see Lupton 2014 and 2015). The ubiquity of online sources of health and sex-related information means that young women are capable of supplementing their formal education; at the same time, online research, and mass media more generally, are easily disparaged as unreliable sources of health information. Through my research, I take seriously the role that these websites play as an alternate (or perhaps more accurately, additional) source of sex education, while also acknowledging that they are not a panacea necessarily offering more progressive discourses of sexuality than those found in formal educational curricula.

In order to contextualize online sex education for young women, I begin my dissertation by providing an introduction to some key issues facing women as they navigate their health in contemporary Canadian society. Through this literature review, in Chapter 2, I outline how healthism (Crawford 1980) operates to position the maintenance of good health as the moral responsibility of individual citizens in an increasingly neoliberal cultural context. I then shift to outline the literature on postfeminism, and identify how postfeminism interacts with and fits into a neoliberal, healthist society. Just as neoliberalism offloads the work of the government (in this case, the work of health and of health care) onto its individual citizens, postfeminism offloads the collective, feminist struggle to negotiate gender relations onto individual women. Postfeminism denies that work still needs to be done to advance gender equality, offering women's sexual emancipation as "proof" that feminism is outdated. Gendered work (e.g., women's responsibilities for the management of sexuality and sexual activity in a relationship) is reframed as pleasurable, self-fulfilling activities for women to engage in. Through the language of "empowerment" and "choice", women are pressured to maintain self-surveillance and engage in self-directed health care. This pressure encourages and expects women to seek out and even enjoy engaging with health information available through traditional and online media.

Because of the intersections between postfeminism and sexuality, and neoliberalism and health empowerment discourse, this critical stance on postfeminism is an ideal position from which to examine the discursive construction of sexual health. Concepts and understandings of "sexual health" are shaped in particular ways by postfeminism and by neoliberal approaches to health and health care. To examine these discursive constructions, my research focusses on websites that offer young women information on sexual health and examines the ideological work that is being performed through these websites. I argue that postfeminism, defined as the assumption of feminism, exists in and permeates online sexual health information discourses. Postfeminism is largely discussed in relationship to popular culture, and so through this project, I aim to expand the academic literature on postfeminism through its application to women's health discourse.

In Chapter 3, I introduce the critical discourse analysis methodology that I employed to execute my research, focusing on the work of Foucault (2002, 1984). I begin with a discussion of Foucault's concept of discourse, and consider how the way that we talk about (and represent through images) certain topics functions as a reflection of some of the values held by particular members of the social and political context from which they emerge. I also consider Foucault's discussion of power, knowledge, and truth to consider how some members of society or some institutional sources have more power than others to reflect or reinforce a particular narrative. I move from there to discuss Feminist Critical Discourse Analysis (FCDA), which also includes a consideration of how FCDA can address postfeminist culture and the intersections of gendered, neoliberal health and postfeminist discourses. In the second half of this chapter, I outline my research questions and objectives, my sampling and coding procedures, introduce the five websites selected for this study, and operationalize the concept of "sexual health".

In Chapters 4-6, I discuss the three major themes that I identified in my data. In Chapter 4, I discuss the discursive construction of an imperative of good sexual health, and outline how young women are mobilized through discourses on STI risk, monogamy, and low sexual desire to maintain a safe and active sex life for the good of their physical and emotional health. In Chapter 5, I discuss the discursive construction of a choice-making subject, and outline how young women, regardless of sexual orientation, socio-economic status, or ethnic background are responsabilized to consume and evaluate health information, and to use the knowledge they gain from that process to make decisions regarding when to come out to their families and to avoid sexual assault. In Chapter 6, I discuss the discursive construction of the sexually savvy subject, and outline how responsibilities for sexual health are gendered, particularly in relation to the acquisition of birth control products.

I conclude with Chapter 7, where I place the results of my research in conversation with the theoretical literature on healthism, neoliberalism, and postfeminism.

Chapter 2

2 Literature Review

2.1 Women's Health and Neoliberalism

In this section, I provide an overview on the literature related to women's health, neoliberalism, healthism, and the consumption of health information. Activists from the women's health movement initially succeeded in increasing the attention paid to women's health issues from government, policy makers and researchers. These successes are not fixed, however: in Canada, organizations designed to attend to issues of gender equity and health, including the Women's Health Contribution Program and the Canadian Women's Health Network, have had to suspend operations or seek alternate sources of funding following cuts in the 2012 federal budget (Polzer and Power 2016, 34). Health care in Canada is currently structured through a neoliberal model, characterized by decreases in funding (including to the women's health organizations founded through the efforts of the women's health movement) and an assumption that all individuals are entitled to equal care and service, a reality not fully realized by Aboriginal² and "other" diverse populations in Canada. I use Crawford's (1980) work on healthism to discuss how it is up to each individual to prioritize his or her health, a priority that can facilitate for individuals a sense of control over the multitude of health risks they are informed about. Consuming health information is one way individuals ease the anxiety that accompanies considerations of these risks; however, this consumption is work that is increasingly expected to be performed by individuals. Women are responsible for making good choices based on this information, regardless of the social constraints that structure and limit choices.

In Canada, the women's health movement was not singular, but emerged in the 1970s and 1980s and focused on refuting the notion that women's bodies made them inferior to men (Morrow 2007, 33). Activists challenged the way the medical field was dominated by white, male health professionals. This domination was twofold: first, women were not

² I use the term "Aboriginal" throughout this project to refer to the Indigenous peoples of Canada, including First Nations, Inuit, and Métis people. This term was selected for consistency with the data I use from the National Aboriginal Health Organization, one of the websites included in my sample for analysis.

trusted authorities on their own experiences of health, and second, the institutionalization of medical information rendered that information inaccessible (and therefore unusable) to a lay population. These challenges were based in the understanding that a lack of authority over one's own body, as well as a "lack of information prevented women from making informed decisions" (Boscoe et al 2004, 8). In other words, women activists sought to wrest power from men who controlled not only health and medical information, but therefore, the decisions that can be made about women's bodies and health as a result of that information. One of the tenets of this movement was the understanding that knowledge was power, and the realisation that women "could understand medical information if it was presented in an accessible form" (Boscoe, Basen, Alleyne, Bourrier-Lacroix and White 2004, 7). This movement argued for dialogue and discussion about strategies and policies that would "empower women to make informed choices about health" (Boscoe et al 2004, 9). Information, clearly written, enabled (and continues to enable) women to exercise decision making power.

These efforts to democratize health information and to value women's embodied, experiential knowledge were, to varying degrees, successful, as "women's health concerns have become very popular and 'acknowledged' in the mainstream" (Boscoe et al 2004, 9). Women campaigned for control over their own bodies through women's health centres and self-help groups, supported by feminist writing wherein "theorists spoke about the body as a site of knowledge ('embodied' knowing)" (Morrow 2007, 41). Canadian feminist activists also produced several publications about women's health, including the 1968 *Birth Control Handbook* from McGill's Student Union, which predates the oft-cited 1971 *Our Bodies, Our Selves* from the Boston Women's Health Course Collective (Morrow 2007, 42). Feminist agitation continued into the 1980s, which resulted in the establishment of the Canadian Women's Health Network in 1993 (Morrow 2007, 43), which I noted above recently lost its funding under the Harper Government in 2012. However, this institutional recognition and popularization of women's health issues comes at the risk of being co-opted or used by authorities and institutions that shape meanings about health and the health system; indeed, the "language of the women's movement has been taken on by governments and media, but too often without

a deep commitment to giving women a real voice in health care policy and planning” (Boscoe et al 2004, 9).

Morrow (2007) outlines some of the compromises that have come with the mainstreaming of women’s health issues: women are becoming increasingly involved in bureaucratic and institutional structures, where they are able to exercise “increased influence over the development of women’s health initiatives, policy, and research” (49). However, she also indicates that government and institutional agendas function to co-opt “some of the more radical and progressive aspects of the women’s health movement” (Morrow 2007, 49). In particular, the inclusion of women in the bureaucracy of health care can be heralded as the success of the movement itself, as though this success indicates the end point of the movement. Through this inclusion, the continued mobilization of the collective power of women is no longer identified as the necessary locus of change: rather, individuals are guided by various institutions, including educational curricula and popular media, in their pursuit of health and health information.

While women’s health concerns have gained institutional recognition, health care as a social service has become increasingly subject to financial constraints through neoliberal policy making. Frank (2000) argues that the “increasingly severe constraints” of health care as a social service are justified by the “problem” of rising health care costs, and a generalized sense of health care “crisis” pervades discussions as a result (213). Women’s health resources face similar constraints. Morrow (2007) argues that although governments have adopted new initiatives in women’s health (e.g. by establishing the Canadian Institutes of Health Research (CIHR) in 2000 and the Centres of Excellent for Women’s Health Program by Health Canada and spearheaded by the Canadian Women’s Health Network in 1996),

cutbacks in health have occurred and have been accompanied by massive health care service restructuring in the 1990s... including controlling public expenditures on health care, closure of hospitals and the shift to community and home-based care, the privatization of the delivery of

health care services, and the adoption of private sector management practices (52).

Feminist activists have responded to government funding cutbacks by sharing information and offering sustained critiques of government cuts to social spending (Morrow 2007, 49). In response to the depiction of states as ineffective in providing care to its citizens under a neoliberal mindset, McGregor (2001) additionally outlines that the cost-effective and consumer-friendly private health care market becomes more appealing to governments and individual citizens alike, which results in further cuts to social spending.

These funding decisions have had a particular impact on women, as they have “entailed more women taking on unpaid caregiving work, the degradation of women’s working conditions in the health care sector, and the inability of many women to access the health care they need” (Morrow 2007, 52). This shift to a more neoliberal health care model facilitates a reduction in the role of the government, and leaves open space for for-profit commercial ventures to fill. Through this shift, individuals change from being “patients” to “consumers” of health care (Frank 2000, 213). This change in nomenclature within health care discourses was intended to empower persons seeking medical treatment under the banner of consumer rights relating to choice and control over their care (Frank 2000, 214; Henderson & Peterson 2002). However, this individual-consumer is still subject to a new form of self-discipline and self-regulation, where she is responsible for her own health in order to qualify for her “patient’s rights” (Irvine 2002). Cuts in health care funding, accompanied by rising discourses of the importance of lifestyle in determining health (Crawford 1980), have produced an emphasis on individual responsibility for health as a moral obligation not only to self, but to one’s family and one’s state as well.

There are additional challenges facing women in a contemporary Canadian context, against which women, feminists, and other activists continue to agitate. Concerns over women’s experiences of health and questions about access to (shrinking) health care services and information must be considered in the context of hierarchies of power in historical and contemporary society. The Euro-centric values of white, able-bodied,

heterosexual, middle class men continue to constitute the unstated norm of health. Further, Hankivsky and Christoffersen (2008) stress the need to consider power explicitly through intersectional approaches (277). For example, they indicate that an exclusive focus on gender when discussing health

carries the risk of treating all women the same...overlooking the fluid and changing nature of gender; overlooking the ways in which economics, race, ability, geography, ability, sexuality and other influences shape and intersect with gender; and diverting attention away from differences among women (Hankivsky and Christoffersen 2008, 276).

In a Canadian context, taking an intersectional approach requires attending to the legacy of colonization against Aboriginal populations, in addition to other dynamics. De Leeuw and Greenwood (2011) discuss how the forced enfranchisement of Indigenous people by the Government of Canada, including through Indian residential schools and the confinement of Aboriginal people to reserves continues to have “repercussions for indigenous peoples in Canada, particularly in the realms of health and well-being” (53). Whether on reserve or not, approximately fifty per cent of Canada’s Aboriginal population lives in rural and remote locations, where “low population density, lack of transportation infrastructure, ability to speak only Aboriginal languages, long wait times, inadequate human resources, and northern climate conditions” all act as significant barriers to health care access (National Collaborating Centre for Aboriginal Health 2010, 3).

Federal programs designed to ameliorate barriers are not accessible to all Aboriginal people who may need them. The Non-Insured Health Benefits Program (NIHB) offers primary care services on-reserve in geographically remote areas where provincial services are not readily available; however, only status Indians and Inuit are eligible for this program, not the Métis and other Aboriginal peoples who do not qualify for registration under the Indian Act (National Collaborating Centre for Aboriginal Health 2010, 4). The Indian Act continues to regulate, categorize, and govern how “indigenous people interact with the various systems of health care services in Canada” (de Leeuw and Greenwood 2011, 63). This continued regulation has affected the health and well-

being of this population: Aboriginal peoples in Canada experience higher rates of unhealthiness than their non-Aboriginal counterparts, and this includes elements of sexual health including infectious diseases such as hepatitis, chlamydia, and HIV/AIDS (de Leeuw and Greenwood 2011, 63).

Tang and Browne (2008) cite Henry and Tator (2006) to argue that Canada currently operates under a “liberal democratic ideal of equality where everyone is purported to have equal access to resources and life chances” (110). This ideal of equality extends to health care services: all Canadians are entitled to access the health system, as promised by the principles of universality and accessibility that govern the Canada Health Act (Minister of Justice 2012). According to Tang and Browne’s (2008) study on egalitarian discourses involving Aboriginal people in the Canadian health care context, health care providers “tended to take for granted [or presume] that ‘everyone is treated the same’ irrespective of the patient’s background or social positioning”, even as many Aboriginal patients “wondered if their health care experiences were shaped negatively by their ‘Aboriginality’ or their racialized background as Aboriginal persons” (110). The authors stressed that their aim is not to elucidate a “truth” of racism in the Canadian health care system, but to examine the ways in which Aboriginal people in their study read their experiences receiving health care services through the larger discursive context of colonialism and racialized stereotypes of Aboriginal people (Tang and Browne 2008, 115). Even if the care delivered is the same, without discrimination, there are processes of racialization through which Aboriginal people navigate the health care system (as well as their everyday lives). Similarly, “Other” populations in Canada, including queer youth, must navigate discursive contexts of homophobia and heterosexism. Tang and Browne (2008) warn that these differences are not adequately accounted for in a liberal democratic context where it is assumed that “everyone has equal opportunity and the freedom to make free choices in their lives” (117). Having access to the same information or the same health care services may not be adequate to deliver the same level of care to all people in Canada.

2.1.1 Healthism as Self Control in a Risk Society

There are many challenges in women's experiences with health care today that cannot be understood solely as a direct co-optation of the women's health movement (or other movements to achieve liberal democratic ideals of equality). I nevertheless draw important parallels to explore and discuss how these limitations can be presented as not only palatable, but desirable and indeed, empowering. There are elements in contemporary health systems that continue the legacy of the women's health movement: specifically, women's resource centres, an emphasis on self-help and peer support, and a de-professionalization of medical knowledge in terms of health promotion and education persist to this day (Boscoe et al 2004, 8). However, healthism reframes the collective imperatives of the women's health movement: collective efforts have been depoliticized and have resulted in the responsibility for health being placed on women for whom these changes were meant to benefit. The demand for access to information has shifted through neoliberalism and healthism into an imperative for women to access (and assess) all available health information, and to choose to act and structure their behaviour according to that information.

To explore this imperative (and appeal) of responsibility, I turn to Robert Crawford's (1980) notion of healthism, which he defines as "the preoccupation with personal health as a primary – often the primary - focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles, with or without therapeutic help" (Crawford 1980, 368). Crawford (2006) identifies the late 1960s and early 1970s as a time period where a renewed emphasis on health consciousness emerged, both through political controversies over governmental regulation of environmental hazards and through an increased awareness and concern over lifestyle hazards (407). These two categories emerged in tandem, as "people increasingly worried about health could not wait for or depend upon the elimination of environmental carcinogens" through government oversight (407). Although Crawford (2006) does not cite the influence of the women's health movement in increasing health consciousness at this time, he does indicate that the "new health consciousness" represents an ideology whereby problems of health and their solutions are defined as

within personal control, and as a desirable pursuit and expression of individual progress, excellence, and in some cases, as a way for women to challenge expectations of feminine passivity (408).

Health became a prevailing discourse in the particular historical moment of the 1960s and 1970s because of its power to reorient responsibility for well-being onto individuals and families and away from governments. Discourses of health increasingly revolved around the problems and possibilities of lifestyles, where positive changes to lifestyles (e.g. engaging in dieting, exercise, or other self-help projects) could bring about good health. The ideological effect of this focus on lifestyles is that the solution to (ill) health is to be found in personal responsibility, a solution that both reflects and contributes to the “common sense” tenets of neoliberalism (and of decreasing governmental responsibility with regard to national health care benefits, particularly in the US, as Crawford outlines, but also in Canada, as I discuss below) (Crawford 2006, 409). Healthist movements also functioned to extend the effects of medicalization further throughout society by locating the causes of health and disease in the body and emphasizing the importance of self-control in a world of growing uncertainty. Healthism, then, is about applying an expectation of responsibility on individuals to care for their own health, and to make their health a primary focus of the choices they make about how to live their lives. Healthism, with its focus on personal change, promotes the illusion “that we can as individuals control our own existence”, regardless of the environmental and social conditions which impact health (Crawford 1980, 368). The illusion of control is significant; Crawford (2006) explains that “through health, the modern self demonstrates his or her agency, the rational capacity to re-make self and world” (402). This agency is limited by what an individual is actually capable of controlling, and the perceived gap between risks or dangers and control can increase anxieties about ill health (thus spurring further individual action and responsibility) (Crawford 2004, 512).

Crawford (2004) argues that current healthism is characterized by exposing and expecting individuals to acquire “information that conveys a sense of endangerment, along with a mandate to undertake instrumental actions for protection” (507). There has

been a growth in professional health promotion and health education, which operate not only to identify and communicate the existence of “lifestyle hazards”, but to “get people to take seriously the threat” of these hazards, including through scare tactics or emotional appeals (Crawford 2004, 508). These tactics become additionally important for health promoters and health promotion campaigns when they are identifying risks that accompany behaviours that individuals otherwise enjoy engaging in, such as sexual activity. The language of risk – “a kind of knowledge about potential hazards (or, more broadly, harms and benefits)” – has come to dominate discourses of health (Crawford 2004, 513). There is a “utility of risk discourse for lay people” in the way that it operates to guide personal choices and give a “compelling illusion of control”; individuals need only to access the right kind of information, which purportedly allows people to respond appropriately to that risk (Crawford 2004, 522).

Prevailing health discourse is marked by an emphasis on the ability of an individual to manage risks to their health, which promotes both a sense of responsibility and empowerment. However, this responsibility also carries with it an assumption of individual blame for those who do not (or cannot) manage these risks (Crawford 1980, 378). Consistent with neoliberal imperatives, social and material conditions are overlooked in favour of a view of poor health as deriving from individual failings, and some illnesses or diseases, such as sexually transmitted infections, are considered the “fault” of the afflicted person for not abiding by the moral proscriptions of society or making the right “lifestyle choices” (Crawford 1980, 378; Lupton 1994b, 89). However, individuals can avoid the stigma of sickness as long as they are doing everything they can to get healthy again (Crawford 1980, 380). For Cheek (2008), the work to maintain health “increasingly means embracing a range of lifestyle choices and technologies”: working out at a gym, undergoing cosmetic surgery, taking drugs to enhance sex drive, and other such practices that promise to make us feel good about ourselves and our bodies (and bodily appearance) are as much a part of health practice and health discourse as vaccinations and prescriptions (975). In other words, individuals are always at-risk and potentially sick, and must remain vigilant (and display or perform that vigilance) at all times.

As one exercise of vigilance, individuals are encouraged to participate in screening programs to identify risks or the “signs of impending disease”, whether or not they have experienced symptoms of ill health (Lupton 1994b, 99). Discourses on health risk raise anxiety levels in well people for which screening programs and self-vigilance offer reassurance. There is a temporary sense of calm that comes from technological and medical monitoring and testing as a result of this anxiety, where procedures like baseline mammograms or prenatal ultrasounds reassure patients who are invested in their self-management (Morgan 1998). Polzer (2010) also discusses how individuals become reassured by knowing and doing all they can do to manage risk in the context of predictive genetic testing for breast cancer; for some, genetic testing allows for a sense of hope and control over risk (71). However, this sense of control also requires individuals to actively question their own sense of health or their knowledge of their own bodies: for well people who do not experience symptoms, they must rely upon medical intervention and technologies to identify the “invisible signs of disease” (Lupton 1994b, 99). The body has become a menacing object which must be watched over: physicians teach patients the need for this watchfulness, and in turn patients hire and engage physicians as part of their body’s surveillance system (Frank 2000, 212). This extends as well to health information and health promotion literature which both informs surveillance and is employed in the exercise of surveillance.

2.1.2 Health Information: A Particular Kind of Consumption

Health promotion and education efforts rely on discourses of risk and individual responsibility, important tenets of healthism, to “encourage” individuals to pursue good health as a moral obligation. Healthism operates not only to scare individuals into acting in their “best interests”, but to offer the reassuring promise of control over risk and uncertainty. In addition, acquiring health information is constructed as a desirable and enjoyable pursuit in its own right for many individuals, particularly women. Good citizenship and individual autonomy are defined through the individual responsibility for and pursuit of health information, and through it, good health; indeed, Crawford (2006) states that “individuals are expected to acquire medical knowledge”, an educational

pursuit supported by extensive media coverage of health matters (402). This media coverage includes women's magazines: Roy (2008) notes that women's health issues, however depoliticized, circulate through popular media, and argues that magazines constitute important sites for the communication of ideas about responsibility for health. Roy (2008) argues that women's magazines frame health primarily as an individual responsibility and moral obligation to "pursue good health [...] through personal, individual adherence to the many and varied protocols for healthy living" (465). Additionally, particular forms of self-discipline and self-surveillance are invoked in magazine readers through the presentation of norms about health and healthy behaviour. Crawford (1980) argues that it is through the level of daily living, of which magazine readership is part, "external to medical institutions and relationships, that experiences, activities, and ideologies about health are being elaborated" (370). Health promotion and health information are included as regular features of most (if not all) mainstream women's magazines, indicating that learning about health is expected to be a regular part of women's leisure and entertainment activities. Increasingly, learning about health has become an activity that young women can conduct online, with specialized websites offering health information on a range of topics, including sexual health.

The contemporary turn to responsabilizing women in a healthist society has not been accompanied by an increase of trust in women to truly make the "right" choices. Women are expected to (enjoy) access to medical and health information through a variety of media outlets, including magazines, that offer a combination of professional and personal testimonies. This combination presents health information in accessible language, and functions to open up medical expertise to laypersons. However, doctors remain as the true experts on women's bodies and women's health (Morrow 2007, 36). For example, magazine articles present health issues (as well as websites offering sexual health information, as I discuss in my results chapters below) in ways that rely on medical experts and reinforce the authority of medical models of health: articles often conclude with messages that implore individual readers to ultimately "ask your doctor" about the health issues at hand. This directive functions to relieve the particular magazine (or website) of responsibility for the accuracy and efficacy of their information, and also

places that responsibility on the individual reader to call on and reinforce medical professionals as the ultimate and true authorities on matters of (their) health. The reinforcement of medical authority also contributes to the medicalization of women's bodies and women's health; Boscoe et al (2004) indicate that women continue to be seen as incompetent, and that all of their health issues are in need of medical intervention (10).

Cheek (2008) indicates that women's ability to make health care choices is similar to a type of consumption, stating that the philosophy of a neoliberal market state is to "maximize the choices available to individuals, so that individuals can then exercise free choice (a new form of 'buying' or window shopping)" (980). In a neoliberal healthist society, individuals are expected to consume health information; this health care consumer has emerged through the process of medical consumerism, which Frank (2000) defines as the consumption of increasingly discretionary, enhancing, or "lifestyle" services (205). Medical consumerism extends the responsibilities placed on individuals and on women, as consumer-based medical services expand the options available for individuals to "buy-in" to or to purchase to take care of their own health. However, the consumption of health services, products, or even information and the choices individuals are expected to make based on that consumption are not optional; Frank (2000) indicates that the aggregate density of health promotion messages creates "'ambient social values' into which the consumer is drawn" (207). These social values function to shift an individual's health from a biological imperative to a social imperative, where for women, "choice" is situated in the context of how gendered power dynamics are exercised (Davis 2002, 49). Cheek (2008) additionally warns that health care choices are framed in particular ways to make some choices more appealing than others. The result of this hierarchy of choice is that the individual "has the freedom to make choices but then can be held accountable for the consequences of those choices, or even for making those choices in the first place" (Cheek 2008, 980; see also Crawford 1980, Polzer and Knabe 2009).

The pursuit of health through lifestyle consumption activities (e.g. reading magazine articles about health issues or visiting websites that offer sexual health information) are

informed by broader, societal approaches to consumerism. Lupton (1994a) argues that everyday consumption activities may be considered cultural practices whether they are related to good health maintenance or not; the active choice and consumption of commodities (including information) is integral in the “creation and maintenance of the multiple, changeable and highly contextual identities of individuals” (Lupton 1994a, 112). In other words, what we choose to consume defines and expresses who we are. Mass media health communication campaigns generally, and online sexual health information specifically, should be examined for the role they play in constructing and offering subjectivities to the individuals consuming them. Health promotion campaigns are directed towards a view of the client-consumer-patient as someone who has the power and authority to make the right choices for their health; at the same time, these campaigns “routinely position members of the public as ignorant, apathetic, and passive, needing guidance from state agencies [who are sponsoring the messages] to conduct their lives wisely” (Lupton 1994a, 115). In the section that follows, I expand my discussion on neoliberalism and healthism to conceptualize how postfeminism contributes to this construction of the subject as capable of making choices to take control of health and lifestyle risks.

2.2 Postfeminism

In this section, I provide a review of the current academic literature on postfeminism, focusing on the work of Genz and Brabon (2009), Gill (2007, 2009), and McRobbie (2004, 2007, 2011), among others. Although each author offers a slightly different take on the key elements of postfeminism, I argue that postfeminism is best characterized as a discourse, a way of framing ideas about feminism that works to assume feminism. In other words, postfeminist discourse assumes that: (1) feminism has “succeeded”; (2) all women have equal access to and enjoyment of the gains of feminism; and (3) feminist success is static and requires no further work to expand or maintain its goals. People who write from a postfeminist position implicitly or explicitly assume that feminism has succeeded, and through this assumption, reinforce a conservative and apolitical form of feminism. Postfeminist approaches accept a limited conception of feminism (singular),

rather than feminisms (plural, with multiple perspectives, approaches, and complexities). Simply, postfeminism assumes that feminism has succeeded in making men and women equal to each other, and further, assumes that all women are equal to each other. Through this assumption, postfeminist discourse advances a politics of “sameness” that flattens identities and political aims. In so doing, postfeminist accounts advance a specific and limited conception of the postfeminist subject, one that occupies privileged status in terms of race (white), sexuality (heterosexual), ability (able-bodied), and social class (middle- to upper-class, educated, and professionally employed, or is at least striving to achieve these markers of success). Postfeminism relies heavily on sexuality to define the subject, as it variably credits the sexual revolution and pro-sex feminism for the success of feminism, embraces “raunch” culture, reclaims language such as “slut”, and resists sexual taboos to encourage women to have sex “like men”. The postfeminist subject is a sexual subject, and an open, free, and active sexuality is a strong source of evidence of feminism’s success. Finally, postfeminism argues that this success is static, and rejects the notion that any further work is required to maintain or expand feminist goals of women’s sexual and reproductive health rights or sexual emancipation.

There are several ways to conceptualize postfeminism, and as such, it is difficult to identify what, exactly, postfeminism is. For example, it is not a theoretical perspective, although it can be used to theorize certain phenomena (such as discourses of sexual health information, as I explore in this paper). Further, it is not a “movement” as feminism (broadly defined) can be described; there are no figureheads advocating for the development of postfeminism, although some prominent pop culture figures or TV or film characters may be described as postfeminist. McRobbie (2004) understands postfeminism to “refer to an active process by which feminist gains of the 1970s and 80s come to be undermined”, resulting in the undoing of feminism even as it seems to be “engaging in a well-informed and even well-intended response to feminism” (255). Gill (2009) defines postfeminism as a “sensibility” characterized by

- a taking for granted of feminist ideas alongside a fierce repudiation of feminism; an emphasis upon choice, freedom and individual empowerment; a pre-occupation with the body and sexuality as the locus

of femininity; a reassertion of natural sexual difference grounded in heteronormative ideas about gender complementarity; the importance placed upon self-surveillance and monitoring as modes of power; and a thoroughgoing commitment to ideas of self-transformation, that is, a make-over paradigm (346).

In its repudiation of feminism, postfeminism appears to be formulated around and responding to a general definition of feminism which argues that “women, purely and simply because they are women, are treated inequitably within a society which is organized to prioritise male viewpoints and concerns”, and further, that feminism is dedicated to changing this situation (Gamble 2004, vii). Through its response to this conception of feminism, postfeminism presents the claim that women have been but are no longer treated inequitably within society, thereby arguing that feminist work is not needed to expand or maintain this success.

It is important to note that although postfeminist assertions dialogue with and make assumptions about the success of feminism, postfeminism is not necessarily motivated by a desire for the continuity of feminist politics (Genz and Brabon 2009, 161). Banet-Weiser (2007) draws distinctions between postfeminism and third wave feminism, the latter of which is positioned more overtly as a kind of feminist politics that extends the historical trajectory of first and second wave feminism; postfeminism, however, acknowledges feminist values and ideologies only to determine them to be dated and passé (206). In contrast, third wave feminists have embraced the normalization of gender equality and feminism within the media and popular culture as an indication that feminism remains political (Banet-Weiser 2007, 209). To illustrate this normalization Kinser (2004) indicates that women of the third wave take equal rights as a given, and continue to discuss issues related to “sexism, reproductive rights, sexual autonomy, fair treatment, lesbian-gay-bisexual-transgender issues, workplace equity, global awareness and intersections of race, class, and gender” (Kinser 2004, 134). The political perspectives of feminists active in the third wave emerged from many women of colour leaders in the second wave in response to the need to address intersections of feminism and racism (Kinser 2004, 130), and thus, “third wave feminism defines itself as a budding

political movement with strong affiliations to second wave feminist theory and activism” (Genz and Brabon 2009, 156). Within postfeminism, the political stance of feminism is constructed as a necessity of the past to suggest that women no longer need to participate in this activism.

The view of feminism as no longer necessary is distinct from a backlash or anti-feminist attack: postfeminist discourses contribute to the popularization of particular feminist ideals (e.g. empowerment, access to choice) and to making feminist ideas, stripped of politics, accessible to a wider audience (Lazar 2009a, 373). I distinguish postfeminism from a backlash against feminism in one key way: while neither perspective has any interest in continuing the work of feminist politics, postfeminism assumes the gains of feminism, and it is through this assumption that the popularization of feminist ideals occurs. In other words, postfeminism assumes that the various advances made by feminist movements in the past are mostly positive gains that enhance and contribute to women’s lives, and in so doing, ignores (rather than actively rejects) the historical and contemporary goals of feminism that are intended to be politically threatening to the function of patriarchy, power, and the status quo (Gamble 2004, vii). For example, Lazar (2009a) argues that a postfeminist discourse assumes that “feminist struggles have ended...that women today enjoy full equality and can ‘have it all’ if they put their minds to it” (371). Braithwaite (2004) warns that by conflating postfeminism with backlash, the nuances of how much feminism has saturated or become part of the “accepted, ‘naturalized’, social formation”, we risk limiting the “possibilities of analysis” (19). Although Braithwaite’s (2004) arguments concern popular culture, it does reflect a “sensibility” (to borrow Gill’s term) whereby we can understand that young women are navigating a contemporary social and cultural terrain that has been truly shaped and positively influenced by feminist activism, even if that influence is not yet complete or realized by these young women.

2.2.1 The Norm of Feminist Success: Choosing Conservatism

While postfeminism recognizes the success of feminism(s) past, this positive recognition is rejoined by a move toward conservative action. As a process, McRobbie argues that “post-feminism positively draws on and invokes feminism as that which can be taken into account, to suggest that equality is achieved, in order to install a whole repertoire of new meanings which emphasize that it is no longer needed, it is a spent force” (McRobbie 2004, 255). Later, McRobbie (2007) argues that under postfeminism, the success of feminism is deployed to position girls as “the future” with the caveat that these girls conduct their lives under a “new meritocracy” (McRobbie 2007). In other words, postfeminist accounts argue that work is no longer needed to challenge the gendered hierarchy characteristic of a patriarchal society, and encourage women to believe that they no longer need to engage in collective feminist politics to work toward this goal (McRobbie 2007). Lazar (2009a) warns that we cannot understand feminist progress as universal or final, but as an on-going struggle to maintain rights earlier won by women (396). Women’s status and security remain in many ways tenuous, and “postfeminism broadly functions as a cover story” for that reality (Negra 2009, 44). There is an appeal to postfeminism, where it seemingly celebrates women and feminist success; however, this celebration functions to silence the political force of feminism (Lazar 2009a, 396).

Genz and Brabon (2009) expand on these definitions by arguing that postfeminism is not only apolitical, but that through this lack of organized politics, it produces “a retrogressive and reactionary conservatism” (167). This conservatism, characterized by “an increased emphasis on ‘choice’ and ‘self-empowerment’ in neo-liberal rhetoric” produces an understanding of feminism as “common sense” within an individualistic discourse (Genz and Brabon 2009, 167). Young women are called on to participate in the current neoliberal landscape through postfeminism; postfeminist accounts highlight the individual empowered positions of young women in ways that work to produce discursive silences surrounding collective feminist politics. As Lazar (2009a) argues, “adopting an apolitical stance is the marker of the modern feminine subject who has ‘arrived’. Those who press on with feminist activism, therefore, are likely to be viewed as fanatical, misguided and totally old-fashioned” (396). McRobbie (2011) also argues that

“it is a mark of cultural intelligence in young women who renounce or disavow the need for a new sexual politics – to this extent, young women have been expected to become both quiet and quiescent” (McRobbie 2011, 180). In other words, young women who take up a postfeminist subject position are rewarded by being seen as savvy and “in the know” through their rejection of “outdated” feminist politics.

There is a utility to postfeminism: it offers young women a veneer of empowerment and rights, and obscures the same old conservative mores operating beneath the surface. By offering these rights, feminism is invoked through postfeminism for the particular purpose of characterizing feminism as redundant and therefore unnecessary. Feminism is constructed as common-sense, but through this construction, “it is easy for young women to conclude that gender equality is the norm, and that, therefore, feminists who argue for it are simply unnecessary” (Kinser 2004, 134). In the current context, conflicts surrounding discussions of equality are interpreted as a type of postfeminism where feminist interventions are not rejected outright, but have been instead characterized as both successful in their time and now unnecessary (Negra 2009, 5). One way in which postfeminist accounts presents feminism(s) as simultaneously successful and unnecessary is through the representation of the postfeminist subject as in control and as capable of making choices, regardless of who controls the choices available (Negra 2009, 117). With a focus on female individualization, the postfeminist subject is one who can make the “right choices” within a regime of personal responsibility (McRobbie 2007).

Young women, and girls in particular, are targeted through postfeminist discourses for their potential to become self-reliant, individual, entrepreneurial, talented and competitive neoliberal subjects (McRobbie 2011, 181). The language of personal choice, normalized through postfeminist and other popular culture texts, carefully defines the parameters of what constitutes livable lives for these young women without affording them the benefit of a politicized feminism (McRobbie 2004, 262). Genz and Brabon (2009) identify that postfeminist accounts invite young women to focus their attention and energies on individual agency rather than collective politics, which largely benefits the middle class and lacks political seriousness (68). Returning to Crawford (1980), he indicates that

healthism similarly benefits the middle-class, as they are the ones who not only possess the personal resources to support a change in lifestyle, but who have also acquired a fundamental understanding of their professional achievements as the result of individual effort (384). McRobbie (2004) draws on the work of Beck and Giddens to argue that under this form of “female individualisation”, there is an emphasis on the expansion of freedom and choice, which carries with it an expectation that individuals self-monitor to access this freedom (260).

Gill (2009) identifies that transforming the self is a key element for the postfeminist woman: “the work required here is not that associated with acting or performing, but, more profoundly, involves remodeling one’s very sense of self” (357). Alongside this individualisation, the “resources of sociality (and welfare) are stripped away, leaving the individual to self-blame when success eludes him or her” (McRobbie 2004, 260).

Neoliberalism operates to construct the individual as an entrepreneur and consumer-citizen who should engage in an on-going project of the self that requires multiple lifestyle choices and active participation; postfeminism, then, is “part of a neo-liberal political economy that relies on the image of an ‘enterprising self’ characterized by initiative, ambition, and personal responsibility” (Genz and Brabon 2009, 166). Genz and Brabon cite Gill’s critique of this phenomenon, wherein she argues that the postfeminist focus on the individual erroneously extends the status of an “entirely free agent”; rather, the postfeminist subject is characterized by a return to femininity and a push to reprivatize “issues that have only relatively recently become politicized” as a result of second wave notions of collective politics and community activism (Genz and Brabon 2009, 171).

Negra (2009) argues that postfeminist culture reinforces conservative norms as the ultimate “best choices” in women’s lives (4). Gill (2009) describes McRobbie’s concept of “double entanglement”, where postfeminist culture grants women agency and choice so that they can use their “feminist” freedom to choose to re-embrace traditional femininity (363). This reinforcement of conservative norms is evident in the way that postfeminist culture encourages women to reclaim an “uncomplicated” identity, defined

as identities and gender roles otherwise “complicated” by feminism (Negra 2009, 4). Genz and Brabon (2009) identify that there are contradictions in the rhetoric of choice that “the postfeminist woman grapples with: what looks like individual empowerment, agency and self-determination can also signal conformity and docility” (151). Conservative choices are thus upheld as the empowered and best option for women, and as the choice women make for themselves to display this empowerment (Tasker and Negra 2005, 108). For example, the language of empowerment, equality, and taking charge is employed to encourage women to engage in traditional and conservative behaviours such as looking for a man, getting him to propose, and having an active but monogamous sex life (Gill 2009, 362).

2.2.2 Girls as Empowered Choice Makers and Consumers

The conservatism that shapes the choices made within postfeminist culture is also embedded within the recent cultural phenomenon of “Girl Power”, a term best exemplified by the musical group the Spice Girls in 1996 and itself appropriated and commodified from the more radical youth feminist Riot Grrrl movement of the early 1990s (Riordan 2001, 289). Genz and Brabon (2009) identify Girl Power as a particularly pervasive aspect of postfeminism, as it contains an “implicit rejection of many tenets held by second wave feminists” while upholding or re-asserting the empowering aspects of femininity in a male-dominated society (76). Lazar (2009a) identifies that some second wave feminists adopted a “critical view of femininity, considering it – with its associations of passivity, subservience and dependence – to be an obstacle to achieving gender equality” and arguing that a feminist identity is antithetical to a feminine one (381). In contrast, postfeminist discourse aims to reclaim and re-signify “stereotypical feminine values and practices as pleasurable and signalling confidence in women’s gender identity” (Lazar 2009a, 381). Alongside this “celebration” of femininity, Girl Power also refers to “a popular feminist stance...that combines female independence and individualism with a confident display of femininity/sexuality” (Genz and Brabon 2009, 77). In other words, Girl Power assumes

feminism to argue that women and girls are entitled to success through, and not despite, their engagement with traditional femininity.

Girl Power is unique because of the way it focuses its attention on girls and young women. McRobbie (2004) identifies that feminism is repudiated in different ways, including the “shrill championing of young women as a ‘metaphor for social change’” (257). Although the minds and bodies of young women are seen as the “privileged subjects of social change” by governments and organizations worldwide, McRobbie (2004) warns that these expectations and responsibilities are placed on individual girls without a recognition or cultivation of feminist politics (258). Girl Power assumes that girls and young women have benefited from feminism, but argues that feminism has characterized feminine grooming and display as oppressive. Girl Power thus seeks to argue that girls can and should enjoy a “return” to the femininity that was taken away through feminism, and frames this return as further evidence of the success of feminism: feminism allows girls to engage in any behaviour they may choose, even (and especially) if it contradicts specific feminist critiques. However, engagement in femininity is not unanimously liberating, as it conceals a trap of conformity and disempowerment (Genz and Brabon 2009, 79). The range of choices available to girls is “suspiciously narrow” and conforms to “patriarchal ideals of feminine beauty” (Genz and Brabon 2009, 79). As a result, any positive arguments about girls’ potential are constructed under Girl Power and postfeminism as essentialist and oppressive notions of what it means to be female.

Discourses on Girl Power and empowerment do not uniformly result in a delineation of feminist politics. For some Third Wave feminists, Girl Power represents an aspect of agency which creates space for forms of independent action. Indeed, Girl Power is founded on the belief that valuing girls and celebrating their culture, which has so often been devalued, will result in girls with higher self-esteem who feel positive about themselves (Riordan 2001, 289). Young girls are depicted as excellent choice makers, echoing discourses which position girls as “having taken the gains of feminism, such as increased freedoms, assertiveness, and economic independence, and applied them to the

market” (Harris 2004, 166). This consumer behaviour has been characterized as a kind of “Girl Power market,” a market that sells “an image of savvy girlness” to young girls by offering them a sense of empowered individuality through good product choices (Harris 2004b, 167). However, the use of choice in these materials appears to appropriate, rather than celebrate, some of the language promoted through feminism as well as the culture surrounding “Girl Power.” Indeed, the modern young woman is made an individual through her acts of consumption and participation in popular culture, emblematic of a new style of meritocracy exercised at the expense of collective feminist politics (McRobbie 2004, 258). The effect of this process is a responsabilization of young girls, who must reflect on and choose the kind of life they want to live while attempting to avoid the dire consequences that will presumably result from making the “wrong” decision (McRobbie 2004, 261).

Consumption based on “Girl Power” empowerment is a key feature of post-feminism. Historically, the recognition of children, and more specifically young girls, as potential consumers with buying power emerged from the establishment of teen magazines such as *Seventeen* in the 1940s. *Seventeen* creators described girls as buying items like clothes, electronics, cosmetics, and entertainment, but were also considered “housewives in training,” ensuring market loyalty to potential advertisers when they grow older (Massoni 2006, 36). Girls were also described by the makers of *Seventeen* as influential, indicating that girls and their peers are copycats of one another, each desiring what the other has. There is a significant amount of literature that explicates how youth, and tween girls specifically, are aspirational in their consumer behaviour. For example, Cook (2004) explains how young teens desire to be treated as “older” than their age by being granted agency and treated as a person through their consumption habits (118). The “stuff” that tween girls seem to consume most reliably are accessories, clothes, make-up, and shoes, representative of a “trickle-down” of contemporary adult, sexualized, and feminine consumer display (Cook and Kaiser 2004, 204). In addition to consuming products, tween girls also consume information that prepare them for young adulthood: the text of magazines such as *Seventeen* discuss topics such as dating dilemmas and issues related to sexual or gynaecological health. Although moral panics regularly emerge regarding the

early or “premature” sexualisation of tween girls, girls are discursively afforded the ability (and responsibility) to make the right choices as they age into young adults.

2.2.3 Self-Sexualized Subjecthood: Pleasures and Obligations

In postfeminist culture women are depicted as knowingly engaging in the construction of their sexual object-/subject-hood, where for these women it is something they are seemingly doing out of choice and for their own enjoyment (McRobbie 2004, 259).

Indeed, this embrace of sexual display is defined in postfeminist discourse as indebted to the success of feminism, where the postfeminist woman believes that the right ideology (feminism) and the best sex are not mutually exclusive (Shalit in Genz and Brabon 2009, 92). This form of sexual emancipation hinges upon an assumption of feminism because it takes place within a current social context fundamentally altered by the achievement of feminist goals in the sexual revolution (Genz and Brabon 2009, 92). Feminism is assumed, and both allows and demands that the subject position of the sexually voracious woman exist. Morrow (2007) argues that the focus on women’s pleasure and sexuality is rooted in the “so-called ‘sexual revolution’” of the 1960s, wherein “feminists had been actively involved in reclaiming women’s sexual pleasure, both through exposing the myths about women’s sexuality that had been proliferated by the medical and psychological establishments, and by actively promoting lesbian sexuality” (46). Loe (1999) describes how promises of sexual liberation offered through the sexual revolution influenced the emergence of pro-sex feminism in the 1970s (709). These movements have also influenced more contemporary iterations of feminism, where younger generations of women embrace a self-identity that is confident, assertive, and “unapologetically sexual” and understand “that good pleasures make good politics” (Wolf in Genz and Brabon 69).³

³ Advancements in birth control, specifically the Pill, should be noted when considering contributions to the sexual revolution and the ability of women to divorce sexual activity from reproduction. For a discussion of the contribution of the Pill to women’s career and educational pursuits, see Bailey (2006) and Goldin & Katz (2002). For a discussion of the way that (single) women navigated gaining access to the Pill, see Bailey (1997). For a discussion of the racist implementation of birth control pills, programs, and eugenics, policies intended to work against the sexual and reproductive emancipation of Black and Aboriginal women, see Davis (2008) and Savage (2013). Tone (2012) provides a discussion of the way the Pill’s popularity contributed to the expansion of the medicalization of reproduction.

Sexuality is increasingly deployed in popular culture as shorthand for women's empowerment and independence from outdated patriarchal ideals that used morality and shame to regulate women's bodies and sexualities and that positioned women as sexual objects for the enjoyment of men. McRobbie (2004) points to the use of pro-sex and sexualized imagery in popular culture, stating that contemporary advertisements take "feminism into account by showing it to be a thing of the past, by provocatively 'enacting sexism' while at the same time playing with those debates in film theory about women as the object of the gaze" (McRobbie 2004, 258). Through sexualized displays in consumer culture, Attwood (2005) argues that "sexual openness, individual empowerment, an entitlement to pleasure and 'consumer choice' have become the key terms used to delineate the post-feminist sexual ideal" (401). Through the postfeminist ideal, young women are reclaiming and redefining their sexuality as something that they have control over; however, this redefinition still requires women to display their sexualized bodies in ways that have traditionally appealed to (certain hetero-patriarchal) men. In other words, ideologies of women's liberation and the sexual revolution are blended and co-opted to produce a postfeminist understanding of sexually provocative appearance and behaviour as acts of female empowerment, where women deliberately make sex objects of themselves and of other women (Genz and Brabon 2009, 91). The function of this co-optation of women's sexual liberation is an invitation and a command to young women, who must "move from a sexual subjecthood characterized by shame, secrecy and 'hang-ups' to a newly made-over 'open', 'healthy' and 'uncomplicated' (!) sexual subjectivity, in which one's 'sexual potential' is 'unlocked'" through the discourse of postfeminism (Gill 2009, 360). The postfeminist subject is both entitled and obligated to experience and display her sexual emancipation.

Levy (2005) uses the term "raunch culture" to argue that this kind of sexualisation becomes a litmus test for how "chill" or how "uptight" women are. Participating in this kind of self-sexualization is what now "makes you a strong, powerful woman", and further, we have "determined that all empowered women must be overtly and publicly sexual" (Levy 2005, 26). While some women genuinely choose to express themselves in

this way, publicly sexual display is increasingly required of all women. Raunch culture operates to set up a relationship between “generations” of feminists that is used as the basis for inciting particular kinds of action: how can young women refuse to claim and perform their sexuality after all the work that older feminists have done to make this possible? Declining to participate comes with risks, as raunch culture functions to label women who opt-out as outdated, unliberated, and behind the times, untenable suggestions in a postfeminist climate where women’s liberation is assumed. However, participation also requires a certain amount of work. Maintaining the correct sexual attitude requires constant vigilance and self-surveillance, and a willingness to engage in activities such as pole dancing, lap dances, and strip teases; these activities are recommended for keeping the spice in women’s (heterosexual) sex lives and also represent an increasing normalization of practices associated with pornography and the sex industry (Gill 2009, 360). Postfeminism reclassifies pornography as hip, ironic and mainstream, and decreases the stigma associated with participation for both performers and consumers (Negra 2009, 99). Within an increasingly sexualized culture, informed by the “pornographication of mainstream media”, women are targeted as sexual consumers through the tenets of female pleasure (Attwood 2005, 392). Women are increasingly expected to be consumers (and performers) of products, information, and practices meant to improve and display their sexual skills. Within a postfeminist culture, the work of vigilance and consumption that this form of sexual display requires is re-framed as an exercise in sexual liberation and as an avenue for women to achieve their best life.

By presenting an iteration of the sexual revolution within which (heterosexual) sex is framed as the required route to liberation, postfeminism casts women “in just as strong a thrall to men, with new pressures to perform sexually at every occasion” (Whelehan in Genz and Brabon 2009, 95). This pressure is accompanied by a sense of relief among male viewers who enjoy the permission, “once again, to enjoy looking at the bodies of beautiful women” (McRobbie 2004, 259). The postfeminist man is constructed as heterosexual and as bitter about the “wounded” status of his masculinity allegedly resulting from second wave feminism (Genz and Brabon 2009, 143). Although he is anxious about this wounded status and the increased social freedom enjoyed by the

postfeminist woman, the postfeminist man is invited to embrace the 'new equality' that accompanies her sexual emancipation. However, women are tasked with performing the work required for this invitation to be successful. Emotional labour remains gendered within a postfeminist culture. In what she terms "men-ology", Gill (2009) discusses the way that relationship advice articles in women's magazines construct men as "programmed" in particular ways, and as in need of being "told" what women want (by women) in order to understand how to satisfy them sexually (364). The postfeminist woman must carefully navigate this "telling": she must approach relationships with men under the auspice of mutual respect and communication. In so doing, she must silence her needs and hide her anxieties while gently and reassuringly dealing with men's (Gill 2009, 364).

The postfeminist woman, presumed heterosexual and constantly desiring sexual activity, is expected to manage the emotional and sexual needs of both herself and her male partner in a relationship. Magazine articles offering relationship advice educate women to understand men, and encourage these women to take (asymmetrical) responsibility for the work of emotional management in relationships where even failed relationships serve as personal development (Gill 2009, 354). Attwood (2005) identifies that there has been a shift toward an emphasis on self-care in popular media texts about women's sexuality, such as in women's magazines, which is "clearly a sign of progress", although she cautions that expert voices (rather than the voices of women) still dominate discussions of sex in women's media (397). In her discussion of the marketing of beauty products Lazar (2009a) indicates that advertisers emphasize the pleasurable aspects of caring for the self to re-frame the labour involved in maintaining traditional feminine gender presentations (395). The postfeminist emphasis on personal development is key: since managing relationships or an appropriately feminized sexual display is presented as the route allowing women to achieve their sexual peak (and thus true feminist liberation), this management and emotional labour is reframed as care a woman is performing *for herself*, not for a male other.

Lazar (2009a) argues that the discourse of “it’s about me” in postfeminist beauty culture turns the focus from social and collective politics to personal and individual consumption, and additionally convinces the postfeminist subject that normative beauty (or sexual) practices are internal desires (389). Any objections to traditional sexual or beauty regimes are rejected as the woman objecting is understood to be old-fashioned, outdated, or too staunchly feminist and political. As a result, the postfeminist subject is “despite her freedom, called upon to be silent, to withhold critique, to count as a modern sophisticated girl, or indeed withholding of critique is a condition of her freedom” (McRobbie 2004, 260). The assumption that feminism has succeeded in redressing inequality based on gender functions to endorse “a new regime of sexual meanings based on female consent, equality, participation and pleasure”, but this assumption also functions to “free” women of politics and the ability to have their objections and critiques heard (McRobbie 2004, 260). Young women are entitled to the sexual freedoms gained through feminist activist efforts during the sexual revolution, but this entitlement is taken up as a responsibility in a postfeminist culture: she is obligated to perform the work of relationship and self-management without the benefit of collective or community support to challenge, renegotiate, or extend the terms of her “freedom”.

2.3 Neoliberal Health and Postfeminism

Drawing from my previous work on discourses of HPV vaccination in Canadian magazines, I position popular media (including websites) as a site for the exercise of biopower (Cayen, Polzer and Knabe 2016, 86). In *The History of Sexuality*, Foucault (1978) asserts that the increasing interest in and production of knowledge about sexuality in the Victorian era was intimately connected to the exercise of biopower, which in contrast to sovereign power, is dispersed and circulated through multiple sites and functions to discipline the body and regulate the population. Foucault challenges the idea that sexuality was repressed during this time and rather shows how “sex” and sexuality emerges as effects of discourse. As an effect of these discourses, Foucault (1978) uses the term “pedagogization of children’s sex” to describe the ways in which children came to be defined in the eighteenth century as “preliminary sexual beings” (104) who were

seen as inevitably prone to sexual activity. Parents, teachers, and doctors were called upon to “take charge of this precocious and perilous, dangerous and endangered sexual potential” (Foucault 1978, 104). In my work on HPV vaccination, I identified the gendered dimensions of this pedagogization, as it is the female tween body that is problematized in relation to cervical cancer risk and mothers who are responsabilized to take charge of the sexualized tween body by ensuring their daughters receive vaccination (Cayen, Polzer and Knabe 2016, 87). The gendered dimension of the pedagogization of children’s sex persists in contemporary discourses surrounding young women’s sexual health. The ways in which young women are being educated about their “sexual health”, whether through formal education curricula or through websites offering sexual health information, is a contemporary expression of the pedagogization of children’s sex. Aided by a postfeminist sensibility and a culture characterized by healthism that work together to position young women in particular as capable of taking charge of their health, young women are called upon to take charge of their own “precocious and perilous, dangerous and endangered sexual potential”.

The function of healthism (and neoliberalism more broadly) is to get the body to regulate itself, without requiring government (financial) assistance or intervention. It does this by convincing individual citizens that the pursuit of health is moral and good, and that being moral and good can be achieved by making health a number one priority. It is also characterized by blame, where failing to achieve good health is understood as a personal failure. There are certainly ways in which healthism and neoliberalism are gendered: as one example, women are responsabilized as mothers to care for the health of their children and families (Roy 2008; Cayen, Polzer and Knabe 2016). I use postfeminism as a way to think through this gendering, as this “sensibility” is well suited to give additional insight into healthism. Young women are in the best position to prioritize their health: feminist activists in the women’s health movement opened up conversations about women’s capacities to understand health information and to make informed choices about their lives. However, this resistant position has been effectively co-opted and incorporated by neoliberal policies and governing practices; Polzer and Power (2016) indicate that “demands for greater autonomy over health care made by the women’s

health movement, which actively resisted the medicalization of women's bodies and lives, have been co-opted by postfeminist discourses in popular culture and risk management technologies that claim to provide women with the ability to make 'informed choices' and decisions about their health" (15). Critics of the medical system-as-system, including feminist activists in the women's health movement, have been offered solutions through neoliberalism that rely on the choices that can be made by an individual. Just as neoliberalism downloads the work of government onto individuals, so too does postfeminism download the work of collective feminist politics onto individual women.

Polzer and Power (2016) discuss how neoliberalism is characterized by a governmentality that operates to regulate not through force, but through freedom. Freedom offers the subjects of neoliberal governance "possibilities for action", a range of choices for individuals to practice self-examination and self-care (Polzer and Power 2016, 13). These choices are limited and defined, however, and "alternate choices...are not morally equivalent": there are right choices to be made, namely, choices that reduce risk and enhance health (Polzer and Power 2016, 14). Freedom has a regulatory function, where neoliberal governance operates to call on the subject to regulate herself in ways that "are aligned with broader political and economic objectives" (Polzer and Power 2016, 13). Restrictions and force give way to discourses of freedom through both postfeminism and neoliberalism. For example, repressive discourses that frame sex as an activity that carries the risk of STIs and pregnancy (and that should thus be avoided) are joined by discourses through the sexual revolution that position young women as entitled to enjoyable and pleasurable sex. Young women are identified as uniquely capable of managing their lifestyles: they aspire to achieve a successful life, bolstered by feminist gains that opened personal and professional opportunities for them, including access to safer and more effective forms of birth control. Maintaining good health is a vital component of lifestyle management for young women: Harris (2004a) outlines the way in which teenage pregnancy renders young women at-risk of not achieving the markers of success that they are entitled (and expected) to meet. Young women enjoy a certain level of empowerment and freedom, but are expected to not squander it. Indeed, Harris

(2004a) identifies that this freedom is narrowly defined as financial, where young women are positioned as future consumers and contributors to capitalist society.

The majority of the literature produced by scholars working to theorize postfeminism has focused on this relationship between consumerism and the popularization of feminism-as-postfeminism in mass media and popular culture. However, the body of literature examining the relationships between postfeminism and health is small, but quickly growing. Theorizing on the mass-media and consumer culture aspects of postfeminism has influenced this discussion: Negra (2009) argues that the postfeminist approach to health is consistent with its emphasis on individual responsibility in a consumer culture. For example, postfeminist culture “manages the decline of social health by emphasizing the importance of personal (physical and emotional) health in an individualized, isolated context” (Negra 2009, 118). In the context of decreasing state support for social services, health and healthcare is increasingly characterized as a class entitlement in the US, where the “semantics of luxury function in a postfeminist context [by taking] seriously the power of a well-kept home and well-kept body as the new indices of achieved adult femininity in America” (Negra 2009, 118). This emphasis on luxury often overwhelms the emphasis on health, where the postfeminist entitlement to self-care is best exercised through services such as spa days and manicures. These luxuries intervene to “soothe the awareness of intensified competition and inequality in American life” and assign the postfeminist subject a sense of entitlement to “rewarding-transformative consumerism” (Negra 2009, 141).

Gunn and Vavrus (2010) also focus on the consumer aspect of health and postfeminist discourse, examining the marketing campaigns for three pharmaceutical products designed to manage “the ills alleged to derive from” aspects of menstruation across the life course. In their discussion, the authors point to feminist analyses that have offered critiques of medical discourses on menstruation that produce the feminine body as the abject and “pathological Other to the masculine norm” (Gunn and Vavrus 2010, 121). The feminine body thusly constructed demands that women must work to regulate, control, and conceal menstruation (and related emotional symptoms) through the use,

perhaps, of pharmaceutical products. The work of self-regulation is made palatable through postfeminist discourses on empowerment and consumption: the marketing campaigns for pharmaceutical interventions ensure success by promoting their remedies as “woman-friendly”. This woman-friendly framing is distinctly postfeminist: while a feminist framing would enable critiques of “many of the constructed identities on which advertising of all kinds relies”, including constructions of the feminine body as abject, a postfeminist framing encourages women to “think in terms of commodification and consumption” (Gunn and Vavrus 2010, 121). The marketing offers to women the subject position of the good woman through consumption: by use of these pharmaceuticals, she is able to manage PMS-related mood swings and bloating to ensure she maintains her status as a happy, smiling, and slim woman (Gunn and Vavrus 2010, 125).

There is a regulatory function of discourses on women’s health, framed by postfeminist self-empowerment, and aimed exclusively at women (Gunn and Vavrus 2010, 113). Cairns and Johnston (2015) examine the self-regulatory practices espoused through the “do-diet”, a “healthy eating discourse that reframes dietary restrictions as positive choices, while maintaining an emphasis on body discipline, expert knowledge, and self-control” (154). Postfeminism is characterized by consumption, including of food, and the authors argue that “the do-diet works to remediate a tension at the heart of neoliberal consumer culture: namely, the tension between expressing freedom through consumer choice, and embodying discipline through dietary control” (Cairns and Johnston 2015, 155). Postfeminism operates through the do-diet in ways that naturalize gender inequality: women are offered ways to “indulge” in food through empowering acts of informed choice that remain implicitly body-focused (Cairns and Johnston 2015, 171). In other words, women are able to maintain their “good” health and good womanhood by avoiding fatness through acts of self-regulation framed through postfeminism as acts of freedom and self-care.

There are compellingly similar discursive strategies evident in the way that postfeminism and neoliberal healthism operate together that work to produce and reinforce “traditional” gender roles, like the role of the good woman who makes healthy-eating choices to avoid

fatness as identified by Cairns and Johnston (2015). The focus on the self-production of good womanhood is not a remnant of sexism, yet to be excised from an otherwise progressive narrative. Rather, this focus is an integral part of the way we understand narratives of women's health. Dubriwny (2013) offers a thorough contribution to the discussion on postfeminist discourses in women's health matters in her book, *The Vulnerable Empowered Woman: Feminism, postfeminism, and women's health*. In it, Dubriwny (2013) outlines the regulatory function of neoliberalism through the topic of HPV risk, where promotional materials for HPV vaccination construct girls as vulnerable to the dangers of sex and as in need of protection through vaccination because they are presumed to be heterosexual: they are future sexual actors, where sexual activity poses risks. Arguments about girls' vulnerability rely on and reinforce traditional gender roles for young women, where young women are expected to make the "right" and "smart" choices for themselves to support their health through the avoidance of promiscuous (read: dangerous) sex and through the consumption of pharmaceutical products. In addition to risk- or danger-based discourses, promotional materials for HPV vaccination also include discourses of postfeminism. Young women are constructed as empowered, in addition to being vulnerable; but, this empowerment is based in a neoliberal model of choice and consumption (Dubriwny 2013, 140).

Dubriwny (2013) argues that young women are empowered in the medical sphere to choose HPV vaccination in ways that I argue apply to young women's navigation of sexual health risks more broadly: "she is told to focus on herself, her risks, and her responsibilities to avoid and/or mitigate these risks" (153). Risk is mitigated through self-discipline and self-regulation, where young women have the choice to abstain from sex until an appropriate age and get vaccinated in the meantime. However, young women's choices are facilitated "by a forgetting of the fact that access to medical choice is unequal" (Dubriwny 2013, 140). In their discussion of the way that HPV vaccination campaigns position the "not-yet-sexually-active 'good girl'" as their target consumer, Polzer and Knabe (2009) indicate that the emphasis on individual responsibility for health (being smart and "choosing" right) obscures social conditions and determinants of health, such as those "associated with higher rates of mortality from cervical cancer among

marginalized women (e.g. Aboriginal women, immigrant women, women living on low incomes)” (869). The individualization characteristic of postfeminism and neoliberalism work well together to overshadow the political action characteristic of the early women’s health movement as a dominant discourse in discussions of women’s health.

To conclude, I return to my conceptualization of postfeminism as an assumption of feminism. To reiterate, postfeminist discourse assumes that: (1) feminism has “succeeded”; (2) all women have equal access to and enjoyment of the gains of feminism; and (3) feminist success is static and requires no further work to expand or maintain its goals. Through an alignment of neoliberal and postfeminist discourses (Dubriwny 2013, 171), the assumption of feminist success has been incorporated into the way we understand women’s sexual health. Young women are constructed as self-regulating, no longer needing parents (mothers) or schools to impose restrictions or protections on their sexual activities. Through the empowerment and freedom offered through neoliberal healthism and postfeminism, they are taking on the responsibility of being smart, informing themselves, and submitting to or consuming appropriate biomedical interventions so that they can pursue good health and good sex. Risk avoidance is constructed as a matter of choice, positioning good health as a fundamental feminist right that is equally accessible to “all” women. Risk is also individualized, supplanting focus from the work that needs to be done to address the structures and policies that produce differences in access to health care and to health outcomes.

2.3.1 Sources of Health Information: Websites as a Focus of Analysis

Women are invited to exercise their responsibility for self-health management through a variety of forms: for example, mass media texts such as women’s magazines serve a dual function, offering women a source of entertainment as well as information. Often, this “infotainment” concerns health care practices, as magazines combine “expert discourse on health found in medical journals” with lay understandings to communicate information about issues related to health and sexuality to readers (Roy 2008, 464; Jackson in Clarke 2009, 418). Although there is some evidence that magazines “are

approached in contradictory ways by their audiences and with a combination of cynicism, resistance and acceptance”, magazine readership has become understood as a “taken-for-granted aspect of daily living”, simultaneously creating, reflecting, and mediating social realities (Clarke 2009, 416). For some women, whether actively seeking health-related information or not, magazines are a principal source of this information, used more frequently than other sources including other media, family, friends, or health professionals (Kassulke in Bonner and McKay 2000, 133). The magazine format for distributing sexual health information has been influential for other products as well: in her analysis of sex shop websites, Attwood (2005) notes the use of layout designs which mimic the “codes of upmarket glossy women’s magazines” (394).

Health information is found through a variety of media sources, and there is a confluence of styles that capitalize on the familiarity of the magazine and website format to present information in an accessible way. Further in Attwood’s (2005) study, she argues that “sexual consumerism is equated with the development of sexual knowledge and the need for women to access sexual material ‘without feeling ashamed and secretive’” (394). There is a repackaging of sex across a variety of brands in Attwood’s study, which reveals a “very clear perception that sex must be made over as nice, bright, and accessible. This is achieved by clearly signifying sexual representations, products and practices as stylish, classy and fashionable” (Attwood 2005, 399). The privacy afforded to young women who access health and sex information through magazines or websites offers a space through which they actively engage with and construct their sexual identities, for example by resisting the ways in which female sexuality is depicted as “dark, dirty” or shameful.

The availability of health information online has the potential to challenge traditional and hierarchical doctor-patient relationships, where claims to medical knowledge that arise from individual lived experience or through alternative or holistic medicine are ignored or demeaned (Morgan 1998). This availability also offers particular opportunities for feminist critics of biomedicine to assert the uniqueness of women’s embodied experiences in relation to their own health (Lupton 1994b, 131). However, this

availability is also easily co-opted by discourses of neoliberalism and healthism, as information-seeking behaviour supports the extension of the individualization of responsibility through the proliferation of health information into everyday life. Healthist accounts construct patients as empowered; by turning to the internet to seek out sources of health information, individuals are provided with a sense of ownership over themselves and medical risk, reducing a reliance on information created and disseminated by medical professionals (Wilkins in Goetzinger et al 2007, 128). However, this challenge to medical authority (that is, to the expectation that health information is best disseminated from medical professionals to their patients in a clinic setting) introduces new potential concerns: what other organizations are invested in the dissemination of health information, and for what purpose? What ethical or professional responsibility do they have to their potential readers?

In Chapter 1, I discussed how grade 8 students Hill and Valente used an internet-based petition platform to agitate for more comprehensive sexual health information in school curricula, a traditionally-recognized source of health education for young adults. In the remainder of my project, I analyse websites as a source of sexual health information for young women, and question the discursive constructions produced through these sources.

Chapter 3

3 Methodology

In the literature review above, I discussed healthism, neoliberalism, and postfeminism, and how each function as discourses through which knowledge is understood and produced. In particular, each discourse produces understandings that position the individual as a social actor who is responsible for exercising control over her own life in a cultural climate characterized by risk and uncertainty. Together, these discourses construct health as a key concern for young women. The postfeminist emphasis on sexual liberation highlights sexual health as an avenue through which young women are particularly capable and in need of taking charge of their own sexual potential, and the risks that accompany it. To examine the meanings and understandings we have of young women's "sexual health", I undertake a feminist critical discourse analysis of five websites offering sexual health information. In the chapter that follows, I outline my methodological approach to this project, which is informed by Foucaultian Critical Discourse Analysis, Feminist Critical Discourse Analysis, and Visual Culture methodologies.

3.1 Foucault and Critical Discourse Analysis

3.1.1 Discourse

For my dissertation, I employ a Foucaultian approach to discourse analysis in order to examine the meanings and assumptions of textual and visual data related to online sexual health information. It is the everyday nature of sexual health information – its popularity, its availability across a multitude of sources, and the way women are implored and deployed to seek this information not only as a responsibility but also as a source of self-fulfillment and enjoyment – that makes this material particularly appropriate for this approach to discourse analysis. Foucault (2002) calls for the necessity of examining everyday discourses, recommending that we must question the way that discourse appears to be ready-made, and the way discourse is accepted and validated without examination (24). This is particularly true as it concerns discourses with which we are

very familiar (Foucault 2002, 24). Cheek (2004) argues that the familiarity of certain discourses, understood from a Foucaultian perspective, frequently renders the assumptions that constitute those discourses as taken for granted or invisible (1142). Rose (2012) understands Foucaultian discourse as “groups of statements that structure the way a thing is thought, and the way we act on the basis of that thinking. In other words, discourse is a particular knowledge about the world which shapes how the world is understood and how things are done in it” (Rose 2012, 190). Critical Discourse Analysis (CDA) is thus best suited to a task of critical examination, as it offers a way to think and speak about this knowledge about the world, and identifies that not all discourses are given equal notice or authority (Cheek 2004, 1142).

The “speaking” which occurs in discourse is distinct from the speaking which occurs in language. Foucault (2002) argues that there are rules governing both language and discourse; however, while the rules of language facilitate an “infinite number of performances”, the rules of discourse “form a finite grouping” (30). For example, the rules which both constrain and produce discourses may operate through a limitation on the particular group of individuals or institutions who have “the right to speak, ability to understand...and the capacity to invest this discourse in decisions, institutions, or practices” (Foucault 2002, 75). Van Dijk (1993) indicates that a CDA can aid in the analysis of these rules, as CDA involves a “study of the relations between discourse, power, dominance, social inequality and the position of the discourse analyst in such social relationships” (Van Dijk 1993, 249). The methodological question facing the discourse analyst is thus to determine the rules which have governed particular statements and discourses, and to determine how it is that particular statement which has appeared rather than any other (Foucault 2002, 30). In my analysis, then, it will be important to determine the rules and limits on the discourse of sexual health as it appears in sexual health information online; for example, the historically contingent nature of discourses mean that contemporary knowledge of “sexual health” is likely to reflect and incorporate understandings of the sexual revolution.

The rules of discourse operate to provide “conditions of existence”, which contain or classify groups of statements to a single or overlapping system of discursive formation such as clinical, economic, or medical discourses (Foucault 2002, 120). Foucault (2002) argues that “these rules define not the dumb existence of a reality, nor the canonical use of a vocabulary, but the ordering of objects” (54). To explain this, Cheek (2004) argues that discourses work to order reality in particular ways (1142). As a result of this ordering of objects and reality, knowledge production is both enabled and constrained, where discourse is determined by who can speak and with what authority, and who cannot (Cheek 2004, 1142). In other words, discourse constructs reality, where objects are made intelligible in particular kinds of ways. Discourse, then, is more than a series of statements describing reality, and it is this “more” which is of interest to discourse analysts. To access this “more”, it is my task as a discourse analyst to determine the rules which order and authorize particular statements about women’s sexual health in particular online locations, and to determine what understandings about sexual health are produced and privileged through this ordering.

3.1.2 Images as Discourse

My discourse analysis focuses on images as well as text. As Sturken and Cartwright (2001) explain, representation “refers to the use of language and images to create meaning about the world around us. We use words to understand, describe, and define the world as we see it, and we also use images to do this” (12). To return to Rose’s (2012) discussion of Foucault from above, her understanding that discourse is “groups of statements that structure the way a thing is thought” (190) does not need to be limited to language alone. Phelan (2003) argues that “what one can see is in every way related to what one can say” (106). In their discussion of feminist content analysis in the “second millennium” of the internet age, Reinharz and Kulick (2007) argue that in order to access discourses and the meanings embedded in them, feminist researchers must pay attention to the artifact (or website) itself, as well as the “contextual and social processes of cultural production and reader reception” (Reinharz and Kulick 2007, 258). These authors argue that it is important to examine the structural elements of websites, such as

the graphic techniques and navigational headings, as well as the narrative and visual elements (Reinharz and Kulick 2007, 265). In my discourse analysis, I took into account the relationship between the text of a given web page or article and the images or graphics used by each website to illustrate the meaning of that text.

Text and images speak to one another, and together constitute the way we understand information, messages, and meaning. Sturken and Cartwright (2001) indicate that photography and images have “been a central factor in the functioning of discourses since the nineteenth century”; considering this long history, the authors argue that Foucault’s concept of discourse helps in examining how “power systems work to define how things are understood and spoken about (and by implication, represented in images) in a given society” (94). Phelan (2003) cautions that researchers must work to expose the ways in which images are employed in the establishment and maintenance of discourse and power (107). This relationship between discourse and visual culture is relevant to my methodology and analysis, which entailed questioning how images receive and produce particular social, political, or cultural value required to contribute to our understanding of the world (Sturken and Cartwright 2001, 31).

3.1.3 Power/Knowledge

Discourse is powerful, according to Foucault, because it is capable of producing knowledge. In their discussion of Foucaultian discourse analysis, Sturken and Cartwright (2001) argue that “modern power is not something that negates and represses so much as it is a force that produces – it produces knowledge, and it produces particular kinds of citizens and subjects” (Sturken and Cartwright 2001, 97). As it concerns discourse, power relations “establish the criteria for what gets to count as knowledge in a given society” (Sturken and Cartwright 2001, 97). Accordingly, Foucault “also suggests the need to consider the broader, non-discursive context of discourse”; in response, Rose (2012) argues that the institutional location of a discourse is crucial (220). For example, information (e.g., about health) that comes from a source that is viewed as authoritative (e.g. medical professionals, particularly in the context of a healthist society) is likely to

be understood as more knowledgeable than information coming from any other source. In other words, discourse analysis must pay attention to the social context which shapes the production of discourse (Rose 2012, 221). In my literature review, I discussed the availability and accessibility of sexual health information through magazines and websites; in my discussion on the websites included in my sample in this chapter, I discuss the various types of organizations (e.g. not-for-profit, governmental, commercial, medical) that offer sexual health information to begin to open up a discussion on the range of institutional perspectives that offer “authority” to the topic of “sexual health”.

Discourse is productive; however, that productivity may be realized differently depending on the extra-discursive context of that discourse. Rose (2012) argues that the grounds on which discourses are made powerful shift historically (193). Foucault (1984) indicates that the power and existence of discourse is transitory, and can and will be overcome by other, more dominant or powerful discourses over time (109). Discourse, then, is a power to be seized (Foucault 1984, 110). Those discourses which are not made “known” through power are often marginalized or relegated to the realm of “alternative”; for example, medical and scientific discourses on health dominate over other ways of thinking and speaking about health and health care (and in demonstration of the historically contingent nature of discourse, this has not always been the case) (Cheek 2004, 1143). Cheek (2004) identifies that the “understandings of ‘appropriate’ health care (health care being a text) that we have are at least in part produced by and, in turn, produce understandings about health, disease, and illness” (1145). In other words, institutional distribution of particular knowledge imbues that knowledge with the power of being respected and understood as “truth”, and in turn informs the development of additional discourse on that topic: because of this, it is important to examine the sources of, rather than merely the content of, sexual health information.

3.1.4 Truth

Particular discourses, located in and distributed by socially powerful institutions, are powerful because they also claim “absolute truth” (Rose 2012, 193). Discourses with

these truth effects produce in us a desire to know that truth, and to know ourselves in relation to that truth. The result, for Foucault (1984), is a “system of exclusion, a historical, modifiable, and institutionally constraining system” that is reinforced and renewed by “the way in which knowledge is put to work, valorized, distributed, and in a sense attributed, in a society” (113). In addition to analyzing the content of texts, discourse analysis is thus also concerned with determining the context in which texts have been constructed and distributed, and the historical and social location in which certain texts take hold (Cheek 2004, 1144). In explaining the notion that discourses are not merely value-free conveyors of information, Cheek (2004) reiterates that there can be and are a number of texts which represent reality, rather than one “authentic” or “right” text (1145). Multiple, often competing, discourses are produced through texts and images: for example, healthist accounts highlight the risks that accompany lifestyle decisions (e.g., the risk of acquiring a sexually transmitted infection following sexual activity), while postfeminist accounts highlight young women’s entitlement to sexual freedom. However, these discourses cannot be oversimplified as being in opposition to each other, as both healthism and postfeminism rely on discourses of control to mobilize the individual to act and make particular choices. The task for a critical discourse analyst, then, is to access the richness of textual or visual data through examining the organisation and distribution of discourse itself, focusing on how a particular discourse is structured and therefore, how it produces a particular kind of knowledge and privileges particular ways of being in the world (Rose 2012, 209). My analysis includes a consideration of which and how knowledges are presented as authoritative; this involves examining the discourses of sexual health information as offered by a range of sources including professional, governmental, and commercial associations, as well as the strategies used by these institutions to frame particular forms of knowledge as valid.

One tactic to determine the type of discourse a particular source or website deems “valid” or “true” is to explore the topics and issues related to sexual health that are excluded from their discussion. In addition to analysing what is read and seen, discourse analysis involves reading texts and images for what is not said or seen, where “invisibility can have just as powerful effects as visibility” (Rose 2012, 219). This invisibility may

involve an omission of certain topics related to sexual health which may not fit with, for example, a profit-oriented commercial website's brand identity, such as issues related to dis/ability or diverse sexual orientation. To account for this invisibility, it is important to look for moments within online health information where "dissent from a discourse is acknowledged (even if implicitly) and dealt with", and where work is "being done to reconcile conflicting ideas, to cope with contradiction or uncertainty or to counter alternatives" (Rose 2012, 216). In a section below, I provide an overview of the topics discussed by each website selected in my sample to begin to access the meanings and understandings of sexual health that are created through discursive inclusions and exclusions.

However, the task of my dissertation is not to deconstruct, or to dismantle the dominant discourses of sexual health information in order to unearth the hidden or "alternative" discourses which are obscured. Foucault (1984) argues that although there are systems (such as institutional distribution and valorization) that reify or establish particular discourses as "truth" over others, this does not mean that "beneath them or beyond them there reigns a vast unlimited discourse, continuous and silent, which is quelled and repressed by them, and which we have the task of raising up by restoring the power of speech to it" (126). Rather than approaching texts to access "the" true content or meaning held within, discourse analysis is "about explaining how certain things came to be said or done, and what has enabled and/or constrained what can be spoken or written in a particular context" (Cheek 2004, 1147). In other words, texts do not and cannot represent a single, "true" reality, but instead are made up or constructed by and within that reality, and, contribute to an understanding of reality (Cheek 2004, 1147). As such, my primary motivation is not to determine what "is" sexual health; rather, I seek to examine how particular notions of sexual health emerge in relation to postfeminism, neoliberalism, and healthism.

3.1.5 Trustworthiness

As a discourse analyst, I am aware that I have a certain amount of power to impose meanings on another's text through my reading of it: indeed, as a researcher, I not only read text, but I also produce discourse through ascribing meaning to the texts through the process of my analysis (Cheek 2004, 1146). Wodak (2008) advises that researchers must be critical in order to account for their influence in the interpretive process. Conducting critical research means engaging in constant self-reflection, defining my position and values as well as my research interests explicitly, and being aware of the potential for multiple readings when analysing specific texts (Wodak 2008, 196). Being critical also involves not taking social phenomena, power relations, and ideologies for granted (Wodak 2008, 196). Rose (2012) explains that it is particularly important to identify any interpretative repertoires, or mini-discourses, which consist of "systematically related sets of terms" which make up the "common sense" ways we talk about a culture (218). As such, it is important in my own analysis to identify and question the interpretative repertoires within health websites which are part of the "common sense" ways of talking about women's sexual health (for example, in the terms and language of postfeminism).

3.2 Feminist Critical Discourse Analysis

Lazar (2007) proposes the use of Feminist Critical Discourse Analysis (FCDA) in light of the ways in which discourses are influenced by and disseminate ideas about concepts such as gender, postfeminism, blatant sexism, and claims of reverse sexism. Her goal is to examine and critique "the complex, subtle, and sometimes not so subtle, ways in which frequently taken-for-granted gendered assumptions and hegemonic power relations are discursively produced, sustained, negotiated, and challenged in different contexts and communities" (Lazar 2007, 142). Lazar (2007) identifies that a "feminist" Critical Discourse Analysis (CDA) challenges the supposedly neutral and objective nature of traditional CDA that does not explicitly attend to issues of gender, and seeks to establish a distinctly "feminist politics of articulation" to be "guided by feminist principles and insights in theorising and analysing the seemingly innocuous yet oppressive nature of gender" (143). Although a CDA "identifies and analyses the workings of (often

gendered) discourses, ways of seeing or representing the world” (Sunderland and Litosseliti 2008, 9), a Feminist Critical Discourse Analysis (FCDA) explicitly and intently isolates “gender” as a variable or factor in investigating social phenomena (Wodak 2008, 193).

Lazar’s FCDA offers a “critically useful view of discourse as a site of struggle, where forces of social (re)production and contestation are played out” (2007, 143). In other words, FCDA is concerned with examining and exposing the interrelationships of gender, power, and ideology in discourse (Lazar 2007, 144). Lazar (2007) advocates a form of feminist analytical activism through her FCDA, where an analysis of “the workings of power that sustain oppressive social structures/relations contributes to on-going struggles of contestation and change” (145). In other words, Lazar aims to mobilize theory in order to create critical awareness and develop feminist strategies for resistance and change, and to challenge the hegemony of gender ideology in particular texts.

Wodak (2008) points to the importance of an intersectional approach to FCDA, arguing that analyses of gender “should be related to social class, ethnicity, profession, culture, religion and so forth”; the relationship between gender and other identities and subject positions should be taken into account in the FCDA researcher’s deconstruction of “hegemony and symbolic violence of gender in sociopolitical contexts” (197). In other words, the FCDA researcher should avoid viewing gender within the frame of a simplistic dichotomy. The researcher should instead consider the whole range of gender identities in context, which includes incorporating awareness of multiple identities and considering whether or not “gender” is actually the most relevant identity to the discourse and to the analysis (Wodak 2008, 194). This is of particular importance when the discourse itself only talks about or assumes one identity (e.g. for postfeminism, this singular identity is frequently of a white, able-bodied, middle-to-upper class heterosexual female). As an example, the distribution of sexual health information through commercial websites may have implications for readers from lower socio-economic backgrounds if the purchase of particular products is positioned as the key to “good health”. Further, immigration status or language may impact the ability of particular

persons, regardless of gender, to understand and access information or in-person health care services offered by the government. Religion and culture may also differently impact the ability of younger women to openly discuss issues of sexuality that they may learn about through online information with their families or with doctors. In a healthist society, the ability of individuals to pursue health is often seen as a requirement for responsible citizenship; the elucidation of how sexual health discourse excludes particular social identities illustrates how opportunities for citizenship in neoliberal contexts is discursively and unevenly distributed.

3.2.1 Postfeminism and Feminist Critical Discourse Analysis

What is interesting and useful about critical discourse analysis generally, and feminist critical discourse analysis specifically, is the way that it recognizes that discourse, texts, images, and other “cultural products of any given society at any given time reverberate with the themes of that society and that era” (Weitz in Reinharz and Kulick 2007, 258). Recalling Foucault’s (1984) discussion of the transitory nature of the power and existence of discourse, I argue that FCDA is a particularly a useful tool to access and analyse web-based discourses on sexual health, considering the (relatively) recent development and use of the internet to disseminate information. The ability of FCDA to attend to the transitory and temporal nature of discourse also makes FCDA well-suited to the analysis of post-feminist discourses which emerged in a particular global, neo-liberal context in the 1990s (Lazar 2007, 154), and which are often in conversation with the so-called “second wave” feminist gains of the 1970s (Lazar 2009b, 339). As I discussed in my literature review, postfeminism, varyingly understood as a rejection or disavowal of feminism, as a feminist backlash, or as “power” or popular feminism, nevertheless operates by speaking “the language of feminism, but without investment in feminist activism, social justice [or] transformation of prevailing gender orders” (Lazar 2009b, 340).

Lazar (2007) argues that while it is important to celebrate women’s power and achievements, as postfeminist culture purports to do, “there is a need also to exercise

critical reflexivity on the matter” (154). For example, Jones (2003) argues alongside Faludi that there is an “onslaught of anti-feminist discourses that veil their agenda by proclaiming the demise of feminism through the supposedly inevitable development of ‘postfeminism’” (314). Jones (2003) aims to explore the “discursive means by which the death of feminism...has been promoted through photography and written texts, examining what is at stake – politically, culturally, and economically – in this promotion” (314). In the analysis that follows in Chapters 4-6, I examine the discursive “post”-ing of feminism through the visual and textual content of online sexual health information. However, rather than argue that postfeminism is feminism’s death, I agree with Lazar (2009b) that postfeminism relies on and interacts with feminism, that they are “closely related, even interdependent. Postfeminism, in part, draws upon feminism as its resource. Even if feminism is evoked only to be censured, that involves engagement at some level nonetheless” (340). Indeed, for postfeminism to exist, it relies on an assumption of the success of feminism, even as it works to convince women that working to maintain feminist success is no longer necessary. The power of feminism is (attempted to be) usurped by postfeminism, and so the task for feminism today, and the task I take on through this FCDA, is to cast a critical eye upon the ways in which feminism is proclaimed to be no longer necessary and to examine the conditions that make such statements possible and desirable.

In her article on Post-Feminist Text Analysis (PFTA), Mills (1998) argues that textual analysis needs to take into account the appropriation of feminist discourse by postfeminism. The way that postfeminism and feminism are mutually implicated requires a different methodological approach than would be required to deconstruct sexist language. For example, Mills (1998) argues that the research analyst must be aware of the context-specific nature of the meanings of words within texts in light of the reliance that postfeminism has on feminism. By taking into account the context in which words and discourses are produced, it is possible to examine the effects that the status of sexism, the co-optation of feminism, the reclamation of language (e.g. “slut”), and the relationship that gender, race and class has on producing multiple potential interpretations of terms and discourses as a whole (Mills 1998). In her analysis on sex and relationship

advice articles in magazines, Gill (2009) argues that there is a “postfeminist sensibility” evident in the approach to heterosexual relationships in these articles that is intimately connected to neoliberalism and that works to sustain unequal gender relations (345). In other words, Gill examines the nature of these discourses to reveal both feminist and non-/pre-/anti-feminist ideas which are combined in a way that is distinctly postfeminist (Gill 2009, 362). I incorporate this consideration into my FCDA in order to access the postfeminist context in which web-based sexual health information is developed and targeted to girls and young women.

3.3 Methods

3.3.1 Research Questions and Objectives

The aim of my project was to use feminist critical discourse analysis (FCDA) to identify and articulate the discursive constructions that are produced by websites offering sexual health information. Questions that I used to guide this research include:

- 1) What discourses or rationalities help to construct “sexual health” as an object?
- 2) What kinds of sexual citizens are privileged through sexual health discourses aimed at women? (e.g., who is assumed to be reading the health information online?; who is excluded by this conception?)
 - a) How do sexist, heterosexist, racist, classist, and/or ableist assumptions inform women’s sexual health discourse?
- 3) What work is postfeminism, neoliberalism, and healthism performing through websites which offer sexual health information? (e.g., to what extent is feminism “assumed” for the reader?; to what extent are readers encouraged to perform the “work” of health and health care?; how is the pursuit and maintenance of sexual health expressed as a moral obligation?)
 - a) What responsibilities and expectations are being articulated for readers in relation to the discursive construction of sexual health? And, how are these responsibilities gendered?

- 4) What is the relationship between postfeminism, healthism, and gendered, neoliberal health discourse? How do they inform each other and how are they expressed in discourses on sexual health aimed at women?

3.3.2 Data Gathering and Exclusions

To examine my research questions in the context of the increasing availability and popularity of health information through the internet, I located a wide range of websites that offer sexual health information. In addition to sites I was already familiar with through my own information-seeking behaviour online, I broadened my sample by conducting: web searches for terms such as “sexual health”, “women’s sexual health”, “sexual health Canada”, and so on; searches for specific sources that I anticipated would offer sexual health information, such as feminine hygiene products, birth control products, sex shop websites, women’s magazine websites, government agencies, and municipal health clinics; and searches for organizations that were discussed in articles from my literature review. Many of these sites also provided links to external resources, which I used to expand my search. In order to limit my sample, each website had to offer their own fixed articles or resources as created by the site administrators (e.g. separate from external links or message boards).

I identified 44 websites offering sexual health information to a general, lay person audience in the U.S. and Canada, and organized these potential sources through a profile summary sheet. This profile summary lists each website, whether it is produced by a government, non-profit professional organization, or commercial enterprise, and what organizations each site use as a resource in developing their information and/or in financing the web site. For example, some commercial websites source their sexual health information from professional organizations, and provide research funding to these organizations. Other websites do not offer their own sexual health information, but rather provide links to resources available through other organization websites. I also took note of whether the material is intended for a general audience or for a specific population (e.g., young women, residents of a particular province, Aboriginal individuals), the range

of topics addressed by the articles included in the website, and the website's stated mission. Although I had to exclude the vast majority of these websites to make data analysis manageable, they do provide context for and evidence of the proliferation of women's sexual health information. I provide a list of these websites in Appendix I.

I applied a range of selection criteria to narrow this initial sample of 44 websites. First, I restricted my sample to include websites that offer sexual health information to women. For some websites, this means that the information was developed and is presented specifically for a female audience, or that there is a section of the web site dedicated to women's sexual health (and another section for men's sexual health, for example). For other websites, sexual health information is not separated by gender, but is intended for both women and men; for example, some websites aim to offer information to "all Canadians". Because women are included in the intended audience, these websites fit my selection criteria. Just as it is important to examine the potentially gendered nature of information intended for a gendered (female) audience, so too is it important to examine the potentially gendered nature of information intended for a gender-neutral or gender-inclusive audience. This was consistent with my aim to examine websites in relation to discourses surrounding women's sexual health, and the influence that postfeminism and gendered, neoliberal health perspectives have on women's sexual health information.

Second, my study sample included only websites that are created in, by, or for a Canadian audience, because these administrators are explicitly influencing and reflecting the discourse of women's sexual health in Canada. Canadians may look elsewhere for health information – through international sites, as facilitated by the global nature of the internet – but I examined sites that claim to speak for and to Canadians. I examined websites that intentionally contribute to Canadian discourse; although US and international websites are easily accessed globally, including from Canada, websites produced in Canada are uniquely able to reflect the way that Canadian health care values⁴ are incorporated into health information offered by a range of organizations and sources that function

⁴ E.g., values that reflect that Canada has a universal health care system, even as it is increasingly subject to budget cuts and faces neoliberal policy influences.

separately from the Canadian medical system. For this reason, I excluded websites that were created in the United States, or websites that are intended to speak to a North American audience (defined by these companies as the U.S. and Canada; e.g., commercial companies such as Tampax will have a Canadian URL, but will automatically redirect readers to their US website with the implicit understanding that the information has equal relevance to individuals in either geographic location).

Initially, I included sexual health websites based in the 13 provinces and territories and in 5 municipal sites in Ontario, Canada, but for the scope of this research I have chosen to focus on national resources. Regional websites are varyingly funded by federal and provincial tax dollars, and often serve as a resource to direct readers to local sexual health clinics. Although some provide links to national resources, the majority produce and provide their own sexual health information on topics such as STIs, birth control, pregnancy, and emergency contraception. Some address regionally-specific sexual health needs, such as providing bilingual support (Quebec's Tel-Jeunes), addressing (some) LGBTQ needs through M2Men (Toronto Public Health's service for gay men and other men who have sex with men), or addressing Aboriginal, immigrant, and refugee needs (Manitoba's Sexuality Education Resource Centre).

3.3.3 Objects of Analysis: Sample

From my initial sample of 44 websites offering sexual health information, and the selection criteria outlined above, I identified five primary categories through which sexual health information is organized and offered to a Canadian audience: websites created and administered by government agencies, by professional health organizations, by non-profit organizations, by commercial companies, and by interest groups or alternative voices. I selected one representative website for analysis from each category, for a total sample of five. They are: (i) Canadians for Choice (non-profit); (ii) Healthy Canadians (government); (iii) National Aboriginal Health Organization (NAHO, special interest group); (iv) Sexuality and U, administered by the Society of Obstetricians and

Gynaecologists of Canada (SOGC, professional health organization); and (v) We Know Sex, administered by Trojan Condoms (commercial).

These categories impact the context, production, and location of sexual health information. As I discussed above, the appearance of sexual health information in online spaces, rather than through consultation with a medical professional in a doctor's office, has potentially contradictory meanings for feminists who have fought for the democratization of health knowledge but not for its co-optation (or, more precisely linked to postfeminism, for its depoliticized assumption) by for-profit ventures. Likewise, the production of sexual health information on a condom company's website may carry different contexts and meanings than sexual health information appearing on a governmental or professional health organization's website. For example, the SOGC offers sexual health information for health care professionals either as guidelines for administering care or as continuing medical education, in addition to the information they provide for a lay audience. Including organizations that have institutionally recognized authority on sexual health is consistent with a Foucaultian approach to discourse analysis, as the institutional location of a discourse is crucial to the production of knowledge and truth claims. Consistent with my FCDA approach, I describe below the particular mandate of each website and their relationships between funding bodies, corporations, and health organizations where that information is available. As well, I return to the institutional context of these sources in my discussion chapter.

Canadians for Choice describes itself on its website homepage as a "national, pro-choice, charitable organization that regards sexual and reproductive rights as an integral part of the health and well being of all persons". Incorporated in 2002, Canadians for Choice conducts and supports research on sexual and reproductive health and rights, shares information online and in a print magazine with Action Canada for Population and Development titled "Right On", maintains a speakers bureau for presentations in conferences, classes, or at other events, offers an information and referral line for women seeking counseling or abortion services, works to train doctors in the context of patient referrals to necessary sexual and reproductive health services, and maintains a First

Nations, Inuit, and Métis Committee (Canadians for Choice, About Us: Activities). Of interest to my research is the commitment by Canadians for Choice to share information related to sexual health on their website for a general audience. Since my initial data collection, Canadians for Choice has merged with Canadian Federation for Sexual Health (CFSH) and Action Canada for Population and Development (ACPD) to form Action Canada for Sexual Health & Rights, operating as a “progressive, pro-choice charitable organization committed to advancing and upholding sexual and reproductive health and rights in Canada and globally” (n.d.a). Canadians for Choice has articles on sexual and reproductive rights, and sexual and reproductive health issues including abortion, contraception, infertility, and sexually transmitted infections.

Healthy Canadians is a website created by the Government of Canada as part of “the Government’s commitment to improving access to information online”, which includes making available “reliable, easy-to-understand health and safety information for Canadians and health professionals” (Government of Canada 2016). A link to the Healthy Canadians website is featured on the main page of the Health Canada website, the “Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances” (Health Canada 2014). While it is not clear when the Healthy Canadians portal was first launched, the majority of the articles list a content “last modified” date stamp between 2011 and 2013, and the website underwent a significant re-design in early 2014 (following my data collection). The Sexual Health information page is categorized under “Health Concerns”, and is intended to provide “Information on preventing, managing and treating sexually transmitted infections like genital herpes, chlamydia, human papillomavirus and gonorrhoea”, but also includes articles on condoms, syphilis, lymphogranuloma venereum (LGV), HIV/AIDs, and “seniors and aging – sexual activity”.⁵

The National Aboriginal Health Organization (NAHO) describes itself on its website as an “Aboriginal-designed and-controlled body committed to influencing and advancing

⁵ Following the redesign in 2014 (after my data collection was complete), the article on sexual activity for aging seniors no longer appears on the Healthy Canadians sexual health homepage. The sexual health webpage is also now categorized under “healthy living”, rather than “health concerns”.

the health and well-being of Aboriginal Peoples by carrying out knowledge-based strategies”. It is structured through three centres: The First Nations Centre, the Inuit Tittarvingat, and the Métis Centre. NAHO formed in 2000 as a not-for-profit organization funded by Health Canada, but states on its “About” webpage that “Health Canada exerts no influence over the content of NAHO materials nor are NAHO materials attributable, in whole or in part, to Health Canada”. Health Canada cut funding to NAHO in 2012, forcing its closure (National Aboriginal Health Organization 2012). In an interview with the CBC, Simon Brascoupé, NAHO’s chief executive officer, stated that Health Canada was cutting funding for “indirect services like ours” in favour of “protecting the monies that go to regions, to [direct services for] First Nations and Inuit” (CBC News 2012).

According to NAHO’s press release announcing its closure, the organization outlined that in addition to its staff, “one of NAHO’s greatest assets is its web site. When you Google Aboriginal health, NAHO comes up as one of the leading health information sources in the world” (National Aboriginal Health Organization 2012). Although the information on the website has not been updated since its funding was eliminated in 2012, it will remain online until the end of 2017. Despite its closure, NAHO remains the most comprehensive Aboriginal-controlled, national source of sexual health information for Aboriginal Peoples. NAHO’s First Nations Centre, in collaboration with the Native Youth Sexual Health Network, created six factsheets on sexual health as well as a two-part Sexual Health Toolkit. These items are presented in a booklet format downloadable as PDFs through their website, and cover topics such as sexual health, sexually transmitted infections and testing, HIV/AIDS, healthy relationships, sexual abuse and drug facilitated sexual assault, body image and sexual health, sexuality, and traditional views on sexuality.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) is a professional organization founded in 1944, with a membership of over 3500 obstetricians, gynaecologists, family physicians, nurses, midwives, and allied health professionals working in the field of sexual reproductive health. The SOGC launched their sexual

health website, Sexuality and U, in 2001 with the mandate to “provide guidance and advice to help individuals develop and maintain a healthy sexuality”. The website includes separate sections for parents, teachers, and health care professionals, but my focus is on the articles and topics included on the main page for a general audience, on “questions and issues that matter most to Canadians”. Sexuality and U is the most extensive of my sample and includes articles on the following topics: Birth Control (comparing birth control methods, types of birth control, which birth control method is right for me?, talking to your partner about birth control, emergency contraception, controlling your period with birth control, birth control myths), STIs-STDs (types of STI-STDs, what are the chances of getting an STI-STD?, how do I protect myself from STI-STDs), and Sexual Health (understanding sexuality, all about puberty, understanding your body, how do I know I am ready for sex?, going to the doctor, all about menstruation, pregnancy, masturbation, genital piercing, physical problems, statistics, sexual orientation and coming out, sexual diversity, sex and the law, drug facilitated sexual assault, and sex over fifty).

Finally, We Know Sex is a website created in 2010 by Trojan Condoms, a product distributed in Canada by Church & Dwight Canada Corporation. Although Trojan Canada is a profit-oriented organization focused on selling condoms, We Know Sex functions as a standalone website with its own URL, written and developed in association with a charitable research organization. Its homepage states that its content is “developed with the assistance of: The Sex Information and Education Council of Canada (SIECCAN) [and] Josey Vogels”, a Canadian sex columnist and speaker. SIECCAN is “a national registered charitable organization founded in 1964 to foster professional education and public knowledge about sexuality and sexual health” (Sex Information and Education Council of Canada 2016). SIECCAN received a renewal of an “unrestricted resource development grant” from Church & Dwight Canada in 2014, which SIECCAN states “provides essential support for SIECCAN’s work” (Sex Information and Education Council of Canada 2016). Trojan’s We Know Sex has articles under categories labeled relationships, sex, how not to get pregnant, all about STIs, know your body, and stay healthy.

3.3.4 Operationalizing “Sexual Health”

My discourse analysis illustrates the contextually contingent nature of online information about sexual health, and will draw particular attention to the way that this sexual health discourse is contemporarily framed by postfeminism in a specifically Canadian context. As well, I illustrate how the discourse of sexual health is shaped through the particular mandates and perspectives of each of the websites included in my sample, which function as authorities on sex and female sexuality in contemporary Canadian society. I offer the following background on the concept of sexual health to operationalize my critical discourse analysis of online sexual health information targeted to young women.

Sandfort and Ehrhardt (2004) identify that although “sexual health” as a concept is regularly “used in a self-evident way, as if its meaning is patently obvious, the concept is by no means uniformly understood and applied” (181). More broadly, sexuality has been approached as a public health issue since the mid-19th century when “sexuality was primarily conceived as oriented toward procreation” (Giambi 2002, 2). Giambi (2002) cites Lupton (1995), who argues that public health was initially applied to “control people’s bodies and to modify their behaviour for the purpose of promoting a healthy life” (3). Foucault (1978) discusses how the regulation of individual bodies and of populations can be achieved without force through an exercise of biopower, as I outlined in my literature review in Chapter 2. Specifically, parents, schools, doctors, and according to Lupton (1995), public health promotion campaigns are deployed to regulate (rather than repress) children’s sex. Although Foucault (1978) cautions that regulation is not the same as repression, health is used to justify interventions into the sexual lives of children and young adults so that they may be guided to pursue the right kind of sex. More generally, health as a concept has also been used in the past “as a major argument to regulate and control sexual expression”; because of this historical use of health, Sandfort and Ehrhardt (2004) argue that a critical approach to examining the emergence and use of the term “sexual health” is warranted (182). Indeed, Edwards and Coleman (2004) identify that “attempts to define sexual health have been heavily influenced by the definition of health

in general as developed by the World Health Organization (WHO) after World War II”, which states that health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (190). The idea that health is more than the absence of disease has been a significant theme throughout a wide range of efforts to define sexual health.

The term “sexual health” was not introduced or popularized until the mid-1970s (Giarni 2002, 2). Mace, Bannerman and Burton (1974) are largely credited with introducing the concept, which they argue includes three basic elements:

- (1) a capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic, (2) freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationship, (3) freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions (10).

Importantly, although their third element specifically references disease and disorder as a hindrance to sexual health, the first two elements make reference to social and psychological aspects of well-being in relationship to sexual health. Further, the inclusion of reproductive functions constructs an implicitly heterosexual conception of sexual health, although it is possible to include non-heterosexual sex in the meaning of this definition.

The World Health Organization (1975), influenced by Mace, Bannerman and Burton’s (1974) definition, proposed their own working definition of sexual health in the context of supporting sexual health training for health professionals (5). Sexual health is defined by the WHO as “the integration of the somatic, emotional, intellectual, and social aspects of sexual, in ways that are positively enriching and that enhance personality, communication, and love” (WHO 1975, 6). The organization further clarifies that the right to sexual information and the right to pleasure are fundamental to the concept of sexual health (WHO 1975, 6). In this definition, the relational aspects of sexual health are once again underscored through language that emphasizes communication and

sociability. Further, although the WHO definition does make an attempt to separate sex and sexuality from procreation by citing sexual pleasure yet omitting any references to reproduction (as included by Mace, Bannerman and Burton), “love” is specifically cited as an aspect of sexual health.

The WHO’s 1975 definition was revisited and amended in 2002 (and published in a WHO report in 2006) to reflect global changes concerning sexual health. The currently-standing WHO definition of sexual health is:

a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO 2006, 5).

In this current definition, “love” has been omitted as a necessary aspect of sexual health. Instead, the authors once again emphasize that sexual health is more than the absence of disease, but also involves a positive state of well-being. It is also notable that the WHO’s definition, as well as the one by Mace, Bannerman and Burton, was developed and intended for health professionals to improve and guide their care. The language of the current WHO definition, although emphasizing the relational aspects of sexual health, demands a “positive and respective approach to sexuality and sexual relationships” from health professionals to their patients. This reflects a continued commitment to enhancing and equalizing the doctor-patient relationship, a characteristic of the efforts by members of the women’s health movement in the mid-1970s.

The context in which the concept of sexual health emerged and continues to be refined is significant. Coleman (2002) argues that there is “remarkable consistency” across “global, regional, and national health strategies to promote sexual health and responsible sexual behavior”, which each contribute to clarifying definitions of sexual health (5). However, Giami (2002) outlines a range of different conceptions of sexual health, and

argues that there is no, and cannot be any, consensus about the meaning of sexual health because it is “embedded in politics and in the health systems of the different countries” (32). In a North American context, Mace, Bannerman and Burton (1974) also acknowledge that social and political culture has an influence on views of and approaches to human sexuality and specifically cite second-wave era feminist gains such as “the emancipation of women...the technology of birth control, and the general increase in education about sexual matters” as influences in their definition (9). Coleman (2002) also identifies that the 1975 WHO document emerged in the context of the sexual revolution of the 1960s and 1970s (3).

In addition to the WHO’s 1975 definition, sexual health gained popularity and credibility as a concept through the concept of “reproductive health”, itself developed in the 1970s (Lottes 2000, 7). Women’s activists and other non-governmental organisations argued for reproductive rights in order to emphasize “women’s right to decide whether, when, and how to have children. This means the right and access to: full information about sexuality and reproduction, about reproductive health and health problems...[and] good quality, comprehensive health services that meet women’s needs and are accessible to all women” (Lottes 2000, 7). Reproductive rights were advanced at the 1994 International Conference on Population and development in Cairo; the document produced through this conference states that reproductive health “includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases” (Lottes 2000, 9). The link between sexual and reproductive health has continued to develop. In 1995, the Sexuality Information and Educational Council of the United States (SIECUS) offered a definition of sexual health through their efforts to promote adolescent sexual health; their definition explicitly included sexual development and the statement that “reproductive health was a component of one’s overall sexual health” (Edwards and Coleman 2004, 192). Sexual health also gained popularity at the same time that discourses on sexual rights were emerging, which focuses on reproductive self-determination alongside “protection from sexual abuse and discrimination” (Sandfort and Ehrhardt 2004, 185).

Although the inclusion of sexual health under the umbrella of reproductive health was a significant step toward international recognition of the concept of sexual health and its relationship to health and well-being, some sexuality and health professionals urge that the two concepts (sexual health and reproductive health) be considered separately (Lottes 2000, 12). For example, Giammi (2002) identifies that the introduction of oral contraception “created a legitimate medical basis for distinguishing between sexual activity and procreation” (5). The WHO notes in their 2010 publication on sexual health that while “sexual health” is often “subsumed within reproductive health, it is in fact a wider term, as sex does not always involve reproduction” (WHO 2010, 3). Lottes (2000) cites Ketting (1996), who also argues for this separation; Ketting defines reproductive health problems as “medical problems related to pregnancy, childbearing and infancy”, whereas sexual health involves “helping people to gain full control of their own sexuality and to enable them to accept and enjoy it to its full potential. It is not primarily about diagnosis, treatment, or medical care but about lack of knowledge, self-acceptance, identity, communication with partner and related issues” (15).

Through this distinction, Ketting appears to be arguing that reproductive health is defined through the absence of medical problems, while maintaining that sexual health is also characterized by a positive state of well-being. However, there are areas of overlap between sexual health and reproductive health which makes their division difficult.

Lottes (2000) identifies that:

Sexually transmitted diseases can impact one’s sex life including one’s enjoyment of sexuality and therefore one’s sexual health. But sexually transmitted diseases such as chlamydia, syphilis, herpes and HIV/AIDS can also have a negative impact on a woman’s reproductive health by limiting her fertility or harming the health of her new born infant. The ability to control the timing and spacing of children, an aspect of reproductive health, depends on having access to safe and effective contraceptives. The ability to enjoy one’s sexuality, an aspect of sexual health, also depends on being able to experience sex without the fear and worry of an unwanted pregnancy (16).

Considering these areas of overlap, my intention is not to offer my own definition of sexual health, nor to evaluate the content of various websites offering sexual health information to see how closely they align with already established definitions. I do not want to impose limits on what each source includes as part of their concept of sexual health. Rather, I examine what each website includes (and excludes) as a vital part of the discourse on sexual health.

3.3.5 Overview of Sexual Health Topics

In order to address how sexual health is constructed through these sites, it was instructive to first identify the range of issues that were included (and excluded) from the information provided. Of the five sites included in my study sample, it became clear that the definition of sexual health is conceptualized as more than the absence of disease (e.g., sexually transmitted diseases or infections) to include a consideration of sexual health as a positive state of well-being, which may or may not involve sociability and relationships (e.g., many of the websites recognize that sexual pleasure can be achieved through masturbation without a sexual partner). However, the specifics of the definition of “sexual health” ranges greatly depending on the source. The definition of sexual health that each website operates under is either included in a website’s mission statement or is implied through the articles and information they offer (or fail to offer) to their readers. For example, the Healthy Canadians website primarily offers information on STIs, with only one additional article which addresses sexuality, sexual relationships, and well-being, in this case related to sex and aging. In contrast, Trojan Condom’s We Know Sex website offers information on dating and relationships, discussing pleasure, negotiating consent, as well as information on STIs and birth control, but does not address issues related to sex and aging. To begin to access how each website conceptualizes sexual health, I compiled a chart to list and compare the range of issues covered by each source (see Appendix II). In the chart, topics that were covered by a full article are indicated by a checkmark; topics that were discussed in a related article, or topics that were briefly mentioned in passing (e.g., in a list alongside other issues), are indicated by a checkmark in parentheses.

Among the five sites, STIs were covered with the most depth and frequency: every website had information about STIs in general, and provided separate articles about the signs and symptoms of individual STIs. Most websites had separate articles about HIV/AIDS, although the SOGC's discussion of AIDS was included with their category on "viral STIs". In each website, the importance of medical testing and treatment was highlighted: readers were reminded that they may not be able to detect STIs on their own, as STIs do not always have symptoms. Interestingly, considering the recent proliferation of discussion surrounding HPV vaccination (see Lippman, Melnychuk, Shimmin, and Boscoe 2007; Mancuso and Polzer 2010; and Polzer and Knabe 2009), none of the websites in my sample had separate articles on this topic. Rather, HPV vaccination was included in articles discussing HPV or STIs more generally (e.g., alongside general advice to talk to your doctor about preventative treatments, or alongside discussion of the Hepatitis B vaccine). Trojan did not discuss HPV vaccination at all. An article by the U.S.-based Centers for Disease Control and Prevention referenced in the Trojan article on HPV was dated from 2007, around the time the vaccine was being introduced to the market, and it is possible that Trojan's content has not been updated since this time to reflect the emphasis on vaccination (the Trojan article does make mention of the link between HPV and cervical cancer, and advises regular Pap smears to promptly detect and receive treatment for cervical cell changes before cancer develops).

Birth control was also a topic covered with remarkable depth and frequency by most, but not all, of the websites in my sample. Every website discussed non-hormonal birth control in terms of the importance of condoms, although NAHO did not dedicate a separate article to this issue (NAHO neglected any in-depth discussion of the various types of birth control, but did refer readers to the SOGC's Sexuality and U for this information). Canadians for Choice and the SOGC discussed the advantages and disadvantages of natural birth control methods (including the calendar and basal body temperature methods), but Trojan and NAHO primarily defined natural methods of birth control as withdrawal or rhythm methods, and described these as unreliable (I discuss the gendered nature of the construction of withdrawal as unreliable in Chapter 6). Healthy

Canadians did not discuss natural methods, nor did they mention hormonal forms of birth control such as the pill, but did provide an article on condom use.

STIs and birth control are the two largest areas of conversation in the websites in my sample; relatedly, the issue of (desired) pregnancy and infertility do not receive a lot of attention. Pregnancy is primarily discussed through the lens of avoiding pregnancy (Trojan, for example, frames their articles on birth control under the heading “how not to get pregnant”). Pregnancy is also discussed through the lens of STI risk: young women are at risk of transmitting STIs to their children during pregnancy or while in labour, and infertility is primarily discussed as a consequence that may develop if STIs are not promptly treated (I discuss the gendered nature of the discussion of consequences of STIs in more depth in Chapter 4). Canadians for Choice presents information about infertility as a state of wanting to have children and not being able to, and the SOGC discusses what a woman’s sex life might be like following childbirth and into new motherhood. However, none of the websites in my sample offer information on the experience of a (desired) pregnancy.

Abortion and emergency contraception (EC) are not discussed by all of the websites in my sample, and those websites that do cover these issues do not do so in depth. Canadians for Choice provides the most comprehensive discussion about abortion, covering issues such as its historical background, problems in access internationally and in Canada, and a shortage of abortion providers. While it does discuss some of the emotions women who seek an abortion might experience, it does not outline what procedures to expect from a clinic, nor any of the physical symptoms. NAHO and the SOGC both mention abortion; for both websites, abortion is listed as one of many possible options women have when they discover an unintended pregnancy, alongside keeping the child and giving the child up for adoption. Although abortion is listed as an option and a right that should be supported by a woman’s doctor, neither website goes into any depth in this discussion. Canadians for Choice and the SOGC both provide separate articles on EC. Canadians for Choice notes the trouble that some young women may have in accessing EC from pharmacists with conservative or religious beliefs; in

contrast, the SOGC indicates that EC is “easy” to get because it can be accessed in a pharmacy without a prescription.

Of the five sites included in the sample, only three addressed issues of sexual violence, and only two of these focused on the issue in articles dedicated to the topic. Canadians for Choice discusses sexual assault in their article on sexual and reproductive rights, and highlights the problem of gender-based violence in Canada and globally, but does not provide a separate or in-depth article on the topic. The SOGC and NAHO both devote separate articles to the issue of sexual assault, and state in clear language that a victim is never to blame and that sexual assault can happen to and be perpetrated by anyone, regardless of gender. Despite these progressive claims, the safety tips that the SOGC outlines work to responsabilize the victim, constructed as a young woman (see Chapter 5 for my analysis). The SOGC additionally provides an article on sexual assault and the law, where they discuss the age of consent. Both the SOGC and NAHO also discuss alcohol- and drug-facilitated sexual assault, and warn readers to control their drinking. Healthy Canadians omits the issue of sexual violence completely, and Trojan briefly addresses sexual assault in the context of an article on women’s sexual problems, indicating that a woman who has previously experienced a sexual assault may experience lower levels of desire for sex in future relationships.

All of the websites in my sample discussed sexual partners or relationships when addressing their readers’ health and sexuality. These discussions included how to assess whether a relationship is healthy or abusive (NAHO), but largely focused on navigating and maintaining active sexual relations. With regard to sexual pleasure, only three websites (NAHO, the SOGC, and Trojan) discussed masturbation; further, masturbation was most frequently discussed as a tool that could be used by the reader to learn more about her body, where that knowledge could then be relayed to her partner to make sex more enjoyable. General relationship advice also concerned the dating process, found on Trojan’s website, and the difficulty (and importance) of communicating with partners about safer sex. The SOGC and Trojan both offered advice to readers who might be new to dating, or who might be considering sex for the first time with their partner. However,

discussions about relationships were not limited to teens or young adults: both Healthy Canadians and the SOGC had separate articles on seniors and sex, discussing issues such as menopause, aging-related erectile dysfunction, maintaining physical intimacy if intercourse is not a possibility, and being aware of safer sex requirements and STIs when finding new partners after a long-term spouse's passing.

Finally, there was some attention paid by the websites in my sample to broader historical forces that shaped how different populations experience sexual health. NAHO discusses colonization and points to the lasting impact this process has had on the health of Aboriginal peoples and communities generally. Canadians for Choice and Healthy Canadians both indicate that Aboriginal peoples are more likely to experience ill health (e.g., higher rates of STIs or abuse, or more difficulty accessing health services), but neither points to colonization as a contemporary or historical factor that makes this population more at risk for these conditions. No other racial or ethnic group is named by any of the websites in my sample, although "other" markers of difference, such as disability, homelessness, and recent immigration status are listed by Canadians for Choice as barriers to achieving optimal sexual health. Sexuality is also identified as a risk factor: Healthy Canadians indicate that men who have sex with men⁶ continue to be the group most affected by HIV/AIDS in Canada. The SOGC also points to the risk of harassment or discrimination when deciding to come out to family, friends, or co-workers (see Chapter 5). Much of the information on sexuality appears to be intended for a heterosexual audience: NAHO and the SOGC both point to a spectrum of identities (including trans*, intersex, and queer identities), but primarily provide introductory definitions for readers who may not be familiar with them.

I offer this brief description of article content to introduce the issues deemed most important to sexual health by the websites included in my sample. Despite the focus on sexual "health", unwelcome consequences are a prominent focus as demonstrated by the large amount of information about STI risk. This was particularly true for Healthy

⁶ Healthy Canadians uses the phrase "men who have sex with men" to indicate a sexual behaviour rather than a sexual identity or orientation. This website otherwise does not name or address LGBTQ2 identities or issues.

Canadians: unwelcome consequences comprise the almost singular focus of this site with the exception of one article on sex and aging. Every website also discusses a range of issues related to an individual's overall well-being, such as relationship status and body image, indicating that these websites do not merely define sexual health as a physical state. However, there are stark silences on some topics: not every website discusses sexual assault, for example, and there are significant limitations on the discussions surrounding sexuality and racial or ethnic backgrounds. Religion is virtually ignored, and disability is mentioned only once. In addition to this consideration of the kinds of issues that are being foregrounded in the discourse on sexual health, I attend to the context in which these issues are discussed in the discourse analysis below.

3.3.6 Data Analysis and Coding

I used qualitative analysis software NVivo 10 to collect the websites included in my sample in the summer of 2013. NVivo has the capacity to convert websites into PDF documents, which can then be highlighted and annotated. Converting the websites produced static documents and controlled for any website updates or changes that occurred through the course of my analysis (a control that has proven particularly useful, as one website, Canadians for Choice, ceased being available online after its merger with Action Canada for Sexual Health partway through my analysis). In total, I captured 282 web pages, with information ranging in length from one paragraph to three letter-size pages for each web page (28 web pages from Canadians for Choice; 10 from Healthy Canadians; 66 from NAHO; 96 from the SOGC; and 82 from Trojan). Although I used software to organize my data, I coded all of the content manually.

Rose (2012) identifies that the interpretive process undertaken in a discourse analysis can be accomplished through a systematic coding process to lead to the identification of key themes, “which may be key words, or recurring visual images”, or words or images that appear important but do not necessarily recur often (210). She further recommends that coding, or “attaching a set of descriptive labels (or ‘categories’) to the images” collected, should be “apparently objective in a number of ways and therefore only describe what is

‘really’ there in the text or image” (Rose 2012, 90). However, categories can also be developed in relation to theoretical concerns so that categories are “immediately more obviously interpretive” rather than descriptive, and more amenable to qualitative analysis (Rose 2012, 90). Indeed, Gill (2000) states that the “categories used for coding will obviously be determined by the questions of interest” (179). In the coding process I undertook for my research, the coding categories for both the textual and visual elements of my analysis are based on particular theoretical literature on postfeminism, neo-liberalism, and women’s health, in addition to categories which emerge from what is and is not represented in the data itself.

Through my coding process, I was motivated to search for the occurrence of particular postfeminist themes in health information, such as the assumption of feminism, elements of consumerism, and an emphasis on individual responsibility. Although I had these themes in mind, I did not approach my data with a pre-formed coding template. Instead, I remained open to unanticipated themes that emerged from the data, including themes which contradict or complicate my expectations related to the influence of postfeminism on health discourse. In other words, I applied my research questions in a way that allowed themes to emerge from my data; some of these themes overlapped with the theoretical basis of this project, and others added new or unanticipated perspectives. To remain open to “analytic categories” which emerged from the data rather than my framework of postfeminism and sexual health discourse, I used words directly from the text under investigation to form coding categories where possible (Reinharz 1992, 161). For example, I read each document and developed codes for words and concepts as they arose; I also took note of conceptual and rhetorical themes as they emerged, as well as similar concepts that used different language. As an example, I coded each instance of the word “condom” as “condom”. I also indicated where condom use was discussed in relation to themes such as sharing responsibility for protection (under codes such as “equality” and “responsibility”), or how condom use might facilitate or compromise spontaneous sex (under codes such as “planning” or “pleasure and arousal”).

I began my analysis by coding Trojan's We Know Sex website. I read each article, highlighted the text of each paragraph in NVivo, and identified and created codes based on that content. Once I had coded all of the web pages for Trojan, I took notes on the emerging themes and recurring concepts (and omissions), and noted the relationships between the codes. These notes allowed me to maintain a theoretical approach to my data by putting the emerging themes in conversation with each other, and it also allowed me to create a brief, descriptive summary of the website's content as a whole; that is to say, it allowed me to keep the individual paragraphs and pieces of information coded and interpreted in the context of the website.

I continued coding in this manner with each subsequent website, adding content to the codes I created through the Trojan website, developing new codes as required, and writing summaries and observations on each website as I completed them. To avoid coding slippage, I used NVivo to organize my codes into a code book after I completed the coding for the first two websites (Trojan and Canadians for Choice). I identified frequently occurring and analytically unique codes, and grouped similar or related codes under that heading. For example, codes that related to the Pill, the contraceptive sponge, and abstinence were grouped under the heading "birth control". I also added descriptions to each heading (see Appendix III for a copy of my final code book). I continued organizing my data in this way as I added new codes through multiple readings of each subsequent website (in order, Healthy Canadians, the SOGC, and NAHO), and referred to the code book to keep previously developed codes fresh in my mind as I read. Additionally, I re-coded the Trojan website after completing the remaining four websites to ensure that any codes I developed in subsequent websites could be applied to the first website I read.

When I completed the coding process, I had over 60 headings that grouped together hundreds more additional codes. Following the coding process, Rose (2012) recommends thinking about "connections between and among key words and key images", with the aim of examining relationships between statements, groups of statements, and between statements and social or political events (210). Likewise, Gill

(2000) identifies that the first phase in the analysis process is to search for pattern in the data, both in terms of “variability (differences within and between accounts) and consistency” (180). The second phase is to form “tentative hypotheses about the functions of particular features of the discourse, and [to check] these against the data” (Gill 2000, 180).

To search for these patterns and functions, I used a feature in NVivo which allows users to read all content coded at a particular code. I opened each code and read and took notes on the content (and its original source website). By reading the content at each code, I was able to read back through all of the website data in the context of the code itself (e.g., rather than in the context of the webpage or article topic). In many cases, this meant reading through sections of the website data multiple times, depending on how many codes I used for each highlighted paragraph or web page. This re-reading of the data, code by code, allowed me to identify and make analytic notes on recurring themes within the codes themselves, themes which inform the interpretive and discursive themes of my results and analysis. These initial analytic observations were used to develop the thematic headings that structure my results and to examine my data in relation to my research questions.

3.4 Conclusion

In this chapter, I described the methodological approach and analytic processes that were used to explore discourses of sexual health in websites offering sexual health information to young women. In the following three chapters, I present the findings that resulted from this methodological approach.

Chapter 4

4 The Discursive Construction of an Imperative of Good Sexual Health

In this chapter, I identify discourses in my sample that contribute to a construction of good sexual health as an imperative for young women. I describe ways that sex is medicalized in these websites, which conceptualizes sex as both an avenue to and expression of good health. Sex is constructed as inherently good and healthy: young women are entitled to good sex, including sex that is pleasurable for them. Young women are responsabilized to pursue good sexual health through the emphasis on management of risks for STIs, which are positioned as compromising the benefits of sex for both physical and emotional well-being. Within this discourse, an ideal standard of sexual health is produced that presumes and privileges monogamous, heterosexual sexual relationships, and charges young women with new responsibilities regarding the communication of STI risk.

4.1 Medicalization of Sex: Individual Pursuit of Good (Sexual) Health

The websites included in my sample position health as an unquestioned good, whether for its ability to produce physically healthy bodies (e.g., Healthy Canadians) or for its ability to facilitate emotionally healthy relationships (e.g., the SOGC). In an article on STI prevention, the SOGC summarizes this discursive approach to health by stating that “[f]ew things in life are as important as your health” (SOGC, STIs-STDs). Health, including overall health and sexual health related specifically to STI prevention, is established in this passage as something that is important to preserve and protect. However, the SOGC generally assumes that readers are already aware of the importance of maintaining good general health. This assumption is then employed to demonstrate an imperative to maintain good sexual health. The SOGC draws a direct comparison between sexual health and overall physical health: “Sexual health is a big deal - as big as your overall physical health” (SOGC, Sexual Health). This passage constructs the importance of overall health as a norm that has already been established and accepted by

its audience. Sexual health is depicted as involving both physical and emotional aspects, and these qualities are used to demonstrate to readers its importance.

NAHO illustrates the connection between sexual health and overall (physical) health: a “sexual health” article heading is paired with an image of a woman playing hockey outdoors in the winter, holding her stick above her head triumphantly.



Figure 1: NAHO, *Sexual Health Toolkit Part 1*

Canadians for Choice also contributes to a discourse that establishes connections between sexuality and overall health. In this example, the organization reminds readers that health is a “fundamental human right”, and extends the definition of health to include sexual health. Sexual health, then, is discursively constructed as distinct from but connected to overall health.

Since health is a fundamental human right, so must sexual health be a basic human right. In order to assure that human beings and societies develop healthy sexuality, the following sexual rights must be recognized, promoted, respected, and defended by all societies through all means. Sexual health is the result of an environment that recognizes, respects and

exercises these sexual rights (Canadians for Choice, Sexual and Reproductive Rights).

In the above example, Canadians for Choice indicates that sexual health is beneficial for societal well-being. Good sexual functioning contributes to the good health of society; in turn, social environments and societies contribute to the realization of good sexual health and sexuality. Canadians for Choice establishes a connection between sexuality and larger social environments that positions sexuality as a healthful concern.

NAHO contributes to an understanding of the connection between health and larger social structures by identifying several material differences in the lives of Canadians that impact the ability to achieve good sexual health. In this passage, community factors like isolation and discrimination are specifically identified as factors that impact sexual health in Aboriginal communities.

Sexual health includes a range of connected elements from sexual behaviour, attitudes, spirituality, and social factors, to biological risks. It is affected by society and what is considered “normal”. It is also affected by access to information and services as well as community factors like poverty, violence, isolation, and discrimination (NAHO, Sexual Health Toolkit Part 1).

NAHO identifies particular ways that Aboriginal populations in Canada are placed at risk for poorer health, through poverty, violence, isolation, and discrimination. Through this discussion, this source also questions what is considered a “normal” standard of sexual health. By putting “normal” in quotation marks, NAHO questions a white, colonial standard of sexual health that is potentially harmful to “other” populations in Canada. The focus on larger, structural influences only appears sporadically in the discourse on medicalization in my sample.

NAHO supports this construction of health as a community concern through the images it uses to illustrate their discussions. In an article discussing STIs, NAHO provides an image of a group of Aboriginal men participating in a drum circle. Although the article text only provides information regarding symptoms and treatments, the image invites the reader to make a connection between individual health risks and community health and togetherness.



Figure 2: NAHO, *Sexual Health Toolkit Part 1*

Trojan contributes to the medicalization of sexual activity through a discussion of the link between physical ability and sexual ability. Readers are reminded that good overall health and good sexual health is something that they, as individuals, are easily capable of evaluating and enhancing: individuals can improve their sexual health by committing to their physical fitness.

In other words, sexual response involves the cardiovascular system. There are many different biological factors that can affect your sexual functioning like the levels of circulating hormones in your system, but one

thing you can easily do to be sexually fit is to be more generally physically fit (Trojan, *Stay Sexually Healthy: Fitness and Nutrition*).

Trojan also distinguishes between what readers do and do not have control over when it comes to their sexual health, a distinction that works to individualize discourses on risk. Biological factors such as the number of hormones one has affects sexual functioning, and is presumably outside of an individual's control without medical intervention. However, Trojan emphasizes that sexual fitness can be “easily” achieved by pursuing general physical fitness, placing the goal of good (sexual) health within reach. Sexual health is discursively constructed as an aspect of health that is enhanced or hindered by the choices and actions made by individuals, a perspective that is informed by and reinforced healthism.

Like Trojan, NAHO also discusses the relationship between sexual and overall health. However, NAHO describes an Indigenous understanding of health to argue that the mind, body, and spirit are connected, and together, these elements make up the overall well-being of an individual. Sexual health is also part of that well-being, and so individuals must care for their sexual health in order to protect their overall health.

Sexual health is a part of your over-all well-being. The mind, body, and spirit are connected. But, this also means that the effects of unsafe and risky sexual behaviours can affect not only your body but also your mind and spirit (NAHO, *Sexual Health Toolkit Part 1*).

With an understanding that sexual health is part of and contributes to this broader understanding of well-being, NAHO cautions that “unsafe and risky sexual behaviours” can have a negative impact on the body, mind, and spirit. The implication of this statement is that these behaviours, generally defined throughout the websites in my sample as physical risks such as sex without a condom or with multiple partners, should be avoided. Health risks are individualized, and young women are encouraged to make

choices that demonstrate adherence to particular conservative sexual mores in order to achieve good (sexual) health.

4.2 STIs and Young Women At-Risk: A Call to Action

In the above discussion, I outline how the websites in my sample established that regular sexual activity is an important component of (sexual and) overall health, whether defined in purely physical terms (e.g., Trojan's discussion of biomedical understandings of the body's "systems") or in broader terms (e.g. NAHO's discussion of the mind, body, and spirit). In my study sample, young women are consistently encouraged to maintain this good (sexual) health by managing risks to that health. Specifically, sexually transmitted infections (STIs) are identified by each of the websites in my sample as a particular concern for young women that must be addressed.

The SOGC employs statistics to introduce their discussion on youth sexuality to illustrate the high prevalence of sexual activity among this age group. This commonality is then used as evidence to support a concern about teen sexuality. In the following example, the SOGC combines a discussion about research examining age at first intercourse with information concerning HPV risk: the risk of contracting HPV is "usually" immediate, following the "sexual debut" of young Canadians.

HPV is usually acquired at a young age at the time of sexual debut, typically measured as the age of 'first intercourse'. Research shows that sexual debut for young Canadians (male and female) can be as young as 15 years of age and it has been reported that oral sex is practised by girls as young as 12 and 13 years old, regardless of their social or economic background (SOGC, Viral-STIs-STDs: What are STIs-STDs).

By combining the discussion of youth sexuality and STI risk, information from the SOGC contributes to a discourse that medicalizes sex for young women. This passage indicates that both young men and young women begin engaging in sexual activity "as

young as 15 years of age”: the use of the phrase “as young as” invites concern from the reader over youthful sexuality. Further, the indication that “girls as young as 12 and 13” engage in oral sex places a concern primarily on those young girls. The use of the phrase “regardless of their social or economic background” also works to refute stereotypes about promiscuity as a “low-class” phenomenon, advising readers that “good”, middle-class girls also engage in sex and are at risk for STIs. Through this exclusive focus on the sexuality of teenage girls (rather than a shared focus on teenage boys, who may also be receiving or giving oral sex to teenage girls, or to each other), the health risks associated with sexual activity are discursively constructed as a concern primarily for young women. Statistics and non-specific “research” are used in this example to establish young women as sexually active, and to position young girls in particular (rather than boys) as sexually active and as vulnerable to the health risks of sexual activity.

Healthy Canadians also indicates that higher STI rates (in this case, chlamydia, and in another article on their website, gonorrhea) are attributable to the inconsistent use of safer sex practices, in addition to improved screening and higher detection rates. By pointing to lab tests, Healthy Canadians ties the discussion of STIs to medical intervention.

After a period of decline, the rates of reported cases of chlamydia infection have risen steadily since 1997. The increasing rate of this bacterial infection is attributed, in part, to improved lab tests and screening, as well as people not consistently using safer sex methods. Chlamydia disproportionately affects sexually active youth and young adults, especially women ages 15-24 in Canada (Healthy Canadians, Chlamydia).

This passage concludes by indicating that young adults – and more specifically, young women – are disproportionately affected by chlamydia. By following the statement that inconsistent safer sex practices are one reason for the increased rate of chlamydia with a statement indicating that young women are particularly affected by this STI, Healthy

Canadians indicates that young women in particular need to be concerned about the health effects of sexual activity.

For Trojan, the gendered construction of differential STI rates between women and men is understood as a necessary outcome of biological differences. Specifically, this article explains young women's vulnerability in biological terms:

STIs tend to be more common in women than in men. This is mostly because women are biologically more susceptible to STIs than men. In other words, STI transmission is more efficient from men to women than vice versa (Trojan, Intro to STIs: More common than you think).

The websites in my sample cite statistical evidence to establish that the consequences of STI transmission are disproportionately faced by young women. Furthermore, the risk of young women contracting an STI during a range of sexual activities is discursively constructed as inevitable. Trojan offers a "risk chart" to rank a variety of sexual activities. In this chart, risk levels range from "Very Little or No Risk" for activities such as kissing to "Higher Risk" for activities such as anal intercourse without a condom. The category of "no risk" is combined with "very little" risk: by failing to distinguish between which sexual activities carry "no" and "low" risk, this combination constructs "no risk" as an impossibility. Indeed, the image that accompanies the article in which the risk chart appears is a stack of four dice, each with a letter spelling out the word "risk". The association between dice and gambling emphasizes that risk cannot be completely avoided, thus emphasizing the necessity of risk management.

STI Risk Estimates				
	Very Little or No Risk	Lower Risk	Higher Risk	Level of Risk Unknown
Kissing	HIV, Chlamydia, Gonorrhea	HBV	HSV (HSV-1 is very common on the lips & mouth area)	HPV
Mutual Masturbation	HBV, HIV, HPV, HSV, Chlamydia, Gonorrhea			
Performing Oral Sex		HBV, HIV, HSV, Chlamydia, Gonorrhea		HPV
Receiving Oral Sex		HIV, HSV, Chlamydia, Gonorrhea		HPV
Penis-Vagina Intercourse (No Condom)			HBV, HIV, HPV, HSV, Chlamydia, Gonorrhea	
Penis-Vagina Intercourse (Condom)		HBV, HIV, HPV, HSV, Chlamydia, Gonorrhea		
Penis-Anus Intercourse (No Condom)			HBV, HIV, HPV, HSV, Chlamydia, Gonorrhea	
Penis-Anus Intercourse (Condom)		HBV, HIV, HPV, HSV, Chlamydia, Gonorrhea		

Figure 3: Trojan, Reducing the Risk: Risk chart



Figure 4: Trojan, Reducing the Risk: Risk chart

With the risks and consequences of sexual activity laid out as an exercise of odds calculation, readers are advised to avoid a range of “risk activities” to prevent or minimize the chance of contracting an STI. Unprotected sex is consistently identified as a high risk activity for STI transmission, and readers are encouraged to use condoms. Performing and receiving oral sex appear in the chart as “lower risk” activities; dental dams are discussed in many articles in the websites in my sample, but the role they may play in reducing STI transmission is not discussed in this article. Although Trojan and other sources in my sample construct risk as something that can never be eliminated, the

simplicity of the problem and solution for STI transmission is plainly stated: protected sex through the use of condoms poses the lowest risk for contracting an STI.

NAHO echoes Trojan's recommendations to use condoms. In this passage, readers are encouraged to protect themselves from STIs by using condoms to engage in "safer" oral, vaginal, and anal sex. In contrast to Trojan, NAHO explicitly lists dental dams as an option for protection.

Protect yourself from STIs: If you are sexually active the best protection from STIs are latex condoms, female condoms, or dental dams used during oral, vaginal and anal sex. These methods only work if used properly and only protect you in places they cover. It's never too late for safer sex! Even if you haven't been safe in the past, there is no reason you can't be safe now and in the future (NAHO, Sexual Health Toolkit Part 1).

NAHO addresses the reader's potential sexual history, which may include unprotected sexual activity. However, readers are told that even if they have not had safe sex in the past, it is "never too late" to start. This recommendation functions as a call to action, and implies that each new sexual act carries with it a certain amount of risk that must be managed and lowered by the readers through the use of condoms: condoms make sex "safer", though not completely without risk. Condoms are discursively constructed as necessary for sexual activity: there's "no reason" not to use them.

4.2.1 Mobilization Through STI Risk: Threats to Physical Well-being

Most of the discussion surrounding the negative health effects of contracting an STI from the websites in my sample revolve around the physical consequences. STIs, including incurable or chronic infections, are identified as especially dangerous if readers don't pay attention by getting tested and receiving treatment. The SOGC offers "good news" to its readers about the many STIs that can be cured, controlled, or prevented. However, the "bad news" is that some STIs such as HIV can cause death.

If you don't protect yourself from sexually transmitted infections, you're risking a lot. The good news - most sexually transmitted infections (STIs) can be cured and others can be controlled. There are now vaccines to prevent Hepatitis B and the Human Papillomavirus. The bad news - some, such as HIV, can kill you (SOGC, STIs-STDs: What are the chances of getting an STI-STD).

The “good news”/“bad news” strategy encourages constant vigilance: one must never let her guard down. Taking preventative measures – in this case, through vaccination against Hepatitis B and HPV – is stated as paramount. Elsewhere in my data, condoms are identified as essential to helping to prevent STI transmission. The SOGC informs readers that they are “risking a lot” if they do not protect themselves, a perspective that remains consistent with the warnings that sex is never safe. The health effects of STIs – including possible death from HIV – is presented as a consequence of the specific behaviour of not engaging in prevention efforts.

Other websites in my sample also discuss death as a possible outcome of an STI. Canadians for Choice discuss syphilis as a “very treatable” STI that is becoming increasingly common in Canada. However, the treatability of syphilis is contrasted with information that indicates that death is a possible outcome, a contrast that works to underscore the importance of seeking treatment.

Syphilis is a bacterial sexually transmitted infection (STI) that is currently on the rise in Canada. In the 1990's [sic] syphilis was very uncommon in Canada but over the years more and more cases have been reported. If syphilis is detected early on, it is very treatable; unfortunately, when not treated, syphilis can progress until it starts infecting a person's organs, which can result in death. In developing countries where the treatment is not as readily available, syphilis is extremely problematic (Canadians for Choice, Sexually Transmitted Infections: Syphilis).

Canadians for Choice indicates that early detection is key to ensuring that syphilis can be easily treated. For example, in other articles from my data, readers are encouraged to undergo regular STI screening through their doctor or a sexual health clinic to facilitate detection and receive treatment. Despite the emphasis on the treatability of syphilis, Canadians for Choice identifies this STI as “extremely problematic” in “developing countries”. By underscoring the differences in treatment options in “other” parts of the world, readers are encouraged to get tested “here” in Canada: how could one choose to refuse these services when they are available? Canadians are assumed to enjoy access to a full range of sexual and reproductive health services, with few exceptions. According to this discussion, Canadians need only choose to access these services (e.g., by pursuing STI treatment) to protect their health.

The physical consequences of STIs are discussed in gendered ways within the websites in my sample. The following example discusses the link between HPV and cervical cancer. Canadians for Choice employs statistics to emphasize the severity of the risks associated with HPV and cervical cancer. The organization also makes a comparison between the link between HPV and cervical cancer and the link between smoking and lung cancer, the latter of which enjoys a longer precedent of acceptance in Canadian society. This passage concludes with the warning that cervical cancer is the “2nd leading cause of women’s cancer related deaths”.

HPV and cervical cancer are often discussed simultaneously. This is because 99.7% of cervical cancer cases are caused by HPV. In fact, there is a higher correlation between HPV and cervical cancer, than there is between smoking and lung cancer. It is important to be well- informed about cervical cancer considering it is the 2nd leading cause of women’s cancer related deaths in Canadian women aged 20-44 (Canadians for Choice, Sexual and Reproductive Health Issues: HPV).

Two strategies are used to call people to arms and urge young women into action. Statistics about the link between cervical cancer and HPV, as well as statistics on women's cancer related deaths, invoke a discourse of fear surrounding STIs to responsabilize young women (beginning, in this passage, at age 20). Because of the risk of death, young women are told that it is "important to be well-informed about cervical cancer". The encouragement to learn about HPV and cervical cancer relies on an assumption that if women were properly informed, they would implement behaviours and prevention strategies (such as using condoms during sex) to protect themselves from the risk of STIs.

In addition to contracting STIs at a higher rate than men, women are identified as being "especially" vulnerable to the serious health problems that result from STIs. According to Healthy Canadians, chlamydia can lead to "serious health problems", including infertility, if treatment is not immediately sought.

Even without symptoms, however, chlamydia can be transmitted and can lead to serious health problems and infertility, especially in women. Anyone at risk should therefore be tested (Healthy Canadians, Chlamydia).

Healthy Canadians concludes this passage with a specific call to action: "anyone at risk should therefore be tested" for STIs. The risk of infertility is employed to encourage women to receive STI testing and treatment.

Young women are given encouragement throughout the websites in my sample to act to protect their health from the risks and dangerous consequences of STIs. The discussion of STI transmission overwhelmingly emphasizes sexual contact; however, the following passage from The SOGC expands that understanding to include transmission between a mother and baby during childbirth. Herpes, "generally not considered a serious health risk" for adults, becomes a site of concern because of the risk it can pose to the life of a child.

By themselves, HSV-1 and HSV-2 are generally not considered a serious health risk. However, in very rare cases, the Herpes Simplex Virus can cause serious illness. Infected pregnant women can pass the virus to infants during birth, causing lesions and possibly life-threatening infections of the central nervous system of the baby (SOGC, Viral-STIs-STDs: What are STIs-STDs).

The SOGC warns that “life-threatening infections” could develop in infants who contract the herpes virus from their mothers during childbirth. In addition to protecting their own health, women have the additional responsibility of acting to protect future children from the harm that may accompany STIs: young women are mobilized to act now for their future children and for the future of their children. By connecting STIs that are otherwise not considered serious for adults to the potential ill health of future children, all STIs (and thus, the sexual activity through which they are transmitted) are discursively constructed as health concerns.

4.2.2 Mobilization Through STI Risk: Threats to Emotional Well-being

The websites in my sample work to establish the prevalence of STI risk among young adults in general and in young women in particular, including those in longer-term or monogamous relationships, and describe STIs as damaging and dangerous to young women’s health. These dangers are used as warnings to encourage young readers to act responsibly. In this example, Trojan advises its readers to “definitely pay attention” to STIs and the serious implications they pose to health and well-being.

These infections can have some serious implications for your health and well-being so this is something you should definitely pay attention to (Trojan, Intro to STIs: Am I at risk).

By telling its readers to pay attention, Trojan is intervening in an area where it assumes its readers are not already acting. The importance of this action (“paying attention”) is stressed by Trojan when they contribute to a construction of STIs as more than a physical health problem, potentially affecting the well-being of readers. Healthy Canadians similarly indicates that genital herpes is accompanied by both physical and emotional consequences.

Pain and discomfort are the main health effects of genital herpes, but the virus can also cause emotional and social problems for those infected (Healthy Canadians, Genital herpes).

Readers are told that in addition to physical complications, STIs (in this case, genital herpes) can cause emotional and social problems. While these social problems presumably refer to the stress of managing and disclosing this STI in sexual relationships, there are other emotional anxieties discussed in my data. The SOGC addresses the “social and psychological consequences” that women may experience following abnormal Pap smear results related to HPV infection.

Cervical dysplasia seldom causes any noticeable symptoms. It is usually detected through a Pap test (smear) or colposcopy. HPV infection has social and psychological consequences. Studies of women who have received abnormal Pap test results indicate that they often experience psychological consequences including: Anxiety, fears about cancer; Sexual difficulties; Changes in body image; Concerns about loss of reproductive functions (SOGC, Viral-STIs-STDs: What are STIs-STDs).

In this example, the social and psychological consequences of cervical dysplasia for women are described as preceding any physical symptoms. The SOGC indicates that cervical dysplasia caused by HPV infection “seldom causes any noticeable symptoms”. For women receiving abnormal Pap smear results, this news may be the first time she becomes aware of the presence of HPV infection, or the effect HPV is having on her

body. Readers are warned that anxiety and concern about future physical symptoms (including cancer or infertility) could develop following this diagnosis.

4.3 Monogamy as an Ideal Standard for Sexual Health

Conservative messaging regarding sex appears through the discourse on STI transmission, where having one single sexual partner throughout a person's lifetime is presented as the ideal scenario to prevent STIs. Trojan addresses the impossibility of protecting against the spread of STIs, and points to the "reality" of multiple sex partners.

If everybody on the planet only had one sexual partner in their lifetime, there would be a lot less STIs. But that's not reality (Trojan, Monogamy and STIs: Am I still at risk).

STI transmission is discursively constructed as a global issue through Trojan's reference to the "planet". Trojan works to establish the ubiquity of STI risk and reinforce that safety is out of reach: anyone who has had sex is at risk, and all sex is risky. Canadians for Choice also references global realities to establish the ubiquity of STI risk. This source argues that even one sexual partner poses a risk, in this case, of contracting HPV, and that each new sexual partner or each new sexual act represents a growth of that risk.

HPV, or the human papillomavirus, is the most common sexually transmitted viral infection in the world. HPV is contracted through skin-to-skin contact, which means that you can get HPV even without having intercourse. With only one sex act, with or without penetration, a person has a 40% chance of contracting HPV. You can imagine how the chance of contracting HPV increases with every sexual act a person has!
(Canadians for Choice, Sexual and Reproductive Health Issues: HPV).

In this way, STIs are established as an undesirable yet inevitable consequence of sexual activity, as the risk of transmission is present even without sexual intercourse. Further,

STIs are established not only as an undesirable consequence of sexual activity with too many partners, but of too much sexual activity, period. Each “sexual act” involving skin-to-skin contact increases the risk of contracting HPV.

In addition to needing to concern yourself with the number of sexual partners you have, Healthy Canadians likewise identifies that the previous sexual partners and behaviours of your partner pose a risk to you. Risk multiplies through the relational aspect of sexual activity.

Anyone who has had sex is at risk for HPV...Remember that the previous sexual behaviours of your partner are also a risk for you, especially if they have had multiple partners (Healthy Canadians, Human papillomavirus (HPV)).

In this example, STI risk is stated plainly, and functions as cause to pursue STI testing. Throughout the discourse, the reminders of risk are meant to encourage particular actions in the readers: pursuing STI testing and treatment, engaging in safer sex by using protection, or by choosing sexual partners with their sexual history in mind. The invisibility of some STIs invites the reader to become more aware: one of the risks of being indiscriminate about sexual partners or having multiple partners is that STIs often do not present symptoms, and thus can be easily transmitted. This concern is heightened in the discourse when it comes to HIV, which could go undetected for up to 15 years before symptoms present.

In the case of HIV, it is possible that 15 years could pass before the infection leads to visible symptoms; that’s 15 years during which the infected person could pass along the virus to countless partners (SOGC, STIs-STDs: What are the chances of getting an STI-STD).

Although the concern about spreading undetected STIs does appear elsewhere in my sample (particularly when discussing STI risk in monogamous relationships, below), this

passage reflects long-standing stereotypes and moral panics about gay men, HIV, and promiscuity. The SOGC indicates that because of the nature of HIV symptoms, it is possible for someone with HIV to pass the virus onto “countless partners”. According to the SOGC, the solution is simple: “Don’t have sex with someone who has a lot of partners” (SOGC, STIs-STDs: How do I protect myself from STIs-STDs). In these examples, promiscuity is identified as a point of concern for readers. Not only must they monitor their own sexual activity, but they must also consider the sexual history of their partners (and therefore, their risk of STI exposure). Further, readers are called to respond to this risk by opting out of sexual activity with these people or by pursuing STI testing.

4.3.1 Serial Monogamy is the New Promiscuity: Assessing Health in a Relationship

Canadians for Choice addresses myths about sexual relationships and STI transmission. In the following example, they continue the conversation about destigmatizing STIs by discrediting the notion that promiscuity is the problem. In contrast to the above example that avoiding multiple sexual partners is an easy choice to make to help prevent acquiring an STI, the Canadians for Choice website emphasizes that STIs “do not discriminate”, and that they do not only affect people who have many sexual partners, thus reinforcing the idea that one is never safe from risk.

Anyone who is sexually active is at risk of contracting an STI. There are common myths, which are becoming less prevalent now about who contracts STIs. One such myth is that only people who have many sexual partners get STIs. This could not be farther from the truth. STIs do not discriminate from one person to the next. In fact, many people who engage in a series of monogamous relationships (being in a relationship with one person at a time) contract STIs. Often people will contract an STI from one relationship and pass it on to another person in a subsequent relationship (Canadians for Choice, Sexual and Reproductive Health Issues: Sexually Transmitted Infections).

Consistent with the discursive emphasis, above, on the potential to contract an STI after only one sexual encounter, Canadians for Choice further indicates that people can contract STIs when they “engage in a series of monogamous relationships”. Serial monogamy is identified as a new take on an old problem: like promiscuity, the number of sexual partners a person has (more than one) increases the chances of spreading or transmitting STIs from relationship to relationship.

Similarly, in a section of their website dedicated to helping readers “Stay Healthy”, Trojan works to debunk myths about the safety of monogamy. In this example, readers on the cusp of sexual initiation are warned that monogamous commitment is not “forever”. Accordingly, young women must be “serious” about protecting themselves.

The one thing you do need to be serious about is protecting yourself if things become sexual. Even if this person is your first and you’re certain you’ll be together forever. Things can change quickly at this stage in your life and “forever” may end up being two months (Trojan, Your Relationship Status: Dating vs hanging out).

In this example, Trojan questions the feasibility of the conservative standard of two people beginning to date at a young age and staying together for the rest of their lives. For youth in particular, it is pointed out that relationships change quickly and could be short-lived. Trojan posits that it is highly likely – nearly inevitable – that their readers will have multiple sexual partners in their lifetime, which requires the use of condoms and other forms of individual protection from STIs.

The specific risk of serial monogamy is explained in the information provided by NAHO. In this example, people in long-term monogamous relationships think that because they are having sex with only one partner, their STI risk is low. Without testing, undetected STIs can be transmitted if the couple decides to stop using condoms.

People who have many exclusive (monogamous) sexual relationships in a row are at high risk of STIs. People often don't get tested for STIs in these relationships, so you don't know if you or your partner has one. But because you're only having sex with each other you might stop using condoms and put yourselves at risk (NAHO, 10 Things to Know About STIs).

NAHO classifies individuals in serial monogamous relationships as "high risk" of contracting an STI. The sense of trust that accompanies knowing someone in an exclusive, monogamous relationship is constructed as an impediment to preventing the transmission of STIs. Trojan similarly argues that trust creates a false sense of security for monogamous couples, who may decide to stop using condoms before they are tested for STIs.

As you get comfy together, it's easy to get lazy or get lulled into a false sense of security. Trust alone is not a reason to stop using condoms. Even if you're exclusive, you both need to get tested – and, if you're in a hetero relationship, decide on birth control — before you even consider ditching the condoms (Trojan, *Your Relationship Status: Long term*).

In this example, risk is individualized: readers are advised to work against inaction in long-term relationships. Not using condoms is constructed as "lazy": it is work to get tested and decide on birth control, but this work is important to protect one's health. However, Trojan begins to open up a space where not using condoms may be classified as a healthful possibility. Readers might "consider ditching the condoms" once alternate birth control and STI testing has been completed in an exclusive relationship.

The SOGC calls on young women in particular to be concerned about this question of exclusivity. In the following example, young women are specifically hailed to evaluate a monogamous partner's fidelity. A male partner must have "proven himself worthy" of trust before it is safe to stop using condoms.

The only situation in which it's safe not to use a condom is in a long-term, monogamous relationship with a partner who's tested negative for STIs and has proven himself worthy of your trust (SOGC, Male Condom: How do I protect myself from STIs-STDs).

Trojan and the SOGC both outline clear standards that must be met prior to being able to have sex without using a condom. Young women must find themselves in a long-term, monogamous relationship with a partner who has tested negative for STIs. However, the vagueness of what might be required from a man to prove himself worthy of trust opens doubt as to whether this standard can be met. Although it is up to him to prove himself, young women are the ones tasked with the responsibility of assessing this proof: should he prove himself to be untrustworthy, she is to blame for her faulty assessment.

4.3.2 Communication Required to Preserve Good (Sexual) Health

The websites in my sample contribute to an emphasis on social and emotional well-being by consistently emphasizing the importance of communication within a relationship. Communication is presented as serving several important functions, including allowing a couple to grow closer to one another and strengthen their relationship, and to explore and develop more pleasurable sex with one another. Most crucially, communication serves a preventative function: open communication allows each individual to better comprehend the health risks associated with sexual activity, and to make decisions about how to best mitigate those risks. This discourse is gendered: young women are mobilized to protect their own health and to protect the health of their partner through textual advice and images. STIs are also destigmatized in some of the articles that I discuss below through discourses of healthism: young women are told that they are capable of having a good, pleasurable sex life even with a positive STI diagnosis, if they engage in the right kind of communication about STIs with their sexual partner.

Open communication is identified by all of the websites included in my sample as one way to reduce the risk of contracting an STI. Canadians for Choice acknowledges that discomfort can accompany conversations about sexual health, but encourages readers to overcome this discomfort. Young women are given a new responsibility to communicate to protect her own health and to protect the health of her partner.

While for some people talking about sexual health issues can be uncomfortable, it is especially important that you do so with every sexual partner in order to protect both your partner, and yourself, from being at risk of contracting a sexually transmitted infection. Talking about your sexual health and using protection every time you have sex are two great ways to encourage that you and your partner are healthy and happy (Canadians for Choice, Sexual and Reproductive Health Issues: HPV).

Conversations about sex are discursively constructed as uncomfortable, but readers are encouraged to view these conversations as more than mere transactions of information. Canadians for Choice indicates that these conversations help ensure that you and your partner are not only healthy, but also happy. STIs are constructed as a threat to one's emotional and physical health, and so the health of individuals in a sexual relationship is aided by managing this threat.

The importance of open conversation with partners about sexual health and safety is echoed by the SOGC. In this example, the SOGC calls on the stigma of STIs to emphasize the importance of talking about "safer sex in general and STIs in particular" with sexual partners; conversations about STIs may be uncomfortable, but these conversations are positioned as better than "actually getting one".

You've probably heard all of this before... the safe sex talk, or why you should always use condoms, birth control pills and the rest. And let's face it, talking about diseases and infections isn't exactly the most pleasant topic - it's not like you're going to just strike up a conversation on the bus

about genital warts! But if one thing is true of sexually transmitted infections, it's this: It's a lot more pleasant (and a lot less embarrassing) to talk about them than it is to actually get one (SOGC, STIs-STDs).

The websites in my sample are consistent in acknowledging that it can be uncomfortable to talk to a sexual partner about safer sex and STIs. Because of this discomfort, conversations about sexuality must be planned and managed to occur at certain times in a relationship (prior to sexual activity) and at certain locations: in this example, the SOGC indicates that diseases and infections are not appropriate conversations for public settings such as the bus. However, young women are reminded that it is important to have these discussions because they serve an important prevention function.

Trojan visualizes young women's responsibility to manage conversations about STI risk. In this image, a young Asian woman is pictured on a couch, talking to a young white man. She is gesturing as though she is counting off a long list of items that they must discuss; he is bent slightly, turned away from her, and has his hands on his ears in defiance.



Figure 5: Trojan, Talking About Sex: You need to talk

Through this image, Trojan represents the resistance young women might expect when engaging in conversations about STIs with male partners. This image represents the potential resistance she might face from her male partner when discussing issues related to sexuality and safety. However, the image also stresses the importance of these

conversations: young women must exercise their responsibility and persevere through men's reluctance to ensure that STIs are discussed.

4.3.3 Duty to Inform: Disclosing an STI to your Partner

The websites in my sample stress to readers the importance of talking to their partner about safe sex and STIs; this importance is increased when the discourse addresses those readers who already have an STI that must be disclosed. This disclosure is framed as difficult, but important. To address this difficulty, the SOGC works to destigmatize STIs, stating that it is not a disgrace to contract an STI and that you are not “loose” or “unclean” if you do.

It is important not to think it is a disgrace to become infected, or that doing so means you have a “loose” character or are unclean in any way. Anyone who is sexually active can become infected if precautions aren't taken (SOGC, STIs-STDs: What are the chances of getting an STI-STD).

The stigma of “looseness” is typically attached to promiscuous women, while men typically benefit from the sexual double standard that applauds their sexual experience. However, the SOGC uses the ubiquity of STIs to destigmatize those who may have contracted one: multiple partners are not required for STI transmission. Anyone who is sexually active can contract an STI “if precautions aren't taken”. In this example, the stigma of contracting an STI shifts from an association with promiscuity to an association with inaction. In another article, the SOGC outlines the responsibilities its readers have: they must work to avoid infection and must inform a sexual partner if they do have an STI. Indeed, The SOGC provides an overview of the legal necessity of disclosing particular STIs such as HIV. Although this passage opens by telling readers that disclosing HIV status is a difficult personal decision, the choice a person may have to keep that information to themselves is challenged by the SOGC's discussion of legal rulings by the Supreme Court of Canada that determine the obligation that people who are HIV-positive have to tell their sexual partners.

Whether to disclose HIV status can be a difficult personal decision. The laws that relate to HIV disclosure have been tested in recent legal cases involving persons with HIV/AIDS and their sexual partners. The Supreme Court of Canada has stated that persons who are HIV positive have an obligation to disclose their status to their partners before engaging in sexual activity that poses a “significant risk of serious bodily harm”. While “significant risk” has not been clearly defined by the courts, it is generally acknowledged that having unprotected anal/vaginal intercourse, and sharing intravenous needles, represents a serious risk of HIV infection (SOGC, Sexual Health: Sex and the law).

In the above example, The SOGC establishes that disclosure of an STI, particularly HIV, is both a moral and legal obligation. NAHO acknowledges this obligation by outlining the choices someone has who has recently been diagnosed with an STI: their sexual partner(s) must be told, but the person can opt to tell them directly, or they can opt to have a public health nurse tell them.

Stay healthy by getting tested for STIs...If you have an STI your healthcare provider can tell you what your options are. Your sexual partner(s) will need to know so that they can be tested and get treated as well. You can choose to tell them yourself, or have your healthcare provider or local public health office tell them (NAHO, 10 Things to Know About STIs).

Readers are given choices regarding how to disclose their STI status, but disclosure itself is not constructed as optional. STI testing and disclosure is discursively constructed as the way that young women can “stay healthy”. Good sexual health requires open communication with all sexual partners about STI status, treatment, and risk.

Trojan expands the discussion about preserving physical health through disclosure of STI status to a discussion of the health of the relationship. In this example, disclosure turns from an obligation that someone with an STI must perform prior to sexual activity as an act of caring for, and fostering connection with, her partner.

Disclosing an STI can be difficult. Try: “I feel our relationship getting serious. And because I care about you so much, there’s something I need you to know...I want to make sure that we have an open and honest relationship. I hope you feel the same way and know that I am telling you this because I care. I found out some time ago that my ex-partner gave me (whatever STI you’re disclosing) and I don’t want to do the same to you (Trojan, *Talking About Sex: How to bring it up*).

Despite the difficulties in disclosing a positive STI status to a sexual partner, this conversation is discursively constructed as an opportunity to demonstrate to your partner that you care about them. Trojan emphasizes that these conversations can function to establish or develop a relationship that is characterized by openness and honesty; disclosing a positive STI status is one way to demonstrate those qualities.

4.3.4 Accepting and Mitigating Risk: Enjoying a Sex Life with an STI

For individuals who are tested and diagnosed with an STI, abstinence is advised while treatment is pursued. In the following passage from Healthy Canadians, individuals who have herpes are told to “Avoid having sex when skin sores are present. This includes not having oral sex when cold sores on or around the mouth are present” (Healthy Canadians, Genital herpes). However, several websites in my sample stress that an active sex life is possible following an STI diagnosis, providing that future sexual partners accept the risk, and that abstaining from sexual activity due to STI status is only temporary while symptoms are present or until treatment is sought. The SOGC challenges the assumption that those who have STIs are doomed to a life of abstinence. For incurable STIs, such as genital herpes, readers are told that their sex life is not over.

Having Genital Herpes does not mean your sex life is over, but it is an incurable, contagious infection. It can be transmitted through oral sex, and can be transmitted when you have no symptoms. Condoms will help reduce this risk but may not cover all infected areas. So, when deciding to have sex, you and your partner will have to accept a certain amount of risk. It is your responsibility to inform your partner of this risk (SOGC, Viral-STIs-STDs: What are STIs-STDs).

Individuals with genital herpes are responsible for implementing certain precautions to protect their partner from potential STI transmission: they must inform their partner, use condoms, and accept that a “certain amount of risk” remains despite these precautions.

Canadians for Choice refutes the assumption that HIV is a “death sentence”. Because HIV is considered a chronic and incurable infection, a positive HIV diagnosis does require a “large lifestyle adjustment”, but with proper care and treatment, “People with HIV can still live happy and productive lives” (Canadians for Choice, Sexually Transmitted Infections: HIV). In a different article, Canadians for Choice emphasize that the “happy and productive lives” that people with HIV can lead includes a regular sex life.

For people who have a chronic STI, a big and often difficult lifestyle adjustment is often needed after the diagnosis. It is important to emphasize, however, that people living with a chronic STI, such as HIV, can and do continue to have fulfilling lives including a regular sex life (Canadians for Choice, Sexual and Reproductive Health Issues: Sexually Transmitted Infections).

Traditionally understood as a literal death sentence, the improved treatment options for HIV open up the potential for a happy, fulfilled, and sexually active life. Information about treatment is quickly followed by reassurances that one’s sex life can continue.

With the right communication, care, concern, responsibility, and an acceptance of a certain amount of risk, readers are told that their sex life just can continue following a positive STI diagnosis.

4.4 Managing Threats to Sexual Health: Low Sexual Desire

Regular sexual activity within a romantic relationship is framed as an obligation to maintain good health. Differing levels of desire in a relationship is primarily constructed as a concern for long-term monogamous couples, and as a problem that arises after the initial sexual excitement of a new relationship wears off. This discussion constructs monogamous relationships as potential sites of sexual discord or struggle between partners. However, rather than question the social primacy placed on sexual or romantic monogamy and long-term relationships, the discourse constructs lower desire as a problem that women must manage in themselves to serve their relationships. The presence of desire is considered normal and healthy, and so an absence of desire is constructed as a pathology to be overcome, either by seeking medical attention or by engaging in sex anyway for relationship health. This discourse constructs having sex even if one partner does not want to as an important part of sexual health and of the survival of “loving” relationships. The websites in my sample, most notably the SOGC and Trojan, offer advice that claims that it is normal, healthy and positive for young women to consent to sexual intercourse in the absence of subjective desire.

4.4.1 Sexual Assault as a Threat to Sexual Health

The websites in my sample identify that sexual assault and abuse have the potential to compromise the overall and the sexual health of individuals. The SOGC identifies abuse as a threat to health, and in so doing, acknowledges that the behaviour of others impacts the sexual health of young women. Being free from violence, injury, and fear are important characteristics of sexual health.

Being sexually healthy means that you are free from disease, violence, injury, fear and false beliefs. It also means that you are comfortable with your sexuality, and have the ability to control and positively experience your own sexuality and reproduction (SOGC, Sexual Health).

The SOGC offers that the ability to control and shape one's sexual health is integral. The language of control reflects the influence of feminist activism surrounding women's health. More specifically, this passage reflects a postfeminist assumption that women can and should control their sexuality in pursuit of their sexual fulfilment. Further, pleasure is discussed in relation to sexual health: freedom from violence appears alongside requirements of positive and enjoyable experiences of sexuality in order to achieve good (sexual) health.

NAHO also identifies that abuse functions as an external threat to young women's health, and places this in the context of community health. Specifically, NAHO identifies that traditional First Nations culture did not include rape and sexual aggression, but that colonization introduced these forms of violence. This passage offers a broader socio-political context for abuse, indicating that issues related to power within a relationship and the lasting effects of colonization contribute to the commonality of sexual violence against Aboriginal women.

Traditionally, rape and sexual aggression against women were not a part of native culture, even among women who were taken by enemy tribes during war (Green, 1992, p. 24- 26). Unfortunately, in today's society it has become more common. The long lasting effects of colonization have contributed to social problems including sexual abuse. [...] Violence is more common toward Aboriginal women than other women in Canada (Statistics Canada, 2001). Abuse is often about power within a relationship (NAHO, Sexual Health Toolkit Part 2).

NAHO, The SOGC, and Trojan each recognize that sexual assault can have a lasting

impact on an individual's sexual health. In this example, Trojan indicates that women may experience negative feelings about sex following an assault. They also recommend counselling for women to help them manage this issue if it is impacting their sex life.

Some people have experienced sexual abuse or assault, which quite naturally may result in negative feelings about sex. If you have been abused or assaulted and you feel that it is affecting your sex life, you might want to discuss this with a sexual health counselor or therapist (Trojan, Common Sexual Problems: Woman - Lack of desire).

Counselling and support are important recommendations following abuse or assault. Although Trojan does discuss sexual assault elsewhere on their website, the recommendation to receive counselling only appears in this article discussing the "common sexual problem" of women's lack of desire. Trojan constructs sexual assault as an issue requiring intervention only when women's sexual performance in heterosexual relationships is compromised. Through this construction, Trojan contributes to a discourse that medicalizes young women's sexuality: young women are entitled to an active and regular sex life, and are responsible for individually managing low sexual desire that results from violence.

4.4.2 Relationship Health through Sexual Activity: Missing Subjective Desire

Young women are tasked with acting in response to any experiences of low sexual desire, whether the cause is lingering effects of sexual assault or some other cause, unnamed by the websites in my sample. In addition to a healthist discourse that links sexual activity to the obligation to pursue good health, my sample also includes discourses that frame a lack of sexual desire (and thus, a lack of sexual activity) as an issue impeding the health of romantic relationships. Trojan constructs low desire as an experience faced primarily by women. In a section of their website dealing with "Common Sexual Problems", Trojan identifies that men face issues such as premature ejaculation or trouble achieving an erection. In both cases, men's excitement or anxiety about performing sexually with

their partner is identified as the cause of the issue: men's desire to engage in sexual activity is not questioned. The "Common Sexual Problems" faced by women, on the other hand, include a lack of desire. Trojan indicates that some women do not masturbate, and that there is "no set standard of how often a normal person has the desire for sex" (Trojan, Common Sexual Problems: Woman - Lack of desire). This division between common sexual problems faced by men and common sexual problems faced by women constructs a lack of desire as a specifically female issue. A lack of desire is constructed in the discourse as a true lack: it is something that is missing that must be restored in order to strive for good health. Trojan acknowledges that there may be a range of possible reasons that women may have for not wanting to have sex, and indicates that understanding those reasons will allow women to begin to resolve the issue.

Trojan understands the issue of differing levels of desire in a relationship to be a common one, as mismatched desire can occur in both casual and long-term relationships.

However, Trojan stresses the importance of communication in dealing with issues of desire with a partner:

Whether you are in a casual or on-going relationship, it's important to recognize that the level of sexual desire that each partner feels will not always match up exactly with the level of desire felt by the other partner. Sometimes feelings get hurt because of this. That's a reality that we all have to deal with so it's important to communicate with your partner to make sure you know how each other feels (Trojan, Having Sex: Desire).

The commonality of mismatched desire is further stressed when Trojan states in this example that it is a "reality that we all have to deal with". Trojan identifies the commonality of mismatched desire, but also stresses the importance of action. The reader is encouraged to "deal with" the issue through open communication to avoid hurting her partner's feelings. Differing levels of desire in a relationship are understood to be a common but manageable problem, and young women are encouraged to seek solutions to this problem to support the health of her relationship.

The SOGC also offers advice to couples in a sexual relationship characterized by mismatched levels of desire. Some of the advice does address both partners, including the one with the higher level of desire: in the following example, this partner is told to cut back on activities that increase desire. The partner with the lower level of desire is advised to prepare mentally and physically in advance for sexual activity.

Adjust your level of mental desire. If you have a higher libido than your partner does, cut back on activities such as fantasizing or reading/viewing erotic material that stoke your desire. If you have the lower libido, try fantasizing or touching yourself before getting into bed with your partner (SOGC, When one wants sex more than the other: Understanding sexuality).

The SOGC's advice appears gender-neutral, in contrast to the construction by Trojan of lower desire as a woman's problem. Cultural tropes regarding sexuality suggest that men are consistently ready for sex, while women experience (and are expected to express) lower levels of sexual desire. It is perhaps significant that the SOGC is opening up a space where this construction is resisted. However, later in that same article, the advice from the SOGC reflects a rape culture that promotes an entitlement to sex without genuine consent that is often gendered. Readers with lower levels of desire are encouraged to consider having sex with their partner even if they are not feeling sexual desire.

Be willing to start lovemaking from a sexually neutral state. Cultivate a willingness to occasionally say yes to sex for reasons other than a strong physical need. In a healthy relationship, occasionally having sex simply to pleasure a partner can be an act of love (SOGC, When one wants sex more than the other, Understanding sexuality).

The SOGC supports a relational view of sexual health that extends beyond the physical. For example, the emphasis on “love” in this passage requires attention. Rather than merely engaging in sexual activity, readers are encouraged to engage in “lovemaking” as an “act of love” to please their partner. Referring to sex as “lovemaking” in this context calls back to recent historical time periods in Canada where sex was considered a marital obligation women had to their husbands.⁷ Presenting this advice in gender-neutral terms and without historical context absolves the SOGC of the responsibility of addressing the gendered dynamics that operate through this kind of advice.

Sexual pleasure and sexual activity are constructed as important aspects of sexual health. However, sexual pleasure and activity are also framed as an obligation, and as something that young women must work on, particularly within established relationships. Advice to have sex as an act of love for an established partner functions to maintain the “marriage” of love and sex. By positioning decreasing or differing levels of desire as problems to overcome, the websites in my sample are establishing as a norm a conception of sexual health that is characterized by regular or routine sexual activity. In the absence of subjective desire, young women are encouraged to have sex that they do not want to have with their partners in order to achieve and maintain a “healthy” relationship. The discourse on the medicalization of sexuality, through the unqualified link between sexual activity and good health in the particular context of romantic relationships, both reflects and reinforces rape culture.

4.5 Conclusion

In this chapter, I discussed how the websites in my sample construct sexual health in ways that extend beyond the biological and the physical to include social and emotional well-being. NAHO contributes a consideration of power and colonization to this discussion, and points to larger social phenomena that make certain populations more at risk for ill health. Likewise, the discourse identified that there are several threats to health that must be managed, including the physical consequences of STIs and the

⁷ See Randall (2011) for a discussion of the 1983 introduction of Bill C-127, which repealed the legal immunity for spouses who commit sexual assault (14).

emotional health of relationships stemming from differing levels of desire or experiences of sexual assault. Young women are mobilized to respond to these threats through a framing of sexual health as relational. She is identified as a future mother and a caring partner who must work to support the health of herself and of those close to her. More significantly, sexual health is discursively constructed as an aspect of health that is enhanced or hindered by the choices and actions made by individuals, including the decisions to receive medical treatment or to engage in open communication. Young women are called to action and invited to construct themselves as a moral agent by pursuing good health in general, and by pursuing good sexual health in particular. In the next chapter, I explore in more depth how the discourse works to present risks to health as manageable, if individuals choose to become properly informed and engage in the right actions.

Chapter 5

5 The Discursive Construction of a Choice-Making Subject

In this chapter, I outline the ways in which the websites in my sample establish accessing information and knowledge about one's own sexual health as a good and moral pursuit for young women. In particular, Canadians for Choice identifies that readers are indebted to feminists of the past who have agitated for increased access to sexual and reproductive rights. The websites in my sample offer health information to help young adults make the best choices for their sexual health and to grow as "sexual beings". In order to achieve authority on the topic of sexual health, these websites offer critiques of other sources of information – including popular media, friends, educational institutions, family, and doctors – and position young women as responsible for assessing misinformation and capable of pursuing more reliable information. Doctors are discussed in ways that indicate they are potential partners in women's care, but only if women do the work necessary to select the right doctor for her own care. In addition, I examine how young women are responsabilized following their sexual education; through advice about the decision to come out for queer youth or safety tips for sexual assault prevention, the discourse constructs young women as capable of making the right choices for themselves and their health if only they have access to the right kind of information.

5.1 Feminism, Knowledge, and the Postfeminist Subject

Although the websites acknowledge that women's production of knowledge about their own bodies was an important goal for activists in the women's health movement, "feminism" is only explicitly named and discussed by one website. Canadians for Choice cites the fight to legalize abortion as a significant success in the history of the women's health movement in Canada, won through collective demonstrations on Parliament Hill by a group of "independent feminists".

In 1970, a group of independent feminists organized a caravan that traveled across Canada to demand the legalization of abortion and to

oppose the restrictions imposed by Section 251 of the Criminal Code. When the group reached Ottawa for a two-day demonstration, the Abortion Caravan was made up of more than 500 women. Thirty-five women chained themselves to the parliamentary gallery in the House of Commons, closing parliament for the first time in Canadian history (Canadians for Choice, Sexual and Reproductive Health Issues: Abortion - Historical Background).

The article on the historical background of abortion access is accompanied by the following image, featuring the slogan “women unite”. A protest scene is illustrated, with one woman surrounded by (blank) posters and banners, and by a flag with the symbol for woman on it. On the bottom of the illustration, one woman reads from a book to a group of three other women, perhaps working to educate them on the historical struggles that are illustrated on the top half of the image.



Figure 6: Canadians for Choice, Sexual and Reproductive Health Issues: Abortion - Historical Background

It is discursively significant that feminism is only named in the context of an “historical background”. In keeping with a postfeminist understanding, feminism is constructed by Canadians for Choice as a thing of the past: it has an important legacy, the work that feminists did was important, and women of today should truly be grateful. Indeed, the information provided in this historical context is impressive, and demonstrates the political and legal pressure that women – explicitly named as feminists – were able to exert through collective effort in Canada. Postfeminism does not take the form of an anti-feminist backlash in this website; rather, feminist success is used to establish the importance of women learning about matters related to their sexual health.

In an article about issues affecting abortion access, Canadians for Choice emphasizes that young people today do not have enough knowledge of the events surrounding the fight to legalize abortion. Canadians for Choice does indicate that there are contemporary issues surrounding abortion access; in a map of Canada, Canadians for Choice tracks the percentages of hospitals that have accessible abortion services. By providing this information, Canadians for Choice illustrates that difficulties in access continues for many Canadian women, and constructs the young women reading their website as in need of this information.

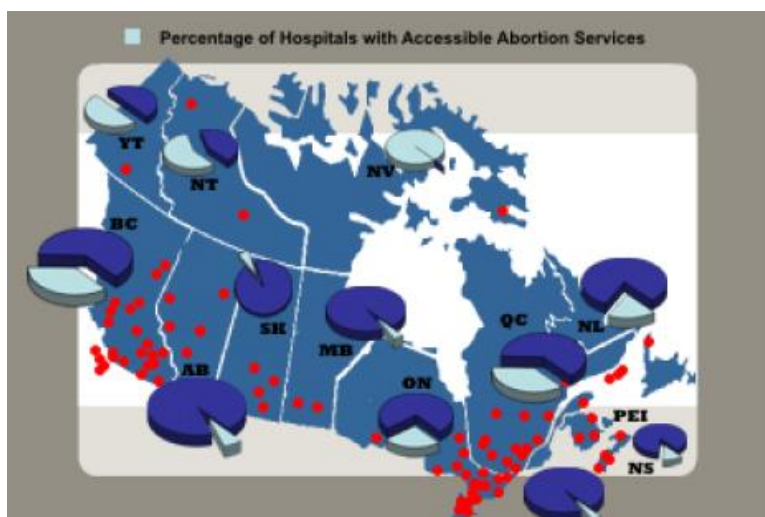


Figure 7: Canadians for Choice, *Sexual and Reproductive Health Issues: Abortion - Problems in Access*

This postfeminist subject is contrasted with feminists of the past: because she did not witness the struggle to decriminalize abortion, she is not aware of the current struggles faced by women in Canada. She is also contrasted with women who experience difficulties accessing services in the present, because they live in rural areas or are impacted negatively by social determinants of health.

Many young people take abortion for granted. They have not witnessed the struggle that took place to decriminalize this critical medical procedure and are often not aware of the horrific occurrences that took place before abortion was legal. Many are also not aware of the problems in access that Canadian women, especially in rural areas, continue to have. This can explain why many people don't feel the need to work on improving access and to continue the struggle to maintain abortion rights so that all Canadian women can exercise their reproductive choices (Canadians for Choice, Sexual and Reproductive Health Issues: Abortion - Problems in Access).

Young women are depicted as ungrateful because they are not knowledgeable: they have not witnessed and have not experienced a lack of access to health care services. The discourse assumes that if young women were aware of the history of abortion, they would continue the necessary work of feminism to expand women's access to sexual and reproductive health care services. The lack of knowledge is a problem shared by youth: young women in particular are depicted as in need of an education, while current activist efforts by youth surrounding health and health care issues in Canada are not discussed.⁸ This omission constructs feminist activism as an event of the past, even as Canadians for Choice calls for its resurgence. The collective politics of the feminists mentioned in the historical context are replaced with a contemporary focus on an individual's level of awareness and knowledge.

⁸ For an example of this type of youth-initiated work from my sample, NAHO partnered with the Native Youth Sexual Health Network, a "North-America wide organization working on issues of healthy sexuality, cultural competency, youth empowerment, reproductive justice, and sex positivity by and for Native youth" to produce the sexual health toolkits I examine in this dissertation.

5.1.1 The Individual Pursuit of Knowledge as the Key to Good Health

Messages offered by the websites in my sample about the importance of knowledge are often directed explicitly toward women. Although feminism is not again named, feminist principles appear to underscore the importance of this knowledge for young women. In this passage on menstruation, the SOGC asserts that knowledge about one's own body can lead to freedom and control: "Knowing about what is happening to your body and understanding the options available for managing your period give you some freedom and control" (SOGC, Sexual Health: Your menstruation-period). Knowledge is also linked to women's power in certain contexts. NAHO points to a historical connection between knowledge, strength, and power for Aboriginal women and their reproductive roles:

Before colonization, women were recognized as having a great power because of their ability to have children. Men and children had knowledge about women's reproductive roles (C. Reading, CPHA conference, 2010). The ability to have and raise children was honoured within the communities (NAHO, Sexual Health Toolkit Part 2).

In this passage, NAHO indicates that the responsibility to have knowledge about women's bodies was shared among men, women, and children prior to colonization. However, women are positioned as a significant beneficiary of this knowledge, as they receive honour for their reproductive roles. This honour has been lost through colonization, and this passage functions to establish the importance of knowledge through a mourning of that loss. Young Aboriginal women in contemporary Canadian society are responsabilized to work to acquire the knowledge they might have had prior to colonization.

The emphasis on broader contexts like feminism and colonization gives a distinct shape to the call to action I outlined in Chapter 4. Becoming informed – and using that

information to make the right choices to protect your health – is framed as a distinctly political act by NAHO and Canadians for Choice. Young women have a duty to not only make the right choices, but to make the right choices for the right reasons. Postfeminism allows for the emergence of the informed, empowered, agentic subject: she is no dupe submitting unquestioningly to medical authority. Rather, she is seeking out her own information, and making her own choices, even (and especially) if those choices align with neoliberal and healthist expectations. In Chapter 4, I discussed the actions young women were expected to take to maintain good sexual health, including working to prevent STI transmission and pregnancy, and to address the negative impact sexual assault can have on their sexual desire. In this chapter, I discuss how the discourse incites young women to demonstrate that they are informed, knowledgeable, and smart through the choices they make to preserve and pursue sexual health.

The importance of an individual's commitment to her own health because of her commitment to the pursuit of knowledge is reinforced across the websites in this discourse analysis. NAHO clearly states the positive relationship between sexual health information and the ability to make “healthy” choices: “Information about sex and your body will help you make more healthy decisions” (NAHO, Sexual Health Toolkit Part 1). Healthy Canadians also draws a direct link between sexual health knowledge and its positive impact on the transmission of STIs, stating that “Sexual health awareness and education are crucial to helping fight the spread of sexually transmitted infections (STIs). STIs continue to be a significant and growing public health concern” (Healthy Canadians, Sexual health). This link assumes that particular actions (should) follow the right kind of information: what is left unsaid in this passage (but stated repeatedly across the websites in my sample, such as in those passages discussed in Chapter 4) is that condom use, STI testing and treatment, and monogamy are the best ways to prevent STI transmission. In other words, knowledge alone does not interfere with STI transmission. Similar to the passage from Canadians for Choice, above, a lower level of knowledge or awareness is constructed as the only thing standing in the way of young women engaging in the “right” sexual health practices.

Knowledge is discursively established as the key to good health and to a position of strength for women. Youth are discursively established as lacking this knowledge. As a result, the discourse functions to responsabilize young women to become more knowledgeable about their health. The SOGC addresses its audience by telling them to do what they need to do in order to learn more about their health. There are a range of sources of information available to young women (including their own inner minds, as evidenced by the advice to fantasize). It is up to each reader to prioritize the source that is best for her, as she is told to consider issues related to trust and comfort when seeking information.

Do what you need to do to answer your questions. Read books, fantasize, and ask a trusted friend lots of questions. Or if you're comfortable, you can talk to your doctor, a school nurse, or a pharmacists [sic]...Just remember that getting answers to your questions will help you grow as a healthy, mature sexual being (SOGC, *Sexual Health: Understanding Sexuality*).

This passage is offering aspirational sexual health and a sexual future to young women. It is assumed that the young woman reading this information is not yet a fully grown “healthy, mature sexual being”, but that the pursuit of this identity is worthwhile and important. Becoming a “sexual being” requires work, and the key to achieving this sexual future is the right kind of knowledge from the right kind of sources. Sexual health is a project and a process, where the effort invested is constructed as beneficial.

5.2 Mobilizing Choice-Making Potential: Evaluating Sources of (Mis)Information

The websites in my sample stress that it is important for young women to gain sexual health knowledge, and they are faced with a wide variety of sources of information. Friends, parents, Aboriginal elders, teachers, doctors, pharmacists, counsellors, websites, popular media, and others are all identified as potential resources for young women to

turn to in their pursuit of sexual health knowledge. However, young women are reminded that they must evaluate each source for herself, as not all sources of sexual health information are equally reliable; in the pursuit of sexual health knowledge, young women must also avoid misinformation. The SOGC emphasizes that sexual health is jeopardized by misinformation as evidenced by the statement: “Being sexually healthy means that you are free from disease, violence, injury, fear and false beliefs” (SOGC, Sexual Health). Young women are required to identify and correct their “false beliefs” if they wish to be sexually healthy.

5.2.1 Challenging Messages about Sex in Popular Media

The websites in my sample work to undermine the influence that popular media has over young women’s understanding of their sexuality. I use “popular media” as shorthand to include a range of media sources, including pornography, television programming, advertising, radio, and newspapers. While Trojan offers a critique of the influence of pornography on assumptions young men may have about their sexual performance and stamina, the SOGC points to the hypersexualization of more mainstream culture to argue that media can create confusion through mixed messages among its young viewers. In the following passage, conservative norms about sex as a “sacred” act of love that readers “may have been told” about (perhaps by parents or schools) are contrasted with the “casual or meaningless” sex depicted on TV and in advertising:

Sex can be pretty confusing. You may have been told that sex is a sacred act between two married people who love each other very much. But then you turn on your TV and you see quite a different story - people having casual or meaningless sex, using it to get revenge or to control people, or using it to advertise everything from soft drinks to vacuum cleaners (SOGC, Sexual Health: Understanding Sexuality).

The SOGC critiques the negative or one-dimensional representations of sexuality available through mainstream media: casual sex is qualified as “meaningless”, and sex is

constructed as a weapon of revenge and control. The critique of the use of sex in advertising campaigns echoes a long history of critique by feminist activists.⁹ In effect, the SOGC appropriates this long-standing feminist critique over the objectification of women's bodies (for they are surely almost always the bodies of women) to provide a contrast with the conservative norm that sex within marriage is the more preferable sexual behaviour. Through this contrast, the SOGC identifies to its reader that she is in a position where she must assess conflicting representations of sex.

NAHO, The SOGC, and Trojan each also describe distorted messaging in the media and the impact these representations may have on the body image of their readers. Readers are reassured that beauty standards represented in popular media are unrealistic, and that all people – not just models – are entitled to an active and enjoyable sex life. These websites offer an intervention into the reader's self-confidence: readers are told that feeling self-conscious about their body because of these unrealistic media images serves to interfere with their sex life. NAHO offers a more thorough discussion of racial stereotypes in Canadian culture and popular media,¹⁰ and argues that these representations have real effects on the body image of Aboriginal youth:

A person with a negative body image may not be happy with the way they look... These feelings happen often in a world where stereotypes describe First Nations people as “easy”, Native women as looking like Pocahontas, and “stoic” Native warrior men who can't express emotions. These stereotypes have real effects on the way we feel comfortable or not in our own skin and bodies. We can work towards challenging these stereotypes through discussions with each other and reclaiming culture. [...] For First Nations people, we are rarely shown in the media in a positive way. Take some time with your friends or classmates to look at the ways we are shown in the media. Ask yourselves, what is missing? Are these

⁹ Kilbourne's (2010) work on this topic through her video series, *Killing US Softly*, is perhaps the best example of this critique of the sexualisation and objectification of women in advertising.

¹⁰ Although some of the other websites, including Canadians for Choice, identify that racial or ethnic identity is a factor that impacts (or is made to impact) an individual's experience of health, the focus on media representation of racialized bodies is not a topic that appears elsewhere in my sample.

depictions accurate? Who is writing this? There are also many examples of good role models. These are First Nations people who are working for their communities. For example, see the NAHO National Aboriginal Role Model program in our resources section. There is also media that is made for us, by us. You can consider contributing to your community's radio station, newspaper or other media (NAHO, Sexual Health Toolkit Part 2).

In this example, hypersexualized and/or racist media representations are identified as having a negative influence on Aboriginal viewers, and it is noted that the media presents inaccurate and dangerous information about Aboriginal people, which has real effects on a viewer's sense of self. However, NAHO also acknowledges that media is not a monolith; they cite an Aboriginal Role Model program and others in First Nations communities who are creating and contributing their own media. Additionally, NAHO argues that viewers of this kind of media are capable of being critical media consumers. They specifically call on Aboriginal youth to evaluate and speak back to these messages by questioning which representations are present and which are missing. School-aged youth are given this kind of guidance by the discourse, although youth are not typically given credit for possessing "a critical faculty to read the image or evaluate its meaning" (Burke 2006, 322). In opposition to flawed and racist media representations, NAHO encourages discussion with friends and classmates as a source of critique and knowledge formation.

5.2.2 Undermining the Knowledge of Friends and Peers

Young women are invited to consider the role that friends may play in influencing the decisions they make for their sexual health. The websites in my sample acknowledge that for many young women, friends serve as an important source of sexual health information. NAHO identifies that friends may serve as a source of support following a sexual assault: "If you have been the victim of sexual abuse or assault, talk to someone you trust. This could be a health-care provider, an elder, a counsellor, or a friend" (NAHO, 10 Things to Know About Sexual Assault). In this example, friends are listed

alongside health care providers and elders, indicating that friends may be able to offer the same level of trust and safety as more professional or experienced sources. This recognizes that for many young women, the relationships they share with friends and peers are an important part of the development of their sexual health.

In contrast to NAHO's recognition that friends can serve as a positive source of support for young women, the SOGC questions the reliability of friends as sources of information. In this passage, the SOGC contrasts the potential reliability of friends as a source of sexual health information against doctors. Doctors are presented as the unquestioned authority; while friends are described as being the source of both good and bad information, doctors are rhetorically presented as the standard and preferable first source for information about pregnancy and birth control.

If you're like most people, you got your first bits of information about pregnancy and birth control not from doctors, but from your friends or other people your own age. You probably picked up some useful information in this way - but there's a lot of bad information floating around out there too. And these rumours don't die easily - some of them have been around for generations! So here's the real deal on some of the most common rumours, exaggerations and full-blown lies when it comes to contraception (SOGC, Birth Control: Birth Control Myths).

The assumption that doctors should be the first source for concerns related to pregnancy and birth control indicates a focus on the physical aspects of sexual health, to the exclusion of interpersonal relationships (i.e. those among friends) as an important aspect of sexual health development. Friends are described as the source of "rumours, exaggerations and full-blown lies" about birth control, indicating that friends not only unknowingly pass on misinformation, but that they also intentionally lie and mislead. Friends – and young people more generally – are in need of more reliable information about their sexual health than they can provide for each other. This reflects the focus of the SOGC website, as it was created by an association of medical professionals in

Canada. I explore the construction of doctors and health care providers across the discourse in more depth in a section below.

5.2.3 Framing Sexual Health Education as Inadequate

Sexual health education is additionally cited as a potential source of information for young women. Its role in offering information to students about STI transmission and safer sex is seemingly accepted by Healthy Canadians without comment, an acceptance that aligns with the government's role in providing sexual education curricula to schools in Canada. Healthy Canadians constructs a link between the efficacy of sex education and the prevention of STI transmission, as this website illustrates an article about chlamydia with an image of "sex education" written on a chalk board, along with a condom.



Figure 8: Healthy Canadians, Chlamydia

In contrast to Healthy Canadians, Canadians for Choice indicates that the formal sexuality education curriculum is inadequate for many Canadians, including that it may offer a limited understanding of sexual health based in abstinence-only education. By offering this critique, Canadians for Choice mobilizes young women to evaluate the information they receive from their schools, and to pursue additional information if they do not have access to this education.

Many Canadians do not receive adequate sexuality education. While sexuality education is present in some form in most school curricula, it is

often taught by teachers who are uncomfortable with the subject matter, who are not trained on the topic, or who provide biased or inaccurate facts such as abstinence-only education. In some schools, sexuality education is no longer taught in a specific class. All teachers share the responsibility of addressing it in one way or another during the school year. This often results in students receiving no sexuality education at all (Canadians for Choice, Sexual and Reproductive Rights).

In this explanation, Canadians for Choice identifies an institutional barrier to young women's sexual health. Formal education offered through school curriculum is present, but is not standard, and is subject to the interpretation of individual teachers who may lack the support or conviction required to adequately teach this material. Presented in this way, Canadians for Choice informs young women that they are not able to rely on formal education for sexual health knowledge.

5.2.4 Skilled and Supportive: Parents as a Resource for Good Health

Sexual education curriculum in schools is also challenged by the argument from some members of the Canadian public that parents should be exclusively responsible for giving their children the information they need regarding their sexual health and development, an argument that I outlined in my introduction. Although this argument does not explicitly appear in the websites in my sample, families generally and parents specifically are discussed as potential sources of sexual health information for young women. NAHO identifies the family as an important source of support and celebration for children transitioning to adulthood:

To recognize the transition from childhood to adulthood, most cultures have coming-of-age ceremonies or naming ceremonies. The traditions and protocol at these ceremonies are different for each Nation and some families may have their own traditions as well. To learn more about your

Nation's ceremonies, speak to your Elders and your family (NAHO, Sexual Health Toolkit Part 2).

In this example, the uniqueness of each Nation's traditions surrounding the transition from childhood to adulthood means that families are best suited to provide this guidance to Aboriginal youth. Families play an important role in imparting cultural traditions.

Young women are constructed by the websites in my sample as interested in learning about sex and sexuality. The problem described by these websites is that young women have questions and are curious about sex, and that they must work to find the right source of information to answer these questions. In the following passage from the SOGC, readers are told that they should think about asking their parents about sex. Parents may not be a definitive source, but they have the skills and experience to seek out the answers that young women may not already have.

Ever think about talking to your parents about sex? They may not have all the answers, but they're great resources on sex because they have definitely been there - you're living proof of that. And in the rare case that they don't have the answer to your question, there's a good chance they'll know where to find it (SOGC, Talking to parents about sex: All about puberty).

This example works to privilege a limited view of sex and sexuality: namely, through the "proof" that the reader's existence provides, that sex and procreation are tightly connected. Sexual knowledge is understood to come from procreative, heterosexual sexual experience, which parents "definitely" have. Experiential knowledge is constructed as important and informative, but is not yet (and should not yet) be accessible to young women. As young women prepare for their proper sexual development, parents are understood to be an open source of information, willing to share their experience and offer support to their daughters.

5.2.5 Entitled to Care: Responsibilizing Women in the Doctor-Patient Relationship

Young women are mobilized to access and evaluate sexual health information so that they can be best informed about the choices they make for their health. In addition, young women are mobilized to access and evaluate medical care from doctors and other health professionals. The relationship young women are constructed to have with their doctors occurs in a postfeminist context where she is entitled to the best care to support her health needs. Feminists in the women's health movement, historically and contemporarily, have articulated criticisms against the amount of control doctors and the medical profession have exerted over the lives of women (a point I return to in my discussion). These critics argue that this control has been to the detriment of acknowledging and valuing a woman's own embodied experiences of her health and needs. Canadians for Choice incorporates this critique in their discussion of abortion access, arguing that:

When a woman chooses to have an abortion, she may face severe obstacles in exercising her choice. [...] In many cases, physicians and hospital employees deny women access by refusing information and referrals, or by referring women to anti-choice agencies (Canadians for Choice, Sexual and Reproductive Rights).

Doctors are positioned in this example as an active source of misinformation, and this is understood to impose constraints on a woman's ability to exercise her reproductive rights; specifically, anti-choice physicians may limit or interfere with a woman's access to abortion services. The critique presented in this passage is a systemic one, where the authority and knowledge held by doctors and medical institutions are explicitly brought into question.

NAHO references the possibility that doctors may offer misinformation or interfere with women's access to reproductive and sexual health services by emphasizing the positive rights that young women hold when facing an unintended pregnancy. In this passage,

young women are told that they have a right to access not only information, but also non-judgemental support from their health care provider.

If you are pregnant or think you might be, you have options. Making a decision about your pregnancy can be difficult. Talk to your healthcare provider. They are responsible for giving you information about your options—such as continuing with the pregnancy, adoption, and abortion—without judging you. They are also responsible for supporting the decision you make (NAHO, 10 Things to Know About Sexual Health).

This passage asserts that doctors have a responsibility to their patients, and this responsibility extends beyond physical care to include emotional support for decisions that may not align with the doctor's own values. The discussion on access to abortion reflects a long history of inadequate attention paid to women's reproductive health. However, some of the websites in my sample work to place this inadequate attention in the past. The SOGC points to "centuries"-long neglect of women's health, specifically as it concerns vulvodynia (vulvar pain), a chronic ailment affecting sexual health with no clear cause. Women experiencing this pain still struggle to find a doctor who is able to make a proper diagnosis. However, modern research has established that vulvar pain is real, and women are encouraged to continue seeking medical care until they find a doctor who is able to provide treatment.

There are few symptoms to be seen during a physical examination, sometimes none. After seeing many different doctors in a desperate attempt to find out what is wrong, some women may be left thinking it is all in their heads? "this [sic] is not so. For centuries, undiagnosed pain in the vulva area was regarded by doctors as a psycho-sexual issue, and women were often sent to sexual therapists. Modern research tells us the pain is real. It is important to find an understanding doctor who is aware of vulva conditions (SOGC, What are vulvar diseases: Physical problems).

The above passage from the SOGC validates women's pain when faced with vulvodynia, and emphasizes the importance of finding a doctor who is both knowledgeable and understanding of the condition. Advice across the websites in my sample encourages women to exercise their postfeminist right (and responsibility) to seek out a health care provider who will ensure that they receive sufficiently modern medical care: namely, medical care that puts their experiences and comfort first.

Canadians for Choice similarly advises women to consider a range of factors when choosing a health care provider that is able to meet their needs. In this passage offering women advice on how to navigate the search for a fertility clinic, readers are informed that factors such as success rates, health insurance coverage, cost, and comfort are all important considerations.

It is important to shop around for a fertility clinic. There are no absolute success rates, therefore do not select a fertility clinic on success rates alone! [...] Also, in order to feel more at ease throughout the process, make sure you and your partner feel comfortable with the staff and the clinic (Canadians for Choice, Sexual and Reproductive Health Issues: Infertility).

This passage uses the language of "shopping" to frame the efforts women should make when considering their medical care and possible alternatives. The language of shopping calls on a consumer model of medical care, and assumes that women enjoy a plethora of options. It obscures larger barriers beyond a woman's individual choice, such as the number of fertility clinics in her area, whether or not she requires (or even has) insurance, and whether her insurance provider limits her selection or treatment options. The advice in this passage rests on a neoliberal assumption that medical care is offered through the market, where young women need only to step up and request (or purchase) exactly what she needs regardless of class or social location.

Trojan also emphasizes the importance of women's comfort with their medical care provider. Once women find the right doctor for them, whether through "shopping around" or through a referral, doctors are constructed as someone working alongside women to serve their health care needs. Gynecologists in particular are constructed as a specialist that women can turn to when they find they are having difficulty having an orgasm. Trojan reassures readers that seeking medical attention and disclosing sexual health problems to an experienced gynecologist is a normal thing to do, and that this disclosure allows doctors to help women.

If you find that nothing works and that having an orgasm is very difficult, talk with your doctor or gynecologist. Gynecologists specialize in women's reproductive system and are experienced in talking about sexuality and sexual response issues with their patients. Asking questions about sexual response problems is a normal thing to do and there is a good chance they will be able to help. If you don't have a gynecologist you see regularly, ask your doctor for a referral (Trojan, Common Sexual Problems: Woman - Trouble having an orgasm).

In this passage, the experience and specialization of gynecologists is called on to ease the difficulties some young women may have with talking about sexual health matters. However, this experience is framed as giving doctors knowledge, not authority: young women are encouraged to ask questions about their sexual response problems so that their gynaecologist has a "good chance" of providing "help". In the next example, the SOGC also outlines ways that young women can engage in a more conversational, less authoritative relationship with their doctors.

If you think you have PMS you should keep a log of your symptoms, their severity and their pattern of occurrence. Make an appointment with your doctor or health-care professional and you can work together to rule out any possible underlying condition (other than PMS) and manage your

symptoms in order find some relief (SOGC, Cramps pimples and PMS: All about menstruation-period).

Young women are advised to keep a record of their (possible) PMS symptoms to bring to their doctors. This log encourages women to engage in a practice of creating self-knowledge, advice that also came out of the women's health movement. This knowledge is also used to facilitate medical treatment, reinforcing that doctors are the experts who women must turn to for answers when experiencing ill health. However, young women are not being asked to merely submit to medical authority: as it appears in the websites in my sample, a patient and her doctor "work together" to address PMS symptoms.

Young women are consistently advised that doctors are there to help them meet their sexual health needs. Canadians for Choice identifies doctors as individuals who will help you find the birth control pill that is "right for you": "In Canada, The Pill is a drug that must be prescribed to you by a doctor. This is because there are many different types of pills and your doctor will help find one that is right for you" (Canadians for Choice, Sexual and Reproductive Health Issues: Contraception). Doctors are discursively constructed in the websites in my sample as having the authority and the knowledge to navigate each individual woman's unique medical needs and medical risks. The fact that birth control must be prescribed to women by doctors is reframed as an opportunity for young women to consult with a doctor for "help" selecting the right kind of birth control. In this example, doctors are not only identified as medical gatekeepers; doctors are additionally positioned as helpers and teammates, supporting women's otherwise independent postfeminist choices and rights.

5.3 Constructing Equality and Health Care Access

In a section on sexual and reproductive rights, Canadians for Choice outlines the identities, social locations, and risk factors that create different levels of access to sexual health information and care for Canadians. In particular, Canadians for Choice identifies

a number of groups marginalized by mainstream society as “more vulnerable” when it comes to accessing sexual and reproductive healthcare.

Different groups are also more vulnerable when it comes to exercising their sexual and reproductive health and rights in Canada. To name a few: youth, people living in rural areas, people living with disabilities, people living in poverty, LGBTQ people, people living in the street, aboriginal people, and new immigrants are among the most disadvantaged people in respect to obtaining proper sexual and reproductive healthcare. For example, the 1993 version of the Canadian Youth, Sexual Health and HIV/AIDS Study found that STI infection risk increases significantly with vulnerability. Street youth are 4 times more likely to be infected with a STI than other youth registered in a university or college (Canadians for Choice, Sexual and Reproductive Rights).

Identifying that different groups are “more vulnerable” leaves open the question of who they are more vulnerable than. In this example, a Canadian Youth, Sexual Health and HIV/AIDS Study is cited to describe these groups as more vulnerable than youth who are registered in post-secondary educational institutions. By using this example, Canadians for Choice contributes to a construction that that norm or standard of sexual health belongs to youth attending college or university, indicating that age and social class are both important factors affecting health. Canadians for Choice is pointing to systemic differences in access to health care services for particular groups made at risk through disenfranchisement, identity, or social class. However, this website also constructs difficulties accessing health services as anomalies to a system that is otherwise meant to operate in support of women’s needs. Indeed, there are legal protections in place to ensure that all Canadians are treated the same. Canadians for Choice identifies that some women may have trouble accessing emergency contraception (ECP) because an anti-choice pharmacist may refuse to dispense it. If a young woman encounters this issue, she has other options available to her to ensure her access, such as going to a different pharmacy: it is her responsibility to “shop around” to other pharmacies.

Since there is no law requiring that all pharmacies offer emergency contraception, be aware that some pharmacists who are anti-choice may refuse to provide you with it...However, according to the code of ethics to which Canadian pharmacists are bound, your pharmacist should provide you with a referral to another pharmacist that can dispense ECP to you. If they refuse to refer you, you can find other pharmacies in your area using a phone directory or online listing...You can also report a pharmacist for refusing to refer you by contacting the College of Pharmacists in your province (Canadians for Choice, Sexual and Reproductive Health Issues: Emergency Contraception).

It is up to young women to discipline unethical pharmacists: Canadians for Choice describes the “code of ethics” to which Canadian pharmacists are bound, and indicates that young women can report pharmacists who violate this code to the provincial regulatory body governing pharmacists. In addition to the code of ethics, the SOGC points to the role of the federal government in ensuring reasonable access to health care services for all Canadians through the Canada Health Act. The UN Convention on the Rights of the Child is additionally cited as an international standard influencing Canada’s commitment to providing access to health care services for young people in particular.

In Canada, the federal government has defined basic principles of universal health care in the Canada Health Act. The Act states that all Canadians must have reasonable access to insured, medically necessary health care services. Health care is a provincial responsibility, but each province must follow the principles of the Canada Health Act. Both the Canada Health Act and the UN Convention on the Rights of the Child underline the rights of young people to adequate health information and services so that they can lead safe and healthy lives (SOGC, Sexual Health: Sex and the law).

Readers are reassured that at a legislative and policy level, Canada is working as a nation to create a level playing field for all of its citizens as it concerns their sexual and reproductive health, even as the universality of health care is compromised by issues of access. Images on the Trojan website work to illustrate this tension between health risk and an entitlement to protection for all. In an article about STIs titled “more common than you think”, they provide a picture of a group of young adults of various races and ethnicities. The multi-cultural tapestry functions to construct all global citizens as equally at-risk for the health effects of STI transmission, something I discussed in the context of monogamy in Chapter 4. However, the photo subjects are also all smiling with their arms around each other, posing that invites a post-racial reading. The photo represents a level of inclusivity, and an indication that because of a shared risk, we can and should look out for each other.



Figure 9: Trojan, Intro to STIs: More common than you think

In this section, I have been outlining the way that the websites in my sample operate to assume that if women have access to the right kind of information, they will be able to make the right choices for themselves to ensure their good health. Some of these websites identify that some individuals and groups do not have access to the right kind of knowledge, support, or care, and are therefore understood to be more vulnerable than the norm of the young adult, enrolled in college or university. Some individuals and groups are made more at risk when it comes to sexual health, due to their age, race, sexual identity, dis/ability, socio-economic status, global location, or due to the lasting effects of

colonization. However, Canada is described as an inclusive society with legislation and policies in place to protect the health rights of its citizens, contributing to a discourse that frames systemic discrimination as the result of individual anomalies, or, as barriers to good health that individuals must overcome on their own, a focus I explore in more depth below.

5.4 Responsibilizing Queer Youth in Canada

The assumption of postfeminist discourse that equality exists between the sexes is extended in my sample to LGBTQ persons, insofar as readers are informed that there is growing acceptance of a range of sexual identities in Canada. However, assumptions or claims of equality and acceptance are then contrasted with the “realities” of difference, including the risks associated with violence and discrimination experienced by queer youth. In the following discussion, I examine the ways that the choices available to queer youth are described as circumscribed by societal and familial responses to their identity. I conclude by discussing how the discourse aims to responsabilize queer youth to protect themselves by providing information on the coming out process (and the benefits of choosing to wait to come out to family) and by encouraging queer youth to form safe space communities for themselves.

5.4.1 Assuming Acceptance of Queer Identities

Readers are informed by several of the websites in my sample about how accepting and tolerant Canadian society is to sexual and racial diversity. In this example, The SOGC points to the increasing visibility of difference on the basis of sexuality, race, ethnicity, and religion.

In the past, sexual diversity within the Canadian population was less apparent and visible than it is today. Over time, Canadian society has become much more tolerant and accepting of the differences between Canadians along lines of religion, ethnicity, race, and sexuality. This includes a recognition that we are a diverse community with respect to

sexual orientation, gender identity, transgenderism, transsexualism, and intersexuality (SOGC, *Sexual Diversity: Sexual Identity and Orientation*).

This example is interesting because it indicates that both the visibility and acceptance of diversity have increased over time. The SOGC identifies the passage of time as an active agent of change, working to create a tolerant and accepting Canadian society, contributing to a narrative of progressive acceptance in Canada where the homophobic or racist views held by certain people can be solved by waiting it out. Time – not community-based activism constituting decades of work by diverse communities – is positioned as the key to change and growing acceptance. The use of “we” is discursively significant: the SOGC identifies that “we are a diverse community”, and by doing so, assumes a commonality of difference and a level of acceptance in the reader.

NAHO points to the visibility and diversity of Canadian society in a “sexual spectrum” wheel, illustrating with rainbow colours several identities and orientations, including asexuality, intersexuality, and bisexuality.

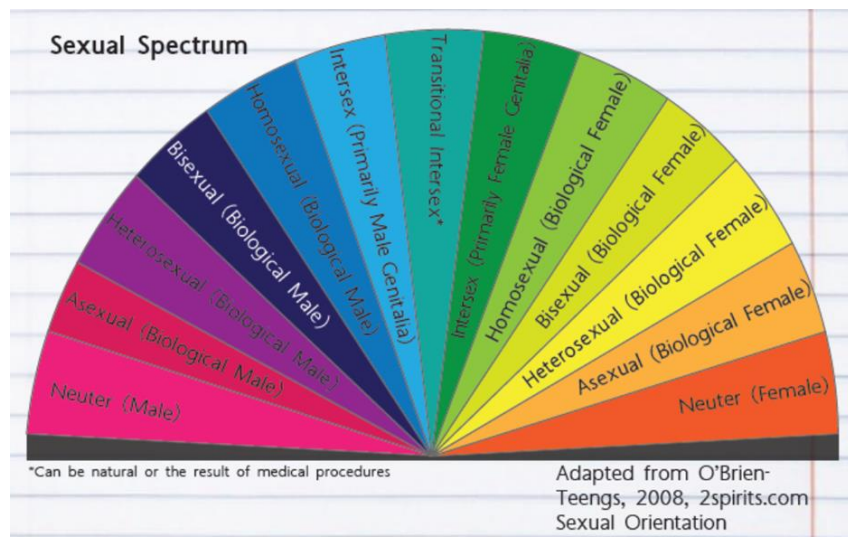


Figure 10: NAHO, *Sexual Health Toolkit Part 2*

NAHO also contributes to a narrative of progress through their discussion of LGBTQ2 terminology that constructs Canada as an already equal and inclusive society, where

homophobic language was used by people “in the past”. In this example, “queer” is defined as a term:

that was used against gay, lesbian, bisexual, transgendered, transsexual, and two-spirited people by homophobic people in the past because it means “different” or “odd”. It is now used by some people to show a sense of pride in being different (NAHO, Sexual Health Toolkit Part 2).

NAHO’s discussion about inclusiveness contrasts with their earlier assertion that colonization has continued and is reflected in enduring effects on the health and equality enjoyed by Aboriginal peoples. Nevertheless, the positive emphasis on pride demonstrates the impact of queer activism and increasing acceptance of a range of gender and sexual identities and sexual orientations in Canadian society. By focusing on difference, NAHO indicates that these sexual identities retain a political impact. The incorporation of positive messages about sexual orientation is particularly important for youth as they navigate their identities. However, the above passage from NAHO overstates the success of such movements toward equality. Although it states that “queer” was used by homophobic people “in the past”, homophobia and discrimination remains a real concern. Indeed, NAHO itself identifies the risk of homophobia or transphobia, which NAHO defines as:

the fear or hatred of anyone thought to be gay, lesbian, transsexual, transgender, two-spirited or intersex. It can be directed at someone else or oneself. It can range from making jokes or avoiding certain people to verbal and even physical abuse (NAHO, 10 Things to Know About Sexuality).

This hatred is presented as coming from others or from oneself. The internalization of homophobia and hatred, alongside the ever-present threat of abuse from external sources, demonstrates that Canadian society is far from already equal.

When the websites in my sample turn their attention toward queer youth, readers are warned that parents and families are a potential source of hostility and rejection. For example, the SOGC warns that coming out to parents can be scary and risky, and that parents may not be as open in this situation as they are promised to be when dealing with a young (heterosexual) woman preparing for her sexual future, as I discussed earlier.

Coming out to parents and family members can be a scary thing for many gay, lesbian, and bisexual people. It's useful to keep in mind that your parents may have grown up in a time when negative attitudes towards gay, lesbian, and bisexual people were stronger and more common than they are today. If you live in your parents or family members home and/or are financially dependent on them, the decision to come out needs to be made carefully. Do you feel confident that they will react in a supportive or at least neutral way? Will you be putting yourself at risk of being thrown out of your home or financially cut off. While it's impossible to predict exactly how your parents and family members will react, if you think that coming out to your parents or family members is likely to be significantly harmful to you, it may be better to wait (SOGC, *Sexual Orientation: Sexual Identity and Orientation*).

The SOGC makes clear that coming out to your family is dangerous, especially when young and financially dependent.¹¹ However, this excerpt also contributes to a narrative of progression in Canada, where the homophobic views held by some parents are described as merely “negative attitudes” that were acquired in the past and that are less common today. After weighing the risks, the reader is told that if coming out will prove to be significantly harmful to them, they should wait. Again, time becomes the active component of progress and acceptance: “negative attitudes” come from the past, and safety will come in time (e.g., once the reader is old enough to live on her own and support herself financially). These are important risks and realities to consider, but this

¹¹ The advice to consider housing stability and financial dependence on family prior to coming out reflects that queer youth make up a disproportionate percentage of those facing homelessness in Canada. See Abramovich (2012) for a discussion.

advice needs to be offered in tandem with resources on how to anticipate, negotiate, and prepare for these possibilities in real time. The individual LGBTQ2 reader is left with the responsibility to negotiate these considerations on her own.

5.4.2 Forming Community

The emphasis placed on the individual responsibility of the LGBTQ2 reader (and more broadly, for all LGBTQ2 people) is also evident in the SOGC's discussion of the benefits of coming out. These benefits include achieving a wholeness of identity and participation in a wider community:

Benefits • Living an open and whole life • Developing closer, more genuine relationships • Gaining self-esteem for being known and loved for who you really are • Reducing the stress of hiding our identity • Connecting with others in the gay, lesbian, bisexual community • Becoming part of a strong and vibrant community • Becoming a positive role model for others (SOGC, Sexual Orientation: Sexual Identity and Orientation).

In this example, the “speaker” is identified as queer (although no author is attributed to this article): coming out is described as having the potential to alleviate the stress of hiding “our” identity. The SOGC is offering its readers inclusion into a discursive community where heterosexuality is not necessarily assumed, an important divergence from the assumption of heterosexuality elsewhere across the websites in my sample. Readers are also offered more than a discursive community: coming out enables her to connect with others in the strong and vibrant GLB community, and, this connection is constructed as a new responsibility for LGBTQ2 youth. LGBTQ2 youth are invited to think beyond their individual position and choices: by coming out, she can and should be a positive role model for others.

The role of community is also emphasized as important to two-spirited people: in a section discussing traditional views on sexuality, NAHO outlines how respect for two-spirited people and an acknowledgement of the gender inclusiveness of traditional First Nations cultures has been lost through colonization.

Before colonization, two-spirit individuals were recognized as having the special responsibility of carrying two spirits and this was considered a gift...Because of colonization, two-spirit people have lost their role in the community (NAHO, Sexual Health Toolkit Part 2).

Later in that same article, NAHO identifies that “First Nations communities, First Nations women, and two-spirited individuals are working hard to bring these traditional views back to the community” (NAHO, Sexual Health Toolkit Part 2). NAHO’s discussion contrasts with its earlier claims about the present inclusiveness of the term “queer”. Far from being already equal, NAHO identifies that there is work that must be continued to be done to achieve a fully inclusive Canadian society.

In response to discrimination within the family and within Canadian society, both the SOGC and NAHO direct queer youth toward support groups. The SOGC notes that making connections with others in “gay/straight” alliances in high schools can reassure youth who are struggling with their sexual identity that they are not alone (SOGC, Sexual Orientation: Sexual Identity and Orientation). Finally, NAHO speaks to the general audience reading online sexual health information by summarizing the effects of discrimination faced by queer youth on their mental health. In this passage, readers are informed that:

Gay, lesbian, bisexual, transsexual, transgender, and two-spirited people are at greater risk for depression and suicide. Ongoing discrimination and isolation is stressful. According to a recent study, gay and lesbian teens are twice as likely to be depressed and three times as likely to have thought about or attempted suicide. You can help your community by

being inclusive and creating safe spaces for everyone, such as in the family or at school (NAHO, 10 Things to Know About Sexuality).

All readers – not just queer youth – are told that they can help their community through forming safe spaces as well as less formal alliances. The emphasis on the potential support that can be gained from forming community contrasts with the emphasis elsewhere in my data that young women should be concerned about their individual health needs and choices. However, this community remains the responsibility of individual queer youth: they are invited to create support groups in semi-private spaces like a school, rather than engage in public displays of protest and effect change towards a more equitable and less discriminatory society.

5.5 Responsibilizing Young Women as Potential Victims of Sexual Assault

In Chapter 4, I discussed how sexual assault is constructed as a threat to women's sexual health because it has the potential to negatively affect women's sexual desire. Women are mobilized to respond to this threat by addressing the resulting lower level of desire through counselling or other interventions meant to support an active sex life and the health of their romantic relationships. In the following discussion, I examine the construction of young women's rights and responsibilities when it comes to avoiding or preventing (her own) sexual assault. I begin by pointing to websites in my sample that state that a woman is never to blame for her own victimization. However, I contrast these claims, seemingly informed or influenced by feminist perspectives, with the overwhelming emphasis through the rest of the data (predominantly, though not exclusively, offered by the SOGC and Trojan) on providing women with "safety tips": information that women are meant to employ to prevent their own victimization. I conclude this section by discussing the limitations placed on the responsabilization of male perpetrators by the discourse.

5.5.1 Managing Consent: Sexual Assault as Avoidable

There are several articles in my data that discuss sexual assault and consent, aimed to help young women avoid sexual violence. This advice is addressed primarily to young women, who are negotiating their first sexual interactions with a partner. In an article about consensual sex, Trojan tells readers that they must be firm in their sexual decisions and resist being pressured to do something that they do not want to do, explaining that agreeing to sex they may not be comfortable with is still “technically” consensual. This remains true, according to the discourse, even when facing pressure from a sexual partner that requires the reader to “stick to [her] guns” about not wanting to have sex. Consent is constructed as a simple matter of verbal communication; however, the onus of articulating consent or of agreeing to sex is placed on young women. It is up to women to state when they are uncomfortable, to articulate their boundaries, and to stick to their guns or leave when challenged: consent for sex is assumed unless young women state (emphatically) otherwise.

[...] sometimes you may find yourself agreeing to sex when you really don't want to. Technically, this is consensual but it may leave you feeling bad about yourself and having regrets. That's why it is so important to be clear about the reasons you want to have sex and to stick to your guns if you don't want to, whatever your reasons. Never let anyone make you feel bad or embarrassed about this. If anyone does and continues to pressure you to have sex, walk away (Trojan, Are You Ready: Consensual sex).

Trojan outlines the responsibilities of the young women reading: they should make their choice, communicate it clearly, and walk away in the face of any continued pressure. The risks she faces in not communicating clearly are emotional: she will feel bad about herself and have regrets. The discursive emphasis on regrettable sex obscures a conversation that could otherwise be had about understanding pressure as sexual coercion that interferes with the ability of young women to give meaningful, and not merely technical, consent. The responsibility to manage consent is placed on young women, and

sexual assault is discursively constructed as the result of poor communication and choice-making.

In the following example, young women are reassured by the discourse that it is never their fault if they are sexually assaulted. The SOGC explicitly states that only the perpetrator is responsible for committing sexual assault. However, the websites in my sample simultaneously speak to and responsabilize young women as potential victims through their sexual assault safety tips.

No matter what, sexual assault is never a victim's fault. And it's not a person's responsibility to "prevent" themselves from being assaulted. The only person responsible for a sexual assault is the person who commits it. But the following tips can help you have a safe and fun time when at a party, bar or just hanging out with friends (SOGC, Safety tips: Drug facilitated sexual assault).

Although this passage tells women that being sexually assaulted is not their fault, the strength of this message is qualified by a "but" that introduces various expectations for how young women should act and behave in order to prevent or avoid sexual assault and to help them have a "safe and fun time" while out with friends. Specifically, the SOGC advises young women to walk away from situations where sexual assault may occur: according to the following passage, the "best way to avoid sexual assault" is to make sure you feel safe, and to immediately leave if you do not. This advice places the onus on young women to be constantly reading their surroundings and to maintain "control" wherever they are. Sexual assault is discursively constructed as something that can be predicted or avoided based on changes in a young woman's perception of safety and control.

The best way to avoid sexual assault is to make sure that you always feel safe and in control of a situation. If you don't, GET OUT OF THERE. You don't have to do anything you don't want to do. You don't have to go

drink at that college party, and you don't have to go park with your boyfriend (SOGC, Sexual assault: Sex and the law).

This advice fails to problematize the ability that young women may have to act on their evaluation of danger: in addition to the ableist assumption built into the advice to “walk away” in the example from Trojan, above, the SOGC fails to consider the social circumstances, privilege, or confidence required to leave a particular situation. This passage makes particular assumptions about the kind of situations in which sexual assault occurs. The SOGC assumes that young women will be facing acquaintance or date rape, and also presents leaving a party that has older, college-aged men in attendance or declining dates with an established boyfriend as a very simple and effective rape prevention strategy. There is also a reference to drinking in this example that positions alcohol use as an activity that young women should not engage in if they wish to avoid sexual assault.

NAHO makes similar arguments about choosing to engage in alcohol use, indicating that a potential victim of sexual assault will be more likely to “ignore or miss signs” necessary to avoid her own assault. Sexual assault is constructed as an event with warning signals that can be reliably predicted by a young woman's (or a young man's) sense of safety and danger. She is responsible for reading the situation, and for drinking less, since alcohol use can interfere with this prediction. NAHO also addresses the perpetrator, arguing that some perpetrators may take advantage of, or forcefully encourage a woman's intoxication.

Alcohol use makes it more likely that a person will ignore or miss signs that he or she is in danger of sexual assault. Alcohol also makes it harder for a person to resist. Women are assaulted more often than men, usually after drinking. An abuser may take advantage of a woman's intoxication and inability to fight back or the abuser may assault a woman after she has passed out. An abuser may also pressure a woman to drink or make her drinks extra strong (NAHO, Sexual Health Toolkit Part 2).

The websites in my sample stress that anyone, male or female, can be victims of sexual assault. However, these tips are gendered in ways that privilege women as potential victims, particularly when date or acquaintance rape or alcohol use is discussed. Young women are invited to identify with the warnings in these safety tips, an invitation that reinforces that the responsibility is on the victim to manage the choices they make and to avoid getting raped. The perpetrators of sexual assault, including their choices and their actions, are not responsabilized to the same extent as victims by the discourse in this example.

5.5.2 Constructing Sexual Assault as Regrettable Sex

The responsibility for young women to avoid their own sexual assault is reinforced through constructions of sexual assault as regrettable sex that are directed primarily to men. Situations that compromise safety are positioned as easily assessed and avoided. When sex does occur in unsafe contexts, that sex is framed as “technically” consensual, as in the example above from Trojan. Consent is addressed as an important component for sexual activity: in “Key Points for Men” in the SOGC’s “General Sexual Assault Prevention Tips” article, myths about consent are debunked. Specifically, men are told that consent cannot be gained from someone under the influence of drugs or alcohol, from body language, nor from an invitation back to a date’s house (SOGC, General Sexual Assault Prevention Tips: Sex and the Law). The passage concludes by stating that open communication is important to establish sexual boundaries and receive clear consent. However, the SOGC, and in the following example, Trojan, maintains an emphasis on the actions and decisions of the victim even in articles that do speak to men as potential perpetrators of sexual assault. In this passage from Trojan on consensual sex, readers are told to never take advantage of a situation where someone is too drunk to consent to sex.

Never EVER take advantage of the situation and force yourself upon anyone who is under the influence. Not only is this a lousy thing to do, if

the person decides once sober that they were forced into something they didn't have the mental capacity to object to, you could be criminally charged (Trojan, Are You Ready: Consensual sex).

In this example, the situation where a woman may be too drunk to consent to sex exists prior to the male reader's involvement. The predatory nature of pressuring a woman to drink is absent from this example. Male readers are warned that legal repercussions may result when "the person decides" that they were assaulted, not when they "realize" they were assaulted. Assault is discursively constructed as a decision made by a victim after the fact, not an act done by a perpetrator regardless of a victim's actions.

In another article from Trojan, readers are told that if someone is too drunk to give consent to sexual activity, the reader should make the decision to say no on their behalf.

If you recognize that someone you're interested in is too drunk to make sound decisions, they are too drunk to decide if they really want to have sex or not. Make a decision on their behalf and stop. Just as you would take their keys away if they wanted to drive, stop them from making a mistake you both may regret (Trojan, Are You Ready: Be the one to say no).

Trojan makes a comparison between drinking and driving and having sex while drunk. Legally, the person driving under the influence is breaking the law. Through this comparison, someone who is too drunk to consent to sexual activity is placed similarly in the wrong. In both cases, men are positioned as good Samaritans, stepping in to prevent someone who is too drunk from doing something wrong. If sexual assault were to occur, it would be the victim's mistake. Further, this mistake would negatively impact both parties equally, as Trojan argues that both parties would "regret" the sexual assault). Again, sexual assault is framed as regrettable sex. Later in the same article, men are addressed as saviours for the poor choices made by women. Men are again encouraged to not take advantage of a pre-existing situation where a woman may be too

drunk to consent to having sex. Men are told not to “force” themselves on anyone, but the sentence that follows constructs women as an active participant who is otherwise actively “doing something” despite being incapable of consenting.

Never ever take advantage of the situation and force yourself upon anyone. The other person will appreciate the fact that you stopped them from doing something they might regret once they are sober (Trojan, Are You Ready: Be the one to say no).

Men are addressed through a discourse that reinforces an understanding of sexual assault as a matter of mistaken consent or a sense of regret that comes on the morning after. Men are given the benefit of the doubt when they are spoken to as potential perpetrators of sexual assault, and are discursively constructed as lacking the predatory intention otherwise attributed to perpetrators when they are spoken about. This example concludes by describing a woman whom a man chose not to sexually assault as appreciative. Indeed, a victim of sexual assault may regret that a perpetrator forced himself upon her; she will appreciate not having to regret being raped.

5.6 Conclusion

In this chapter, I discussed how the responsibility to be informed is constructed as an important goal for the young, smart, postfeminist subject who is expected to navigate risks to her sexual health. The choice-making subject that is formed through this discourse is assumed to have benefitted from the contributions and advancements gained by feminist activists in the women’s health movement, and is thus responsible for actively pursuing and accessing the correct information and doing the work to evaluate it. Choice is individualized in the discourse on sexual health, where young women are presented as capable of easily navigating and pursuing good health and good health care services if only they acquire the right information and use it to make the right choices. Within the discourse, doctors remain positioned as the ultimate sources of medical knowledge about sexual health, although their role in women’s care has shifted from

authoritarian to supportive teammate; the choice-making subject is entitled to good care from these doctors, and is entitled to enjoy the gains of feminism, including increased equality. Queer youth are described as having particular responsibilities that are rooted in their having to face difficult decisions, like when to come out to family and how to access (or create) the kind of community and support they need to thrive. Young women are also expected to make the right choices to avoid sexual assault and to communicate her (lack of) consent clearly in order to avoid situations of assault that are described as regrettable sex for men. Within the discourse, it is the choices of young women matter more than all other factors, including structural disadvantages or marginalization. Social differences, like socio-economic status or Aboriginal heritage, are set aside by the discourse on sexual health. As a result, a neoliberal image of Canada characterized by increased acceptance and equality is reinforced. In the next chapter, I discuss how discourses on pleasure inform young women's responsibilities to make choices that not only benefit her health, but that are seen as "sexually savvy" and work to manage men's (hetero)sexuality.

Chapter 6

6 The Discursive Construction of the Sexually Savvy Subject

In this chapter, I examine how discourses of pleasure contribute to the conceptualizations of sexual health being constructed by the websites in my sample. In my web sample, discussions about puberty are used to naturalize socially constructed gendered differences between men and women. Consistent with the results in the previous two chapters, these differences identify young women as particularly vulnerable to the risks of sexual activity. At the same time, young women are also constructed as more responsible than men in terms of their ability to manage birth control and conversations necessary to preserve good sexual health. The themes discussed below illustrate how this responsibility is reframed within a postfeminist culture where young women's sole responsibility for birth control is heralded as an opportunity for her to experience freedom, control, and equality. Significantly, the level of preparedness that young women must meet prior to having sex is discussed as a route she can follow to achieve sexual pleasure: by having open conversations with her partner and by practicing safer sex through the use of condoms, she is able to enjoy worry-free sex. Young women are entitled to sexual pleasure, but they must also be sexually savvy and knowledgeable. The websites in my sample construct young women's sexual subjectivity in relation to their responsibility to manage men's desires and the dangers of sexuality regarding STIs and pregnancy.

6.1 Girlish Vulnerability: Puberty, Pregnancy, and Responsibility

I begin this discussion by examining the ways that the websites in my sample, particularly the SOGC and Trojan, operate to highlight and reinforce gendered differences. These differences are presented without question as though they are the natural order of things, where women are naturally passive, inferior, and biologically and physically weaker than men. In an article where the SOGC offers facts to debunk myths about birth control, young women are described in infantilizing terms. The SOGC works

to emphasize that young women are vulnerable to the risks of sexual activity by addressing its audience as “girls”. In this example, “girls” are told that they can get pregnant without having an orgasm, and that pregnancy results when a man’s sperm fertilizes a woman’s egg.

Myth #1: A girl can’t get pregnant if she doesn’t have an orgasm.

Pregnancy occurs when a man’s sperm fertilizes a woman’s egg. This can happen whether or not she has an orgasm (SOGC, Birth Control: Birth Control Myths).

Readers are addressed as “girls” in other articles in this website (including articles about puberty, as well as articles about negotiating condom use), and this suggests that the SOGC is aiming to accurately and inclusively address a target audience of (pre-)sexual young women. Making sure that girls and young women see themselves in the advice being offered is an important way to ensure that young women consider that advice. However, the discourse does not interpolate their male readers as “boys”, or to address the male readers in its audience. In the above example, the SOGC switches from addressing a “girl” in the first sentence to a “woman” in the second, where a “man” is also mentioned. This is an important linguistic change, as surely the SOGC is not depicting a scenario where men have sex with girls. However, the SOGC is setting up a linguistic construction whereby a girl becomes a woman through her sexual relationships with men¹²: in the first sentence, on her own, the subject is a girl. In the second sentence where she is joined by a male, the subject becomes a woman. Further, the SOGC contributes to the infantilization of young women by introducing this piece of information as of particular importance to girls specifically (i.e., rather than framing this as a myth about whether or not a man can get a woman pregnant without her having an orgasm): young women are always a little too naive to fully understand the possible consequences of their actions, whereas men are already capable.

¹² See Richardson (1989) for a discussion of gender stereotyping in the English language.

The association between girlishness and sexuality is emphasized in some of the images that accompany Trojan's articles on sexual health. Women's bodies are depicted as playfully or childishly desirable: in the home page of Trojan's We Know Sex, an Asian woman is pictured in two images blowing a playful kiss at the reader. This image functions as a link to the articles offered by Trojan that deal with sex.



Figure 11: Trojan, Homepage



Figure 12: Trojan, Homepage

In an article titled "Desire", a white woman with blonde hair is pictured gazing directly out at her audience. However, she is also holding a large, red, heart-shaped sucker at her lips. Although her gaze both expresses and invites sexual desire, this sexual expression is re-packaged by Trojan through her use of a childish lollipop. Additionally, the light reflecting on the lollipop appears to spell out the word "Love". With this framing, young women are discursively constructed as childish objects of men's sexual fantasy, and as desirous of sexuality only as it connects to romantic love.



Figure 13: Trojan, *Having Sex: Desire*

The emphasis on the girliness of young women in the discourse serves to emphasize essential differences between women and men. Specifically, young women are constructed as biologically and socially vulnerable to the risks of sexual activity. Further, while women are childlike in their sexuality or desirability, men are constructed as active and mature actors. The SOGC emphasizes men's active and productive role in fertilization by personifying and sexualizing the union of the egg and the sperm: fertilization occurs when an egg and "active" sperm "hook up".¹³

If the egg is not fertilized (if it doesn't hook up with active sperm), then the levels of the hormones that helped to thicken the lining of your uterus (progesterone and estrogen) drop, causing the lining to break down so that it (and the egg that was not fertilized) can be shed from your uterus. This is the end of the premenstrual period and the beginning of your period (SOGC, *All about the menstrual cycle*).

The egg in this example is described as having the potential to "hook up" with sperm; however, sperm are given more agency by being described as "active" in this process. Elsewhere, the SOGC emphasizes the active role that sperm plays in fertilization by discussing something the SOGC terms "splash pregnancy". According to the following

¹³ Martin (1991) discusses the way that scientific narratives have constructed a fairy-tale-like romance between the egg and the sperm based on stereotypical male-female roles. In this example, the fairy tale has been updated to reflect increased acceptance of a sexualized dating culture.

passage, although sperm are fragile, they are also so persistent that they “have been known to move very quickly from outside the vagina into the uterus”:

Sperm, although it is very fragile, can also be very persistent. Occasionally pregnancy can occur without intercourse and even if the hymen is intact. The hymen is the membrane that partially covers the virgin vagina. This is called “splash pregnancy”. Sperm have been known to move very quickly from outside the vagina into the uterus. After intercourse sperm can survive up to three days in the reproductive organs of a female (SOGC, Sexual reproduction: All about puberty).

The description of splash pregnancy contributes to a long scientific and popular culture understanding of the perilous journey undertaken by sperm through the female reproductive system. In this example, sperm are described as “surviving” in the reproductive organs of a female. Further, sperm are described as capable of overcoming multiple obstacles and achieving fertilization “even if the hymen is intact” across the “virgin vagina”. Canadians for Choice echoes the concern about the ability of sperm to move, unaided, from the mere vicinity of a woman’s vagina into her body.

If semen spills on or near the vagina, pregnancy may still be possible, even without penetration (Canadians for Choice, Sexual and Reproductive Health Issues: Contraception).

Although this passage from Canadians for Choice removes linguistic signifiers of sperm’s activity and intent (saying instead that sperm may “spill”), it contributes to a discourse that imagines sperm as contributing to fertilization by acting independently of a woman’s reproductive system: sperm are mobile and capable of crossing boundaries.

The persistence of sperm in the fertilization process is framed as a site of concern for young, sexually active (or soon-to-be sexually active) women. In the example below, Trojan identifies that unplanned pregnancy is a particular concern for young adults. This

article recommends that “serious” precautions like hormonal methods of birth control are necessary if readers do not feel that they are “prepared” to have a baby.

Unless you’re prepared to have a baby right now, you need to take serious precautions. Hormonal contraception can be a very reliable option (Trojan, How Not to get Pregnant: Hormonal Contraception).

The above example introduces a standard of preparedness for parenthood, as the discourse works to dissuade young women from having children before they are ready. Trojan and the SOGC establish that there is a difference between being physically capable of producing children through fertilization, and being emotionally or financially ready to keep and raise children. This readiness comes in time, as young women are expected to have children in the future (perhaps, once they are professionally employed or married), but not “right now”. Until the time is right, young women are responsible for properly and consistently implementing available contraceptive options to prevent pregnancy.

6.1.1 Ready for Pleasure: Communication and Sexual Preparedness

The websites in my sample, particularly the SOGC and Trojan, infantilize young women and construct them as vulnerable to the risks and consequences of sex. At the same time, young women are also uniquely positioned as capable of navigating these risks, and are responsabilized to engage in particular activities to support their sexual health and the health of their romantic relationships. For example, the SOGC emphasizes gendered differences in the way that young women and men approach communication about sex in a relationship. The SOGC asserts that men and women “speak different languages when it comes to sex”, where men are more interested in physical sensations and women are more invested in the emotional aspects.

Sex has always been an essential part of life. Yet, after all this time, men and women still seem to speak different languages when it comes to sex.

Men often focus on the physical act of sex - a nuts-and-bolts approach, so to speak. Women, however, tend to talk about sex from an emotional point of view - the caring, sharing and intimacy wrapped up in it (SOGC, Talking to your partner about sex: How do I know I am ready for sex).

This example includes a metaphor to illustrate men's mechanical approach to communication, comparing their interest in physical sensation to nuts and bolts. Alternately, women communicate in ways that emphasize emotional connection with their partner. The SOGC laments that "after all this time", men and women have not found a way to communicate in the same language about sex, and in so doing, stresses that open communication about sex is an important goal that young women must work to achieve within relationships. In the next passage I cite, the SOGC states that sex is not exclusively about orgasms, but includes emotional considerations. It is because of the emotional considerations that communication is necessary. By establishing that women are more interested in the emotional aspects of sex, and then arguing that communication is necessary only because of the emotional aspects of sex, communication is discursively constructed as the responsibility (or, perhaps, the fault) of women.

If sex was just about orgasms, you could just enjoy it without ever having to talk about it. But there are so many things that come along with sex: pain, messy emotions, awkwardness, confusing feelings, not to mention unwanted pregnancies and sexually transmitted infections (STIs). It's like a 1000-piece model airplane that comes in a box with no instructions...so you're going to have to get some help once in a while (SOGC, Sexual Health: Understanding Sexuality).

The advice to communicate about the emotional aspects of sex joins the emphasis on communication about the physical aspects of sex that I discussed in Chapter 4. In that section, I discussed how the disclosure of an STI is a necessary step to prevent transmission and related physical consequences. Communication for physical concerns also functions to support the emotional health of a relationship: those who disclose or

discuss STI prevention and safer sex are engaging in acts of trust, honesty, and openness, contributing to a conceptualization of sexual health in terms of overall well-being. However, supposed natural differences between the sexes are used to contribute to a gendered division in terms of the motivations that men and women have to engage in conversations about sex. In the above example, the SOGC again uses a mechanical metaphor to illustrate sexuality, perhaps to appeal or speak to young men. The description of sex as a model airplane with no instructions is meant to emphasize the importance of getting help by talking openly about issues related to sex and sexuality. Although men are responsabilized here to seek out information, women are positioned as the implicit experts on emotional matters related to sexuality. In addition,

Readers are informed by other websites in my sample that the emotional work of communication is important because there is a connection between communication and physical pleasure. Women in particular may have trouble reaching orgasm with a partner if open communication is not a characteristic of their relationship. Trojan identifies that for women, the ability to communicate follows a sense of comfort with her partner as their relationship develops. Only when these emotional milestones are met are women ostensibly able to communicate for effective pleasure.

Often, the woman is able to have an orgasm when she is masturbating alone but not while with her partner, especially if the relationship is new. If that's the case for you, don't worry. Once you are more comfortable with your partner and able to tell them what feels good to you, it may become easier to reach orgasm. And don't hesitate to tell your partner what you like – in most cases they will be happy to learn (Trojan, *Common Sexual Problems: Woman - Trouble having an orgasm*).

Trojan acknowledges that communication between partners can be difficult: a young woman may only be able to tell her partner what feels good to her after she becomes more comfortable in the relationship over time. However, communication is constructed as the key to be able to have your sexual needs met within a relationship. Trojan

concludes this passage by indicating that “in most cases”, a woman’s sexual partner will be happy to learn what she might need to get off. Young women are urged into action: it is her responsibility to not “hesitate” in communicating these needs.

Indeed, communication is constructed as a prerequisite for good sex, particularly for young, heterosexual women. In the following passage, the SOGC begins by using gender-neutral language like “people”, and then genders the sexual partner of the readers as male (“him”). The possibility that the sexual partner of the reader is a woman is bracketed (“or her”). Combined with the way that the SOGC established that the emotional work of communication is women’s work in heterosexual relationships (discussed above), this passage functions to further bracket potential lesbian (or straight male) readers. However, women are incentivized to engage in this work, as it promises to fulfil their postfeminist right to sexual pleasure.

There are still many people who say, “I couldn’t possibly talk that way with him (or her)!” And in some cases, this may be true. If that’s the case, maybe it’s a good idea to take a look at your relationship and how close you really are. Sex definitely isn’t everything in a relationship, but “bad” sex (if there is such a thing) can sometimes be a symptom of other problems. Think about it - in the end, it’s your pleasure that’s on the line (SOGC, Talking to your partner about sex: How do I know I am ready for sex).

Readers are reminded of the importance of communication by being told that their pleasure is “on the line”: poor communication can result in “bad” sex. In addition, poor communication is positioned as an indication that you are not very close with your partner. The SOGC clarifies what is at stake for individuals who may have difficulty communicating. In the following passage, being too uncomfortable to talk about the risks associated with sex is a sign that the reader may not be ready to have sex with that person.

Because of the risks of pregnancy or disease, sex is a big responsibility. So, if you find that you're way too uncomfortable to talk about these things with your partner, think about this: Maybe it's a sign that you're not totally ready to have sex with them yet (SOGC, Birth Control: Birth Control and your partner).

The SOGC constructs sex in committed, on-going relationships as the most potentially pleasurable (e.g., as opposed to casual hookups) by positioning good communication as a prerequisite for good sex. Closeness to a partner is achieved through communication, but communication takes time and work to develop. The responsibilities that young women must enact prior to sexual activity are best enacted, according to the discourse, through open and extensive communication within an ongoing relationship (consistent with the responsibilities young women must enact surrounding STIs and communication, as I discussed in Chapter 4). Communication about the risks of disease signal a level of preparedness for sex that must be met prior to sexual activity with a partner. Young women are urged into action: they are responsible for establishing open communication with their partner to protect their sexual health from risks such as STIs and pregnancy, and to ensure their sexual enjoyment and pleasure.

6.2 Managing Risk and Pursuing Pleasure: Controlling Contraception

Young women are tasked with the responsibility to take on the role of communicating and managing the risks of sex; this responsibility appears in relation to managing STI risk and selecting and implementing birth control. In articles that discuss birth control, readers are told that men and women share responsibility for birth control and pregnancy prevention, echoing the language and rhetoric of equality. However, young women are given more specific advice and responsibility than men when it comes to implementing birth control. The websites in my sample call on feminist language to argue that women can and should have control over their own bodies and their choice of birth control: indeed, this control is key to sexual and reproductive health, and a sign of feminist

progress in the women's health movement to decouple sexual activity and procreation. Young women are promised more spontaneous and more pleasurable sex through their responsible implementation of birth control, particularly through the use of condoms. In contrast, young men are constructed as untrustworthy or too preoccupied with their own sexual pleasure: unburdened of their responsibility to engage in birth control practices, men enjoy increased access to women's bodies.

6.2.1 Smart Girls Know that Abstinence does not Work

The websites in my sample express concern over young women's sexuality: namely, that young women are commencing sexual activity at too young an age, and that sexual activity carries the dual risks of STI transmission and of pregnancy (see Chapter 1). Abstinence is offered by several websites as an ideal sexual health choice to avoid these risks. In this passage, Trojan identifies that abstaining from "any sexual contact" is the only way to guarantee full protection against STIs, consistent with my finding from Chapter 4 that there is no such thing as no risk.

The only way to protect yourself 100% against STIs is to not engage in any sexual contact (Trojan, *Getting Into a Relationship: Where to Start*).

Although abstinence as positioned as an ideal sexual health choice for young women, discussions about abstinence through the websites in my sample serve to acknowledge that sexual activity among youth is a reality that must be considered. In the following example, Canadians for Choice discusses managing and reducing the risk of STI transmission during sexual activity. Abstinence is offered as an option to prevent "100% against" STIs, but it is positioned as an aside. Abstinence is mentioned as the ideal, but is quickly followed by advice about reducing (rather than eliminating) risk.

While it is not possible to prevent 100% against sexually transmitted infections, unless you abstain from any sort of activity that can transmit STIs, there are ways to greatly reduce your risk of contracting one

(Canadians for Choice, Sexual and Reproductive Health Issues: Sexually Transmitted Infections).

Canadians for Choice positions abstinence as the only way to prevent STIs, and in so doing, contributes to a discursive construction of all sexual activity as risky. However, they argue that there are ways to reduce the risk of STI transmission if abstinence is not practiced, indicating a certain acceptance of the impracticality of expecting youth to practice abstinence and an expectation that young women will learn about and implement risk-reduction measures.

The SOGC addresses abstinence in terms of relationship satisfaction, arguing that there are “no disadvantages” to abstaining from penetrative sex if couples are otherwise able to maintain a “fulfilling relationship”. This passage concludes with an indication that even if abstinence is chosen, it is “wise” for a couple to become familiar with alternative methods of protection.

There are no disadvantages of abstinence if a couple is able to maintain a fulfilling relationship without the need for penetrative sex. When couples choose this approach they are wise to become knowledgeable about contraceptive alternatives and to have barrier methods available in the event that they decide to have penetrative sexual intercourse at some later date (SOGC, Birth Control: Natural Methods of Birth Control).

The SOGC positions abstinence as a potentially ideal choice with “no disadvantages”. However, couples who choose this method are still tasked with responsibility of becoming informed about alternate methods of contraception, an action in a neoliberal risk society that corresponds with feminist aims to take charge and take control. Specifically, readers are advised to keep barrier methods of contraception on hand, even when choosing abstinence, so that they are prepared in the future if they choose to have penetrative sex. By emphasizing the need for readers to not only know about, but also

acquire contraception while practicing abstinence, abstinence is discursively constructed as a temporary decision.

6.2.2 A Shared(?) Responsibility: Risk Management and Pleasurable Preparedness

Despite the emphasis on the efficacy of abstinence in preventing pregnancy and STI transmission, the websites in my sample assume either a history or a future of sexual activity for the young women in their audiences. With this assumption established, much emphasis is placed on managing and reducing the risks that accompany sexual activity. Readers are informed that pregnancy prevention and contraception is a responsibility that should be shared between partners. In this example from NAHO, women and men are identified as being responsible for deciding when to have children, and for preventing pregnancy until that point.

You can prevent unplanned pregnancies. Pregnancy can happen if you are sexually active. Both women and men are responsible for deciding when to have children and for preventing unplanned pregnancies (NAHO, 10 Things to Know About Sexual Health).

The SOGC also emphasizes that contraception is a shared responsibility, and indicates that by taking care of this responsibility in advance, sex can be enjoyed more. In this example, pregnancy is constructed as unintended: the “oops” operates to refer both to an unintended pregnancy and to an act of unprotected sex, discursively constructed as a mistake.

Sex is such an amazing experience, so the last thing you want in the back of your head is, “oh God, what will I do if we get pregnant.” That’s right - we. Contraception is a shared responsibility of both partners. And remember, it only takes one “oops” to get pregnant (SOGC, Birth Control).

In this example, the SOGC is introducing a link between preparedness for and enjoyment of sex. Young women are told that by sharing the responsibility of contraception (implicitly, by discussing these options with your partner prior to sexual activity), the “amazing experience” of sex will not be compromised by worry or concern about unintended pregnancy. Consistent with the example from the SOGC, above, Canadians for Choice emphasizes the relationship benefits of preparedness. The shared responsibility of open communication when using natural birth control methods such as the Basal Body Temperature Method (BBT) can increase emotional closeness between partners.

What are the benefits of BBT? [...] Can increase emotional closeness between individuals because it requires cooperation and communication (Canadians for Choice, Sexual and Reproductive Health Issues: Contraception).

Although Canadians for Choice identifies the relationship benefits of sharing the responsibility for natural methods of birth control, the websites in my sample more frequently discuss the impact that different contraceptive methods have on the sexual spontaneity and enjoyment young women might experience. In the same article on contraception, Canadians for Choice identifies that one disadvantage of using BBT is that it poses a risk to sexual pleasure, as it reduces the potential spontaneity of sexual activity between partners.

What are the disadvantages of BBT? [...] Sexual intercourse must be limited within specific times resulting in the loss of spontaneity (Canadians for Choice, Sexual and Reproductive Health Issues: Contraception).

When listing the disadvantages of the same natural birth control methods, Canadians for Choice indicates that sexual spontaneity may be lost through the scheduling necessary for natural methods to be effective at preventing pregnancy. By positioning that a decrease

in sexual spontaneity is a disadvantage of this birth control method, Canadians for Choice is contributing to a discourse that values sexual activity that does not need to be planned, negotiated, or discussed. This is in contrast to the emphasis above, where being able to communicate openly about sexual activity is framed as a prerequisite for sexual activity.

In other articles that outline the advantages and disadvantages of contraceptive options, sexual spontaneity is consistently listed as a benefit to several methods of birth control. Notably, Canadians for Choice lists privacy and sexual spontaneity as benefits to both tubal ligation and vasectomies: specifically, both methods promise that sexual pleasure will be unaffected. Similarly, the discretion and the control afforded to women through the use of birth control methods such as the pill, the patch, or tubal ligation is that “sex play” remains uninterrupted.

What are the benefits of The Pill? [...] It is discreet...Does not interrupt sex play (allows for spontaneous sex) (Canadians for Choice, Sexual and Reproductive Health Issues: Contraception).

Canadians for Choice does not work to gender the beneficiary of spontaneous sex in this example. Indeed, it would be irresponsible to assume that only men benefit from unencumbered, spontaneous sex play: women, like men, are able to enjoy “spontaneous sex” as a direct result of their use of birth control.

Women’s control and decision-making regarding birth control is emphasized through several different methods. In contrast to those methods which require active negotiation at the time of sex (e.g., condoms or contraceptive films), the websites in my sample provide women with information on birth control methods that allow them to deploy these methods prior to sexual activity and without her male partner’s knowledge or involvement. For example, Trojan heralds the pill as a contraceptive option that allows women “control over her own fertility”.

In addition to its effectiveness, one of the greatest advantages of the pill is that it is a birth control method that is taken and controlled by the woman herself, giving her control over her own fertility (Trojan, How Not to get Pregnant: Hormonal Contraception).

Despite the emphasis, above, on the importance of sharing responsibility for birth control equally between partners, young women's sole control over certain kinds of contraceptive options is framed as one of the "greatest advantages" of the pill. Implicit in this advice from Trojan is an acknowledgement that a woman does not need to (and below, should not) rely on her male partner to participate in the negotiation or implementation of contraception for her to be able to effectively "not get pregnant", as per the article title. That some methods, such as the pill, allow women to keep their contraceptive decisions to themselves and from their male partner reveals the lasting influence and the reality of patriarchal expectations placed on women with regard to sexual activity and reproduction.

6.2.3 Compromising Protection: Men's Pleasure

Although sexual pleasure is listed as a benefit for both men and women depending on their choice of birth control, pleasure is identified as an impediment to men's successful execution of certain kinds of birth control methods. Specifically, withdrawal or coitus interruptus is identified as a risky method because men may not "know their bodies" well enough to anticipate when ejaculation will occur.

What are the disadvantages of Coitus Interruptus? [...] If male partner gets carried away during sexual intercourse or cannot anticipate orgasm and ejaculation, he may pull out too late resulting in a possible pregnancy. Especially in younger men, men who do not know their bodies well and men who have just started engaging in sexual activity, it can be very difficult to know when ejaculation is about to occur (Canadians for Choice, Sexual and Reproductive Health Issues: Contraception).

While young men and women who have just started having sex are identified as particularly incapable of taking on the responsibility of birth control (or, more alarmingly, their own bodies), this discussion contrasts with the expectation that young women are uniquely capable of and responsible for learning about and implementing good choices for their sexual health (see also Chapter 5).

Trojan is more explicit when they discuss the downsides of using withdrawal for birth control. Echoing the assertion from *Canadians for Choice* that a man may get “carried away” during sex, Trojan identifies that not only must a man know his body well enough to be able to withdraw prior to ejaculation, he must also be willing to interrupt sex in this way. The implication here is that some may not be willing to jeopardize their pleasure in service of pregnancy prevention.

The estimated failure rate is about 20%. It’s completely reliant on the male partner’s ability and willingness to pull his penis out of the vagina before he ejaculates every time the couple has sex (Trojan, *How Not to get Pregnant: Withdrawal*).

Trojan concludes this article on withdrawal by stating that not only are men not reliable enough to properly execute (an already unreliable) method of birth control, it is unfair to expect only one partner to take on the responsibility of pregnancy protection.

Withdrawal, or stopping at the last second, isn’t a very dependable method of birth control. Plus, it puts all the responsibility on one person (Trojan, *How Not to get Pregnant: Withdrawal*).

It is significant that a complaint about the uneven balance of responsibility regarding birth control appears in relation to discussion about withdrawal, one of the only methods (alongside vasectomies and, arguably, male condoms) over which men have exclusive control. The ability for women to have exclusive control over birth control is

consistently identified as an advantage, as in the section above. Although there are social and political realities that this control seeks to address and respond to, the result is that even the discursive burden of responsibility for pregnancy prevention remains with women alone. As I will discuss further in the discussion, this burden, however, is also repackaged through a postfeminist lens. The unfairness of placing this burden on men alone is presented as a threat to equality. As I discuss in the following section, women are given the directive to share (i.e., take on from men) the responsibility of birth control.

6.2.4 Re-Defining Equality: Women Carry Condoms...

The websites in my sample deploy the language of equality and fairness to argue that partners should share the responsibility for birth control. Canadians for Choice contributes to this assumption by identifying that the female condom presents an “opportunity” for women to share that responsibility, perhaps to correct the imbalance. However, this framing rests on an assumption that men have disproportionately been responsible for providing birth control up until this point.

What are the benefits of the female condom? [...] Opportunity for women to share the responsibility for the condoms with their partners (Canadians for Choice, Sexual and Reproductive Health Issues: Contraception).

The SOGC shifts the conversation from pregnancy prevention to STIs, and also uses an assumption that men have been traditionally responsible for providing and instigating the use of condoms to encourage young women to share this responsibility. In this example, “girls” are told that because STI prevention is a shared responsibility, they need to know how to talk about using condoms.

Protecting yourself and your partner from STIs is a shared responsibility, so girls need to know how to raise the subject of condoms. Even if you’re really shy, STIs and pregnancy are way too big of a deal not to bring up

the subject (SOGC, Male Condom: How do I protect myself from STIs-STDs).

The SOGC emphasizes that young women in particular need to develop conversational skills to instigate condom use and to achieve a more equitable arrangement in her sexual relationships. Barriers to communication, such as shyness, are depicted as something to be overcome for the good of the reader's health and for the health of her partner. Young women are responsabilized through to care for and protect herself and her partner from STIs and pregnancy by taking on the work of communication about condom use.

The websites in my sample responsabilize young women to protect their sexual health, and frame this responsibility as a way for young women to take charge and right an imbalance. In this passage, Trojan cites a condom survey that claims that there is a division of contraceptive responsibility where women take care of pregnancy prevention (usually by taking the pill or using another form of hormonal birth control) and then expect men take care of condoms. This division is framed as unfair: young women reading this information are reminded that it is "important to share the responsibilities of sexual health" by carrying their own condoms.

Carry your own condoms. According to condom survey, many women said that because she takes care of the contraception, it's up to him to buy condoms. It is important to share the responsibilities when it comes to sexual health but by relying on him, you're putting your sexual health into his hands. Having your own condoms means you'll never be without, even if he is (Trojan, Talking About Sex: Negotiating condom use).

As with the discussion on withdrawal, above, men's reliability and trustworthiness is called into question. Trojan tells young women that they should carry their own condoms: if they do not, they are putting their sexual health into his hands. By describing a scenario where young women should anticipate that men will be unprepared for (safe) sex, Trojan is constructing men as unreliable and less invested in the responsibility of

protecting their own and their partner's sexual health. Indeed, while women are encouraged to take care of her own sexual health and the sexual health of her male partner, this passage from Trojan makes clear that men are not receiving (nor taking up) the same messages.

The images that Trojan uses to illustrate several of its articles on condom use contributes to this discursive construction in which women are tasked with the responsibility of acquiring and providing condoms for sexual encounters with men. In this image from a Trojan article about choosing a condom, a white woman is shown smiling toward the camera while holding out a packaged condom.



Figure 14: Trojan, Condoms: Choosing a condom

In this next image, from a Trojan article about being ready for sex, a black woman is shown holding a packaged condom and handing it to her black male partner. Trojan does not comment on the racial background of the individuals pictured in their articles, contributing to the construction of Canada as an already-equal society: the inclusion of “others” does not need to be complicated or qualified (see Chapter 5). The health information offered to readers is presented as applicable to all people, regardless of difference. In this case, having a condom is constructed as a prerequisite for being “ready” for sex, per the article title, and through the use of the image, women are imagined as the ones responsible for acquiring condoms to prepare for sex with men who

do not already have condoms of their own. This image constructs men as unprepared to take care of their own or their partner's sexual health through condom provision.



Figure 15: Trojan, Are You Ready: Beyond the first time

Trojan also illustrates an article about condom use and STI risk with an image of a heterosexual couple in bed. In this example, a white woman is shown holding a packaged condom while her male partner kisses her. While he is focused solely on sexual pleasure, she is balancing both the pleasures of sexual activity and the responsibilities of preparedness.



Figure 16: Trojan, Monogamy and STIs: Am I still at risk

6.2.5 ...But Men Put Them On

Young women are mobilized to carry and provide condoms for sexual activity with men. This gendered responsibility is supported by images that show women holding packaged condoms or handing them to her male partner. Once handed off, the websites in my sample construct men as responsible for properly putting on condoms: men are shown handling condoms outside of the package, in preparation for use. In this image from Healthy Canadians, a pair of male hands is shown unwrapping a condom.



Figure 17: Healthy Canadians, Syphilis

Trojan's homepage features a shirtless man holding an unwrapped condom; this image functions as a link to the section of Trojan's website that offers advice for readers on "how not to get pregnant". In the image, the man's hand makes an "A-Okay" sign, indicating that condom use can offer readers assurance.



Figure 18: Trojan, Homepage

The SOGC provides a diagram that provides instruction to men on how to properly put on a condom in an article about contraceptive methods. In this example, an image of an unwrapped condom is paired with an illustration of a man rolling a condom onto his erect penis.

Male Condom

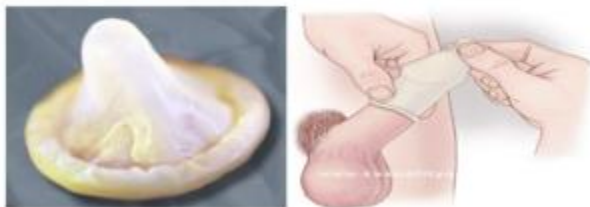


Figure 19: SOGC, Birth Control: Non-Hormonal Methods of Birth Control

Once women provide men with the condoms necessary to comply with safer sex standards, men's responsibility for birth control is illustrated in the discourse by his effective implementation of condoms. In these images, men handle unpackaged condoms and are given instruction on how to put them on properly. According to Trojan, men maintain this responsibility because they are more familiar with "the equipment": their female partners are at risk of "fumbling" to put the condom on.

Get him to put it on. He's familiar with the equipment and there will be less fumbling (Trojan, Talking About Sex: Negotiating condom use).

The websites in my sample work to construct a gendered division of responsibility for the acquisition and application of condoms. Young women are encouraged to carry and provide condoms for sexual activity: they are responsible for planning and preparing to protect both herself and her male partner, out of a sense of equality and shared responsibility. More than simply providing the condoms for men to then put on, however, young women are specifically informed that they must "get him to put it on". Men are discursively constructed as responsible for the physical execution of condoms

prior to sexual activity, but she is constructed as responsible for ensuring that he agrees to use them.

6.3 Empowering Women: Negotiating Condom Use

The websites in my sample offer young women scripts to help them “get” men to wear condoms. These scripts also work to prepare women for men’s resistance to condom use. In the following example, the SOGC outlines that one possible response men may have to a woman requesting he wear a condom during sex is offense: he may be concerned that his partner thinks he is cheating on her, or that she thinks he has been “sleeping around”. This passage gives young women the language they need to refute stereotypes about “disease” as occurring only in those who are promiscuous: young women are advised to tell men that they are concerned about the possibility of undetected STIs.

Usually, your partner will be just as interested in avoiding disease and pregnancy. Still, there’s a chance that he might say: “Don’t you trust me? It’s not like I’ve been sleeping around or anything.” You can say: “Even so, you or I may be carrying STIs without knowing it. I’m concerned about protecting both of us” (SOGC, Male Condom: How do I protect myself from STIs-STDs).

The SOGC calls on the emotional aspects of communication through their discussion of care in this example: young women are given language and scripts to instigate condom use to “protect” both herself and her partner from the risk of STI transmission. This care and protection is framed as a woman’s responsibility: men are discursively constructed as resistant to condom use, and so women must provide evidence to refute these concerns and ensure that condoms are used.

In the following example, Trojan advises women to appeal to medical authority to preempt her partner’s potential desire to stop using condoms once another form of birth control is implemented. Despite being on the pill for pregnancy prevention, doctors

advise that condoms serve as an important backup for both preventing pregnancy and STI transmission.

If you've just gotten your prescription for the pill you can say to your partner, "I'm glad to be on the pill now. My doctor reminded me to keep using condoms as a backup and to stay healthy. And she's right, let's keep using them" (Trojan, Condoms: But I'm on the pill).

By encouraging young women to appeal to medical authority, Trojan offers young women not only the language to use when discussing condoms, but institutional evidence in support of the use of condoms to maintain good health. The implicit assumption in this example is that young women should anticipate resistance from her male partner, and be ready with evidence to continue negotiations: women are given the language and skills needed to negotiate condom use with a male partner who is assumed to prefer to not use condoms at all.

Trojan provides an image to represent that young women should anticipate resistance when negotiating condom use with her male partners. In this image, a woman is pictured holding a packaged condom to her male partner's chest, while he lays back, reclined in bed with one hand behind his head.



Figure 20: Trojan, Talking About Sex: Negotiating condom use

Pictured in this way, she asserts that condom use is non-negotiable; additionally, her touch and their position in bed functions to assure her male partner that sex is imminent. In the section that follows, I discuss how young women are told that they can use conversations about condoms to initiate sexual activity and express desire, and conversely, how they can use the promise of sex to anticipate and persevere through men's resistance to condoms due to the interruption condoms could pose to sexual pleasure.

6.3.1 Claiming Desire: Sexual Initiation through Condom Use

The websites in my sample offer women assistance in beginning a conversation about condoms with their male partners. The SOGC invites women to consider using language and scripts that initiate sexual activity and condom use through notions of romantic love. The SOGC frames this discussion as one occurring between two partners in the early stages of a relationship, prior to the occurrence of any sexual "intimacy".

If you're a woman, you may want to say something like: "You know that at some point we may become intimate." "This is what I expect from someone who loves and cares about me...I want you to wear a condom when we make love" (SOGC, Talking to your partner about sex: How do I know I am ready for sex).

Through the frame of intimacy, these scripts provide young women with a language to initiate conversations about condom use. The importance of condoms is stressed: condom use is established as an "expectation" young women have from a sexual partner who loves and cares for her. In addition, this script also offers young women a way to initiate conversations about sexual activity within an on-going relationship. The SOGC establishes a standard of preparedness through which young women develop their sexual futures: condom use functions as a proxy for the expression of sexual desire, intimacy, and love.

Trojan also offers advice for readers who may wish to initiate conversations about condom use within a relationship. Although love is not mentioned in this example, the rhetoric of care present in the previous example from the SOGC reappears. Rather than a young woman expecting her partner to care for her by using condoms, her use of condoms signals that she is “smart enough” to engage in self-care and protect her own sexual health.

Talking about condom use with your partner doesn't have to be weird. Like everything else, there's a time and place and approach. Some people might feel a little awkward or embarrassed about talking about condoms with their partner. Don't be embarrassed! By bringing up the topic of condom use you are sending a loud and clear signal to someone you are interested in: yes, you want to have sex and yes you're smart enough to take care of your sexual health (Trojan, Condoms: Talking to your partner).

Trojan offers some reassurance to readers who may be broaching the subject of condom use with their partner. Although this passage focuses on easing some of the embarrassment that may accompany conversations about sex, it concludes by emphasizing that communication about condoms and safe sex can serve as a form of sexual initiation: through this communication, young women are able to say “yes, [I] want to have sex”. Discussing condom use is offered by Trojan as a way for young women to loudly and clearly claim and express sexual desire. Later in the same article, Trojan offers flirtatious winks as non-verbal cues that can be used by their readers to communicate the expectation of condom use and to initiate sexual activity.

Maybe it's as simple as whispering to partner: “I always use condoms” or “I've got condoms”. Or if you are feeling especially flirty, you can simply hold the condom up and wink (Trojan, Condoms: Talking to your partner).

Women are offered scripts and tactics by the SOGC and Trojan to not only instigate conversations about condom use with their partners, but to initiate sexual activity. The union of safe-sex conversations with the initiation of sexual activity takes on increased significance when considering the way that women are responsible for “sharing” the work of providing birth control and condoms. As I discuss in the following section, young women are tasked with ensuring men’s compliance with safe sex standards (e.g., the use of condoms) through the use of their sexuality and the promise of sexual pleasure.

6.3.2 Overcoming Men’s Resistance: Deploying Sexual Pleasure

Young women are offered scripts to help them initiate condom use and sexual activity. The websites in my sample also address the concern shared by some men that condom use can negatively impact sexual activity. Canadians for Choice advises that although condoms can “interrupt the mood”, this interruption can be prevented by incorporating condom use as part of your foreplay.

What are the disadvantages of the male condom? [...] Can “interrupt the mood” (Prevent this by making condom use part of your foreplay!)
(Canadians for Choice, Sexual and Reproductive Health Issues: Contraception).

In this example, the disadvantages of using a condom can be corrected through sexual skills: young women are not merely expected to use condoms, but to make the act of using condoms a pleasurable component of foreplay activities. The SOGC also addresses the negative impact that condoms may have on sexual pleasure: they use gendered language to construct the concern over decreased pleasure as one that men have and that women must manage. In this example, men are “just as interested” in preventing pregnancy and STI transmission; however, their preoccupation with their sexual pleasure may make them less likely to want to use condoms to responsibly engage in this prevention. In a call-and-response format, women reading this advice are told to respond

to any hesitation “he” has about condoms with titillating suggestions of increased pleasure.

Usually, your partner will be just as interested in avoiding disease and pregnancy. Still, there’s a chance that he might say: “Sex with a condom does nothing for me.” You can say: “Let’s see if we can do something about that” (SOGC, Male Condom: How do I protect myself from STIs-STDs).

Similar to my discussion about withdrawal as a form of birth control, men are discursively constructed as too focused on their sexual pleasure to reliably engage safer sex methods. The responsibility rests with women to ensure men’s compliance with condom use by deploying and promising more enjoyable sex: in response to his resistance to using condoms, she must offer to explore options to maintain his pleasure and sexual enjoyment.

Trojan identifies some “excuses” that men might offer to women when they are asked to wear condoms. Men may be concerned that condom use will negatively impact his ability to maintain an erection; in the scripted response, the woman offers to use extra lubricant and to physically stimulate her partner. In addition, she offers to experiment with different condoms and sexual positions in pursuit of their mutual pleasure.

Here are some excuses you might get and good responses you can give: “As soon as I put that thing on, I’ll lose my hard-on” [...] “Let’s use extra lube on you first – I’ll get you good and hard. We can try different condoms and try different positions to see which we like best.” (Trojan, Condoms: Saying no to no condoms).

The recommendations to manage men’s anxieties about their sexual pleasure and performance appear in an article titled “saying no to no condoms”: men’s excuses are constructed as something that must be overcome to ensure that condoms are used.

Women are encouraged, through scripts and guides, to ease her male partner's concerns about the negative impact condoms may have on his performance and pleasure. It is up to women to flirt and use the promise of sex to ensure men's compliance with safe sex standards.

Young women's pleasure and entitlement to enjoyable sex are constructed through discussions about condom use as being beneficial to men. There is a utility to young women's sexuality and desire in this regard: women are encouraged to frame the need for protection and care through the use of condoms as a way to make sex more pleasurable for both themselves and their male partners. Indeed, protected sex is discursively constructed as more enjoyable than unprotected sex: the SOGC identifies that worrying about STI transmission interferes with sexual enjoyment, and that using condoms can ease this worry.

One of the big things to make clear is that sex without a condom makes you worried about yourself and about him. Tell him that you just wouldn't be able to relax or enjoy sex without a condom - and let him know that if you can enjoy sex more, there's a good chance he will too (SOGC, Male Condom: How do I protect myself from STIs-STDs).

This example works to construct young women as entitled to a particular kind of sex: namely, sex that is made safe, relaxed, and enjoyable through the use of condoms. Young women are prepared by the websites in my sample to anticipate and respond to men's resistance to wearing condoms: she must "make clear" that condoms are a requirement, but she must do so in a way that is palatable to men. Her enjoyment of sex is deployed to reassure men that protected sex, using condoms, will be enjoyable for them as well.

6.4 Conclusion

In this chapter, I discussed how young women's sexual subjectivities are constructed by the websites in my sample. Young women have been described through the discourse as physically vulnerable to the risks of sexual activity, and as fully capable of responding to these risks by seeking out information and making good choices. Young women are constructed as sexually savvy: they are mobilized to take on the neoliberal responsibility of self-care without compromising their postfeminist right to sexual pleasure. Sexual pleasure is accessed through women's control over contraception, including condoms, for worry-free sex. However, this postfeminist understanding of pleasure relies on a conservative understanding of gendered stereotypes: while women are described as invested in the emotional and intimate aspects of sex and relationships, men are described as incapable of controlling their own sexuality. In the next chapter, I discuss my results in relation to the theoretical literature on neoliberalism, healthism, and postfeminism.

Chapter 7

7 Discussion

In this dissertation, I used critical discourse analysis to examine the discursive constructions that are produced by websites offering sexual health information. Websites that offer this information to a general, lay audience were selected to examine how sexual health is conceptualized for Canadians from a variety of different sources and perspectives. Accordingly, I included the following websites in my sample: Canadians for Choice, Healthy Canadians, the National Aboriginal Health Organization (NAHO), the Society of Obstetricians and Gynaecologists of Canada's (SOGC) Sexuality and U, and Trojan's We Know Sex. Across my sample, a non-profit organization, government, special interest group, professional health organization, and commercial corporation are represented, respectively, as having an interest in disseminating sexual health information. In so doing, these websites contribute to an emerging discourse on sexual health, defining its parameters and exclusions, and with specific implications for the construction of female sexuality.

I Identified three main discursive constructions: (i) the discursive construction of an imperative of good sexual health; (ii) the discursive construction of a choice-making subject; and (iii) the discursive construction of the sexually savvy subject. In Chapter 4, I examined discourses which position regular sexual activity as an important component of good health and well-being. In Chapter 5, I examined and explored discourses which position young adults as responsible for acquiring health information, and using that information to inform the choices and actions they must make to achieve good sexual health. In Chapter 6, I examined how the expectation to maintain good sexual health is gendered, and identified discourses which encourage young women to utilize their sexuality to ensure men's compliance with safe sex standards. In the discussion that follows, I interpret these findings in relation to theoretical literature on neoliberal healthism and postfeminism, which I reviewed at the beginning of this dissertation.

7.1 Ideal Sexual Health and the Postfeminist Subject

As I reviewed at the beginning of this dissertation, the subject operating within neoliberal healthism and within postfeminism is an empowered individual: the individual is positioned as an ideal choice-making agent, capable of taking care of her own needs, without outside (financial) support from government or other social agencies. In contemporary Canadian society, as elsewhere, individuals are expected to take on increasing responsibility for their own health and to conform to particular lifestyle requirements in order to avoid or mitigate risk and thereby qualify as a good citizen, deserving of state-funded health resources, including health care should they fall ill. Postfeminism provides an additional framework for understanding how and why healthism is taken up by young women. Through its celebration of girl power and its emphasis on the power of choice, postfeminism works with healthist discourses, including those of sexual health, to provide young women with a way to exercise their obligation to pursue good health by becoming good choice making subjects: a required and desirable skill in a neoliberal society.

The postfeminist subject is also entitled to new freedoms. Namely, she has access to discourses on health that are increasingly understood through discourses of consumerism: although she is responsible for making the right choices in her own life, she is also entitled to exercise choice and select the products and services that will best serve her needs. Additionally, the postfeminist subject is increasingly understood as entitled to sexual pleasure and self-directed sexual experiences, outside of the socially-sanctioned confines of marriage or reproduction. The relationship between neoliberal healthism and postfeminism could be characterized by tensions, where the neoliberal responsibility to manage (sexual) health risks is contrasted with the postfeminist right to pursue sexual pleasure and control reproduction. However, postfeminism is characterized by a conservatism that serves neoliberalism well. Postfeminism operates on the assumption that feminist work has been completed, and by claiming this “success”, operates to reject the continuing need to address the kind of structural inequities that feminism(s) aim to challenge. It is the individual actor, then, who is left to navigate the tensions between neoliberal responsibility and postfeminist sexual “freedoms”.

The three discursive constructions I identified and explored in my research on online sexual health information function to contain female (hetero)sexuality. Sex is simultaneously constructed as integral to overall health and as dangerous for young women in particular, and so conservative choices that support traditional gender roles are ultimately promoted by the websites in my sample. Readers are told that although sex is good and healthy, the best sex is sex that occurs within committed, monogamous relationships, with protection and following medical screening. The subject position produced by these discourses is akin to Dubriwny's (2013) vulnerable empowered woman, a subject who is empowered in relation to specific sexual risks, but whose empowerment "consistently returns women to the most traditional of gender roles: naïve daughters, passive wives, and nurturing mothers" (25). Harris (2004a) similarly identifies the "can-do" girl as the young women who seizes her potential for success: through "good choices, effort, and ambition alone", she is able to overcome the "socioeconomic conditions of late modernity [that] have created unequally distributed opportunities and impediments for young women" (16). Crucially, the can-do girl navigates her sexuality in a way that allows her to delay pregnancy until she is financially fit to support a child. In other words, through individual will, she is able to avoid the subject position of the "at-risk" girl, vulnerable to risk-taking and the (often racialized) failure associated with teenage pregnancy.

Discourses on health risk functions as an engine to drive behavioural change, inciting young women to seek health information and make appropriate changes to their lifestyle based on that information. Crawford (1980, 2004) and Lupton (1994b) each outline how the drive to gain control in a risk society characterizes healthism. When considering discourses on sexual health, the risks associated with sex (namely, STI transmission, unintended pregnancy, but also sexual assault and discrimination based on sexual identity) come into sharper focus. My analysis illustrates how "no risk" is constructed by the websites in my sample as an impossibility when it comes to sex. However, risk management is constructed as a palatable task through postfeminist discourses, which makes the demands and responsibilities expected by neoliberal healthism more attractive

to a savvy generation of young women who have grown up knowing that they are entitled to sexual pleasure. Through healthism and postfeminist framings, the pleasure of sex (or the promise of it) joins risk discourse to mobilize young women to take charge of their health. Thus, although young women are positioned as uniquely at risk of the effects of sex, they are also positioned as uniquely capable of overcoming those risks: young women are promised the best sex, if only they do the work of managing and controlling risk.

7.2 Sexualized Display: Sex for Health as an Imperative Through Postfeminism

The discourses I examine from the websites in my sample reflect aspects of the sexual revolution in that they re-orient discussion about sex and sexuality from shame to pleasure (Seidman 1989). In other words, sex is positioned as a morally sound activity even when it does not occur in the context of heterosexual marriage for the purpose of procreation. The introduction of the birth control pill in the 1960s aided this project: the uncoupling of (hetero) sex from reproduction allowed (and allows) women to pursue sex for pleasure (Clarke 2009). Attwood (2011) points to the visibility of feminist discourse in public and popular culture, which “worked to challenge the norm of women’s sexual passivity and compliance, making it possible to imagine sex as a source of strength and independence” (205). However, sex and pleasure are heralded as obligatory pursuits within a postfeminist culture (and postfeminist media culture in particular). Levy (2005) argues that contemporary society is characterized by a proliferation of “raunch culture”, where young women are encouraged to express and display a particularly exhibitionist sexuality as a marker of their status as strong, powerful women. This exhibitionist sexuality is more about display, not necessarily about pleasure. The demonstration of sexual agency, desire, and work on the body has joined “older markers of femininity such as homemaking skills and maternal instincts” to become central to the development of young women’s femininities (Attwood 2011, 203).

The results of my discourse analysis illustrate how the obligation of sexual display joins the obligation to be healthy in neoliberal, postfeminist contexts, and act as central components of young women's identity and politics. According to Crawford's (1980) notion of healthism, the individual pursuit of health has become a primary focus for an individual's demonstration of moral worth and deserving citizenship in neoliberal society. Indeed, women are incited by popular discourses, such as women's magazines, to be morally responsible for pursuing good health for themselves (Roy 2008). As my analysis suggests, sexual health is increasingly understood as an integral part of the pursuit of overall health, just as sexual activity and display is understood as an integral part of a postfeminist subjectivity. In other words, having a "healthy" sex life, particularly within a monogamous, committed relationship, is understood as an important lifestyle factor that should be maintained and enhanced. In the websites offering sexual health information in my sample, a "healthy" sex life is one that is characterized as minimally risky as well as active and pleasurable, and one that must be corrected if it fails to live up to this standard. These sexual goals are reflected in the definitions of sexual health offered by many of the websites in my sample, and also appear prominently in the advice offered to women who are expected to navigate the risks of STI transmission and who may experience low or a lack of sexual desire. The postfeminist assumption of the sexual revolution acknowledges women's increased sexual freedoms, but in so doing, extends healthism to include the project of sex.

Despite (and because of) these increased freedoms and obligations, the discourses in my study work to medicalize sex: sexual expression is constructed as a route to good health and healthy relationships. In Chapter 4, I outlined how sexual health and sexual activity contribute to an individual's overall health and well-being.¹⁴ The websites in my sample

¹⁴ My focus in this dissertation is on young adults and young women in particular, but discourses on the medicalization of sex are applied across the life course. The SOGC and Healthy Canadians both included articles on seniors and sex, stressing that regular sexual activity was an important way for seniors to maintain and express overall health, and to ease the effects of aging-related health problems. The SOGC asserts that "As we age, our bodies change and we may encounter health issues that affect our sexual activity. In some extreme cases, being sexually active is no longer possible, but in many cases being sexually active may even help you cope with the health challenges you now have to negotiate" (SOGC, Challenges related to aging: Sex over 50). Healthy Canadians agrees, and states that "Some studies

rely on a common-sense understanding of overall health as good to situate sexual health as just as important for readers to consider. Cacchioni and Tiefer (2012) similarly discuss how sexual life and conduct has been increasingly understood through discourses of health and medicine; however, as my analysis demonstrates, this medicalization is not necessarily a matter of managing sexual dysfunction (however defined), but of encouraging particular forms of sexual activity (that is, frequent and monogamous intercourse) for healthy citizenship. The medicalization of sex is not limited to professional intervention or medical treatment, but extends to personal activity (Cacchioni and Tiefer 2012, 307). In other words, healthist accounts, characterized by medicalization, encourage individuals to manage their individual lives and choices with regard to their good health, including when those healthful decisions (e.g., to have sex to maintain a healthy relationship) do not need to take place within the confines of a doctor's office. Medicalization is extended into the realm of the everyday through sexual activity and discourses on risk.

The websites included in my sample frame everyday lifestyle concerns as sexual health concerns. For example, drug and alcohol use is addressed in several different ways by the websites in my sample. In addition to the role it can play in facilitating sexual assault, drugs are indicated as a risk factor for STI transmission when taken intravenously, using shared needles. Trojan also discusses alcohol and drug use in the context of an article on "healthy living", advising that limiting use of these substances can support one's overall and sexual health. Three of the websites in my sample also addressed body image as an important factor impacting affecting sexual health. For NAHO, body image was affected by stereotypical representation of Aboriginal peoples in the media; combined with the SOGC and Trojan, each of these websites indicated that having a poor body image can impact one's ability to positively experience or enjoy sexual experiences, or to feel confident initiating conversation about sexual health needs with sexual partners or with medical professionals. Discussions about body image and about maladjusted personal coping mechanisms (e.g., drug or alcohol use) are rolled

suggest that sex about three times a week can slow aging and prevent wrinkles around the eyes" (Healthy Canadians, Seniors and aging: sexual activity).

together in ways that elide the systemic nature of some of these issues (e.g., racism in media and society): regardless of the issue, individuals are mobilized to manage their physical health and well-being in order to achieve good sexual health.

There is a unique interplay between the obligation for sex and the obligation for health that complicates the ability to freely “choose” sex. In her discussion of the sexualisation of the medical, Segal (2012) argues that there is an equation of sex and health that has been framed as a kind of feminism through popular culture (369). Through the medicalization of sex (and the sexualisation of the medical), health is established as the “cultural/discursive home for sex”, where “healthy adults are sexual adults, and sexual adults are healthy adults” (Segal 2012, 376). The arguments that sex is healthy, or that sex is an expression of liberated feminist values, makes declining sex (or having sex that is constructed as “unhealthy” or “deviant”) more difficult. When sex is medicalized, “then not having sex, or not having a particular kind of sex, can be pathologized” (Segal 2012, 369). For an example from the websites included in my sample, Trojan identifies several “problems” that men and women may experience, including erection trouble, trouble having an orgasm, or pain during sex; these problems are pathologized, as Trojan suggests that readers should consult with doctors, counsellors, or other medical professionals so that regular sexual activity can resume. Gupta (2011) identifies that “although the ‘sex for health’ discourse may serve to de-stigmatize sexual activity for some, it may also increase pressure on others to be sexually active and may further pathologize sexual ‘dysfunction’” (127).

Discourses of healthism and medicalization that equate sex and health work to construct the maintenance of regular sexual activity as paramount. However, much writing on the medicalization of sex stops short of discussing this equation of sex and health in terms of its implications for sexual assault and consent. Through the discursive construction of an imperative of good sexual health, my results indicate that sexual activity within a relationship is promoted without regard for power relations and imbalances, ones that often operate on the axis of gender. In Trojan and the SOGC’s discussion of differing levels of desire in a relationship, these power imbalances are virtually ignored and erased

through the use of seemingly progressive gender-neutral language. Trojan advises that couples should communicate about their different levels of desire to avoid hurt feelings: here, the absence of desire (and the less frequent sexual activity that results from it) is constructed as a threat to the emotional health of a relationship. The SOGC more explicitly advises that readers who experience lower levels of desire should “be willing to start lovemaking from a sexually neutral state” in support of a healthy relationship. In this context, “consenting” to sex in the absence of subjective desire for that sex is taken for granted as a normal, healthy option for couples (and women) to pursue. The argument that sex should be consented to in the name of love contributes to the medicalization of sex, where the health of a relationship is positioned as the highest priority.

This medicalization of low desire contrasts sharply with the discursive construction of sexual assault as regrettable sex, which outlines particular responsibilities for young women including following a variety of “safety tips” and clearly communicating their boundaries and (lack of) consent. The focus on safety tips places a disproportionate burden on young women to identify and avoid their own victimization, and upholds the impossible standard women must meet to be believed as not at fault when victimization does occur.¹⁵ Sex that couples have in a relationship, even in the absence of desire, is not constructed as regrettable. Consent is redefined: it is healthy (and therefore good) to have sex that is not wanted out of a sense of desire. Rather, a different definition of want and desire is constructed: sex is consensual if it is had in service of a relationship, or to attain a standard of sexual health where sexual health is defined as regular sexual activity. Additionally, this redefinition of consent supports a heterosexist narrative where women trade sex for relationships. Through the medicalization of sex and through postfeminist subjectivities that rely on an active display of sexual freedom, young women face a discursive obligation to participate in sexual activity.

¹⁵ See Harding (2015) and Friedman and Valenti (2008) for a discussion of how rape culture impacts our ability to believe women when they come forward to speak about experiences of sexual assault.

I offer this discussion in order to critique of a model of consent for sexual activity that positions sex as an obligation for young women in the name of health. I do not intend to imply that sex is only consensual when subjective desire is present. Allen (2012) indicates that discourses of desire in sexuality education carry the risk of positioning pleasure as an imperative, which produces a standard that “sexual activity should be engaged in only if it is pleasurable” (464). Allen goes on to argue that the pleasure imperative:

ignores the complexities of sexual activity and paradoxically accords young people a restricted exercise of agency. Sexual activity is often actively and purposively engaged in for reasons other than personal pleasure. It can serve as a means of attaining something else we want, like money, a child, some sleep, peer status, emotional security, to feel desired, to be ‘normal’, to pleasure someone else (rather than ourselves), to heal (ourselves or someone else) or to hurt (ourselves or others). Privileging the attainment of personal pleasure as a reason to engage in sexual activity not only eclipses other reasons for this practice, but invalidates them. Who says pleasure is the best and most valid reason to engage in sexual activity? What moral judgements are cast on other motivations for sexual practice when this one is promoted? (Allen 2012, 464).

In their interviews with young women negotiating sexual agency and desire in romantic relationships, Brown-Bowers, Gurevich, Vasilovsky, Cosma, and Matti (2015) found that women described having sex in their relationships in order to achieve a range of goals, and not exclusively in response to subjective sexual desire (12). These goals included having sex in order to tend to and maintain the well-being of their partner and of the relationship [...] having sex for individual health benefits [...] and] trading sex for psychological or material gains” (12).

I recognize that through the discourse on differing levels of desire in a relationship, the SOGC and Trojan could be contributing to an expansion of the reasons young women might be having sex, perhaps challenging the “pleasure imperative” that Allen (2012)

identifies. However, sex remains an imperative, as mismatched levels of desire is not identified as a potential cause for a couple to break up in any of the websites in my sample. Although I do not cite these examples in my results, NAHO indicates that healthy relationships include boundaries about how individuals want to be touched, and that relationships in which “You’re afraid to say ‘no’ to sex or sexual activities” are unhealthy (NAHO, 10 Things to Know About Healthy Relationships). However, the NAHO fact sheet on healthy relationships stops short of using language like “break up” when discussing abuse, instead referring readers to domestic violence hotlines. While extracting oneself from an abusive relationship is dangerous, breaking up is not even named as an option that could be (carefully) considered. Additionally, the SOGC indicates that healthy relationships require acceptance:

You accept each other as you are. You appreciate your partner’s unique qualities, such as shyness or spaceyness, and don’t try to “fix” them. If you don’t like your partner’s qualities, you shouldn’t be with that person (SOGC, Healthy Relationships: How do I know I am ready for sex).

In this example, readers are told that they should consider not being with a person whose qualities they cannot accept. These qualities include shyness or “spaceyness”; leaving a partner whose desire does not match yours is not listed as an option. The only “healthy” response to a lack of desire acknowledged by the websites in my sample is to engage in sex anyway.

7.2.1 Conservative Choices: STI Risk and Healthy Relationships

When the websites offering sexual health information turn to address the young women in its audience, there is a tension between the postfeminist promise of and obligation to a sex life and the use of fear to ensure that those young women will not start having sex too early. This reflects the ways in which discourses of sexual liberation and freedom that emerged following the sexual revolution were quickly rejoined by discourses which focused on the “increasingly dire threats to life and health posed by various sexually transmitted infections, including HIV/AIDS” (Clarke 2009, 416). Concerns over the physical impact of sexual freedom were also accompanied by a moral panic, particularly

as it concerned youth. Seidman (1989) argues that sexual liberation faced a backlash that held the movement responsible for a range of social ills including teenage pregnancy, herpes, and premarital sex (293). Contemporary discourses on youth sexual health also position youth as mentally, physically, and emotionally vulnerable to the risks that accompany sexual activity, and therefore in need of regulation and protection. It is in this context that young women navigate conflicting discourses of sexual pleasure and freedom, and sexual risk and responsibility.

The moral regulation of sexuality, no longer palatable in a 'liberated', postfeminist era, is rejoined by a moral regulation of health, through which individuals are encouraged to manage their sexuality through conservative choices. This is particularly the case as we consider the role that healthism and the medicalization of sex has played in common-sense understandings of sex. Sex and health are understood as complementary, not contradictory, although risk remains part of our conceptualization of sex. Cacchioni and Tiefer (2012) cite Conrad and Schneider (1980) to indicate that the medicalization of sex "has its origins in the late 19th century when many aspects of life previously seen in terms of 'badness' were now framed in terms of 'sickness'" (308). My findings illustrate how youth sexuality is situated within and constructed by these conflicting discourses of freedom and regulation, and how young women are ultimately responsabilized to manage threats to their sexual health within this complex set of discourses that emanate from multiple sources. Fear, of course, remains present in constructions of sexual health employed to conceptualize consequences to health and to encourage these choices. This is reflected in my results, where substantial emphasis is placed by these websites on warning readers of the physical ailments following sexual activity (and the transmission of STIs that were sure to follow), including illness, pain, infertility, and death.

Sexual risks are clearly outlined for readers, and this discussion revitalizes the moral panic of youth sexuality, re-framing it as a moral concern about health: for example, the SOGC indicates that "HPV is usually acquired at a young age at the time of sexual debut", and follows this by stating that girls "as young as 12 and 13" are engaging in oral sex. Through the phrase "as young as", the SOGC references concerns about "rainbow

parties”, “more or less organized oral-sex games” where a group of teenage girls would apply various shades of lipstick and perform oral sex on their male peers (Best and Bogle 2014, 32). Tying this discussion to HPV risk works to elide questions about the morality of early sexual debut, and constructs sexual activity as a health issue. In addition, this focus on health risk obscures discussions that may be had about women’s pleasure (the desire or willingness to engage in sex acts at a young age), and elides questions about queerness. While the passage from the SOGC does not necessarily leave out the possibility of girls having oral sex with each other, it does not name same-sex activity either; there is also an absence of discussion on oral sex practices among boys – either boys performing oral sex on girls or between boys with other boys. The websites do identify queerness as a risky sexual identity, but the concern and panic surrounds young, heterosexual girls, who because of their position or identity may have the tools to mitigate or, at least, delay the consequences of that risk.

Informed by the imperatives of healthism, the project of sex operates to facilitate and maintain as acceptable certain types of relationships for young women: they are encouraged to build monogamous, long-term relationships in which to have sex. Additionally, the intersection of sex and health relies on a normative understanding of sexual behaviour: Gupta (2011) identifies that an emphasis on the health benefits of “coitus in the context of a monogamous heterosexual partnership” is promoted “at the expense of non-normative sexual desires, identities, and practices” (127). To engage in these “non-normative” sexual activities (e.g., to engage in casual “oral sex parties”) would risk jeopardizing the health of young women. Importantly, abstinence is repeatedly described as an unrealistic standard by the websites in my sample, particularly by the SOGC and Trojan. Parents, doctors, schools, and other institutions invested in the regulation of young peoples’ sexuality no longer exclusively operate with the mandate to have those young people have less sex, but work instead to encourage young people to have the right kind of sex, using protection.

Young women are being prepared in the “right” ways to enter a postfeminist culture characterized by increasing sexualisation and an obligation to pursue good sex. The

avoidance of STIs and pregnancy through monogamous and protected sex is positioned as the “right” kind of sex by the websites in my sample. However, even sexual monogamy carries with it some degree of risk. Readers are reminded by websites like Trojan, NAHO, and the SOGC that relationships, even (or perhaps especially) new relationships, are not necessarily going to last forever. The discourse produced by the websites challenges the notion that true love waits (e.g., until marriage for sex): in the early stages of relationships, sexual activity is a real and present possibility, while discussion of marriage is almost entirely absent. There is an acknowledgement (and acceptance) that young people have sex, and are very likely to do so with several subsequent sexual partners. However, young people are also constructed as a little bit foolish in love, incorrectly trusting that each relationship will last. According to the discourse, this trust leads to risky sexual behaviours: believing that your sexual partner (and you) is free of STIs in the absence of medical testing and believing that your sexual partner will be faithful results in a belief that condom use is not necessary.

Trust, then, is constructed as a threat to health among young adults who are described as not knowing any better: if young people only knew how fleeting love and sexual relationships were, they could be convinced to use protection with every partner. Further, the discourse on sexual health establishes a threshold for trust: the SOGC and to a lesser extent, Trojan, concede that there are some circumstances under which unprotected sex with a partner may not be considered a risky behaviour. This threshold is almost impossible to achieve, however: the SOGC advises that young women may consider having sex without a condom with a partner only if he has already tested negative for STIs and if he has “proven himself worthy of your trust”. Barrier-free (but still healthy) sex is constructed as a prize for young women to reward men with. Young women are still caught up in old narratives that expect them to be gatekeepers of their own sexuality, warding off the wrong kind of (untrustworthy) men and rewarding the right kind of men with sex.

By introducing a discussion on serial monogamy, these websites subtly de-stigmatize the discourse on promiscuity and shift the focus away from moral panics about sex. The

moral argument against sleeping with multiple people is minimized, while the discourse works to expand the population of people who should be worried about STI transmission to include anyone who has ever engaged in any sex act. It is not just the “bad girl” who is at risk, and so therefore, even “good girls” should be concerned about their health. Polzer and Knabe (2009) discuss this expansion of risk (and how that expansion functions to encourage young women to make particular medical choices) in terms of HPV vaccination. They argue that media representations of the HPV vaccine “communicate a potent message that concerns about sexually transmitted infection (STI) are no longer restricted to sexually active ‘bad girls’” (Polzer and Knabe 2009, 869). In so doing, these media representations “firmly yet carefully inscribes the not-yet-sexually-active ‘good girl’ as the primary target” for vaccination, and positions this girl as needing to make the “right” and “smart” choice to get vaccinated (Polzer and Knabe 2009, 869).

The discussion of serial monogamy as a threat to sexual health that emerged in my sample thus appeals to a wide population of “good girls” in its audience: young women who are invested in following the “right” heterosexual dating script based in monogamous love, but who are doing it “wrong” by not being in sexual relationships that last and thus exposing themselves to risk with each new partner. Shifting the focus from moral judgement about sexual promiscuity facilitates the expansion of young women’s moral responsibility to look after their own (and their partners’) health. Through the consistent discursive emphasis on the prevention of STIs, readers are instructed to undergo regular medical testing, abstain from sex while receiving treatment, ask their sexual partner about their sexual history, and use condoms. When prevention fails, however, readers are tasked with the moral and legal responsibility to disclose any STI they may have contracted to future, and in some instances, previous sexual partners.

Disclosure is constructed as an opportunity to care for the self and for one’s partner: it is important not only for physical health, but for the health of the relationship. Conversations with partners are described as uncomfortable yet important, and easier to conduct with a dating partner where trust and open communication already characterize the relationship. Indeed, monogamy and partnership are upheld as key to good health

when individuals must negotiate an STI-positive status. Disclosing an STI to a sexual partner is described as difficult, but this difficulty must be overcome for the greater good of health: the SOGC stresses the legal responsibility that individuals with HIV have to communicate with their sexual partner, and Trojan dismisses the difficulty of these conversations as less embarrassing or uncomfortable than “actually getting” an STI. Ultimately, these conversations serve to test and support the health of a relationship: although readers may not initially receive a positive reaction from their partner, anyone who will judge the reader for having an STI is not worth being in a relationship with.¹⁶ Through disclosure, readers are told that they are still able to access good sexual health: regular sexual activity is possible with an STI if you make the appropriate disclosure and your partner accepts the risk.

There is very little attention paid by any of the websites in my sample to what happens in a relationship following this disclosure and acceptance. Further, many important details of this conversation are omitted. What might it look like to talk a partner through their fears if they do not have an STI and you do? How do you negotiate accepting a certain amount of risk with the knowledge that this relationship may not be forever? Canadians for Choice discusses chronic STIs like HIV and the possibilities of leading a fulfilling life including an active sex life but does not talk about serodiscordant relationships, and none of the websites in my sample discuss the role that pre-exposure prophylaxis (PrEP) might play for those who are HIV-negative (Wilton 2015). The advice on how best to discuss and disclose STIs, and to have a partner that is able to accept the risk, operates on the assumption that this relationship is, in fact, a relationship. Readers receive no guidance on how to disclose an STI in the context of casual sex. This silence reinforces

¹⁶ Open, honest, and in-person communication is constructed as a required characteristic to support the “healthy” continuation of a new or ongoing relationship. It is the responsibility of the person with an STI to discuss and disclose their STI status with their partner. However, the responsibility to inform takes a different shape when considering previous partners: both Healthy Canadians and NAHO indicate that individuals have the option of having a public health nurse call and inform previous sexual partners of their potential exposure to an STI. In this scenario, the health of previous relationships does not need to be tested or supported, as the relationship has already ended, and so more impersonal methods of communication are constructed as an adequate exercise of an individual’s responsibility regarding their STI status.

conservative choices: monogamous sex in a committed relationship is constructed as the best and healthiest choice to manage and mitigate risk.

7.2.2 Preserving Future Fertility and Future Motherhood

Discourses that reflect a moral panic on youth sexuality present young women as particularly vulnerable to the risks of sexual activity. Young women are repeatedly identified across the websites in my sample as more likely to bear the consequences of sexual activity in terms of STI transmission and symptoms: for example, Healthy Canadians states that STIs tend to be more common in women than in men, whereas Trojan attributes this to the efficiency of STI transmission from men to women, pointing to the biological differences (and vulnerabilities) between men and women. However, the websites do not comment on whether or not such differences may reflect how STIs present symptoms in women versus men, nor do they situate incidence rates in the context of the various ways in which women's bodies have been more routinely subjected to medical surveillance (e.g., Pap smears and related pelvic examinations). There is similarly little context provided regarding the gendered nature of the symptoms or consequences of untreated STIs: the websites stress that women in particular need to be concerned about STIs and the health effects these have on them, including the risk of infertility.

The subject position offered to young women in the discourse on STI risk and infertility is that of Dubriwny's (2013) vulnerable empowered woman: through the right kind of care and diligence for her health, she is capable of taking on and avoiding risks to her fertility. However, the advice offered by the websites in my sample urge her to action in ways that reinforce the traditional gender roles offered to women: namely, that of a nurturing mother. Through discourses of STI risk, the role of mother is extended to apply to young women prior to pregnancy: young women are pre-pregnant, and pre-mothers, who must work to avoid STI risk because of the risk not only to her own fertility, but to the health (and life) of the child through transmission during pregnancy or childbirth. Certainly, many young women are concerned themselves about future fertility, and desire

motherhood. Young women are constructed as future mothers whose primary motivation is to preserve their fertility so that they may have children when the time is right.

Within this discourse of sexual health, the vulnerable empowered woman that Dubriwny notes in her examination of popular discourses on breast cancer risk is thus extended to include the subject position of the vulnerable empowered girl who is a potential site of health risk and empowerment as a sexual agent. This sexual agent-in-the-making is informed by the way in which postfeminism celebrates the girl: she is the one who leaves the boys behind in school, aspires for professional greatness, and participates in the consumer market. As reflected in the websites included in my sample, this sexual agent-in-the-making also plans for and minimizes exposure to STI risk to protect her own health, the health of her partner, and the health of her fertility and future children. The vulnerable empowered girl also reflects Harris' (2004a) "can-do" girl, who makes the good choice to plan her pregnancy for a time when she is best suited to support the child (23). Can-do girls are encouraged to delay childbearing until their careers are established and they are able to raise those children in the "right" kind of lifestyle, one that does not require state- or government-support. Teen motherhood, even (and perhaps especially) if it is planned is always read as a mistake, and "is frequently and simplistically correlated with certain class and race characteristics in ways such that Blackness and poverty, for example, are seen to somehow cause young women to be willful, wanton, and stupid" (Harris 2004a, 30). However, young women are not to renounce motherhood altogether: indeed, they are warned that they must not wait until it is "too late" to have children (Harris 2004a, 23).¹⁷ The timing of motherhood that Harris discusses concerns the age

¹⁷ Harris (2004a) argues that "new concerns about falling birth rates and young women renouncing childbearing altogether have led to state intervention in the lives of young professional women in unprecedented ways...fertility is something that must be preserved in order to be used later" (24). In addition to state intervention, private corporations including Apple and Facebook are now offering to pay for elective egg freezing to its female employees "in an effort to attract more women on to their staff" (Tran 2014). News coverage on this issue varies; although some articles have indicated that egg freezing "might be a way for women to build their careers and their personal lives on a timetable of their own choice – not dictated by biology" (Bennett 2014), others indicate that that this seemingly "progressive" perk is offered by businesses "seeking to shape women's reproductive choices via monetary incentives dressed up as empowerment initiatives" (Henderson 2014). The racialized dimension of Harris' arguments are telling in this context. Apple, Facebook, and other high-profile technology corporations are disproportionately staffed by white men, with women and racial minorities making up a growing but

(and assumed financial stability) of a mother, whereas my results indicate that “too late” might follow from the consequences of an undetected or untreated STI. There is a standard of “readiness” constructed by the websites included in my study, where the physical ability to get (a partner) pregnant does not translate into preparedness to raise a child. Financial ability is not discussed explicitly in my sample, but there is an implicit assumption that runs through a variety of topics (including articles that discuss puberty, STIs, and birth control) that while ‘now’ is not the best time to get pregnant, there are future plans to have a child.

7.3 Sexual Subjectivities and Responsibilities for Sexual Health: Seeking Postfeminist Control in a Risk Society

In the discussion above, I described how neoliberal healthism works through discourses on sexual health to reflect a common-sense understanding of sex as an issue of health (Segal 2012). Through the discursive relationships that I have traced between sex, health, and postfeminism, young women must navigate increasing pressures and obligations to have the right kind of sex with the right partner. In addition to the construction that sex should be pursued in support of physical and relationship health, young women must also navigate the expectation that in a postfeminist climate, they are entitled to and expected to display their enjoyment of sexual freedom. In the following section, I explore the relationship between health and postfeminism in more depth by examining how discourses of pleasure combine with discourses of risk to construct the work of safe sex as women’s work in particular.

One thing that keeps postfeminism from being a mere extension of the evolving nature of feminism is that it reinforces the idea that socially constructed differences between the sexes are essential, natural, and advantageous differences. Frequently and historically, these differences are used to depict women as inferior to men: women are understood to

still small portion of the workforce (Mihalcik 2016). Fertility preservation appears both as an incentive and perk for women assumed to become mothers in the future, while the fact that this financial incentive is tied to employment at corporations that do not hire many women of colour means that this option is out of reach for many.

be more natural caregivers, and so they should (only) remain in the home to raise families while men engage in paid labour outside of the home; women are understood to be physically weaker than men, and so they are less suited to professions such as firefighting that require a certain amount of strength; women are understood to be more emotional, and so their intellectual contributions are less valued and less supported in a range of educational and technical fields of work and study. The ways this constructed hierarchy limits women's lives are compounded when we consider the experiences of women of colour, women with disabilities, queer women, and so on. Within a postfeminist sensibility, (some of) these differences are presented as worthy of celebration: rather than using these differences to depict women as inferior to men, women's differences are understood to make them unique from men. Women's femininity, gentleness, and softness are what makes them special, and women's queerness, for example, gives them the opportunity to be a role model for others; these qualities also encompass a particular set of skills that can be perfected. The proliferation of cooking shows and women's lifestyle empires demonstrates an aspirational standard for a traditional sexual division of labour, where women are able to pursue domestic activities for their own pleasure and, in some cases, for fame or financial success (Hollows 2005).

Because the postfeminist subject is a sexual subject, the feminine skills most celebrated in young women are their sexual skills. The expectation that women should be sexually available to men is re-framed, whereby women are told to perfect their sexual skills and receive the pleasure they deserve. For example, young women are guided through the websites included in my sample to select a birth control method that will best facilitate spontaneous sex so that their sexual pleasure is not interrupted. As I have shown, these sexual skills look very similar to the work women are otherwise expected to conduct within their (hetero)sexual relationships: women should worry about contraception and STI prevention, engage in emotional labour, and select one monogamous partner. In many ways, the online sexual health discourse acknowledges a significant shift in women's sexuality: women are not merely laying back, frigid, and thinking of England while their husbands have sex with them. Women are enjoying increasing sexual freedom and reduced stigma surrounding sexuality, and are capable of negotiating a wide

variety of sexual relationships and scenarios. However, the discourse reveals that this negotiation is for women alone to manage, while men remain depicted as hapless, helpless, and untrustworthy sexual partners. In a climate marked by the genuine gains of sexual freedom and women's liberation, fear-based discourses are joined by discourses of sexual pleasure to regulate the abject bodies of young women (Clarke 2009). Thus, the online discourse on sexual health operates to responsabilize young women to choose conservative sex norms through promises of increased sexual pleasure.

Allen (2012) outlines how pleasure has been increasingly incorporated into sexual education curriculum following critiques about its exclusion, most notably those advanced by Fine (1988). The inclusion of pleasure in sexuality education (or information) has the potential to “enhance young people’s experience of sexuality”, and expand our collective “understanding that sexual health is more than being ‘disease-free’” (Allen 2012, 459). Lamb, Lustig, and Graling (2013) also indicate that discussions of the pleasures of sex in sexuality education curricula can go “far to undermine the link between shame and sex that has been present in a number of eras of sex education” (315). Tolman and Higgins (1996) outline the cultural (and legal) sanctions on teenage girls’ sexuality which produce a simple dichotomy whereby good girls are not sexual, and “girls who are sexual are either (1) bad girls, if they have been active, desiring sexual agents or (2) good girls, who have been passively victimized by boys’ raging hormones” (206). Tolman and Higgins (1996) put this dichotomy, which operates to silence the desires of young women, into the context of sexual assault: the “absence of female desire stands as a prerequisite for the identification of a sexual act as rape” (210). If young women were afforded spaces to understand and explore their own experiences of pleasure and desire, the presence or absence of pleasure in a particular sexual encounter could empower them to speak out against or name experiences of assault (Tolman and Higgins 1996, 215).

However, Allen (2012) questions the way that the incorporation of a discourse of pleasure in sexuality education is frequently lauded as “progressive” and “liberatory” by focusing on how this discourse might be “‘being put to work’ in educational settings”

(455). Allen (2012) advises framing pleasure as a “legitimate possibility”, rather than an imperative that could function to re-inscribe normative masculinities and femininities: pleasure must still be considered in the context of cultural narratives whereby men are “expected to experience pleasure easily and display technique in coaxing sexual pleasure from their partners”, while young women are “caught within contemporary discourses of ‘girl power’ where they are expected to both want and achieve sexual pleasure while concurrently not appearing ‘slutty’” (463). Lamb et al (2013) similarly indicate that pleasure is “put to work” in particular ways by sexuality education curricula. In their article, the authors indicate that discussions of condom use integrated discourses of pleasure and safety, whereby the pleasure of sex was described as on par with the pleasure of taking care of the other person (Lamb et al 2013, 311). Pleasure is no longer ignored in sexual education curricula, but “the discourse around pleasure has various functions”; by situating discourses of pleasure with safe sex practices, sex (and pleasure) remains equated with risk and danger (Lamb et al 2013, 315).

There is evidence that “promoting pleasure alongside safer sex messaging can increase the consistent use of condoms and other forms of safer sex” (Philpott, Knerr, and Boydell 2006, 23). My results suggest that this evidence is being put into play by websites offering sexual health information: women are urged that engaging in safe sex can make sex more enjoyable for them. Condom use, and the use of other forms of birth control, are described as integral to a couple’s ability to enjoy sex without worrying (as much) about the risks that accompany it. Safe sex, however, is constructed as work that women must perform: women, in particular, are described as benefiting from having control over birth control. Canadians for Choice outlines several methods of birth control, including the pill or an IUD, which can be employed by a woman without needing to inform or negotiate with her partner. Canadians for Choice avoids spelling out the implications of this freedom: while women certainly have the right and the freedom to use the type of birth control they want without their male partner’s approval, there is no discussion of potential abuse or power issues in relationships where a woman must keep her reproductive choices to herself. Additionally, there is no broader discussion of the way that pregnancy impacts women in different ways than it impacts men, an issue I return to

in a section below. Rather, Canadians for Choice identifies that women's control over their birth control allows for both their own and men's pleasure through spontaneous sex. In this way, men's access to women's bodies and sexual pleasure is re-framed through a postfeminist lens in discourses of sexual health that emphasize the control of contraceptive methods by women, where both partners benefit equally from women's sole control over birth control.

Women benefit from having control over birth control – but, this control is framed through its ability to facilitate sexual pleasure (conceptualized through sexual spontaneity). Pleasure is additionally “put to work” by Trojan, which offers women ways to initiate sexual activity through the use of condoms. In contrast to Canadians for Choice, it is the very presence of and active negotiation over birth control that Trojan identifies as the avenue to pleasurable sex. The young woman who carries her own condoms is constructed as not only smart enough to take care of her own health (and the health of her partner), but as liberated enough to fulfill her subject position as an empowered, postfeminist sexual agent. The vulnerable young woman is entitled to pleasure, but her sexual subjectivity is constructed in relation to her responsibility to manage the dangers and risks of sexuality in terms of preventing pregnancy and STI transmission.

The presentation of young women as sexually agentic through their use of birth control – and the associated responsibility for sexual health that young women are expected to assume in the context of their (heterosexual) relationships – rests in contrast with how men are represented by the discourse: namely, men are consistently described as physically-oriented, concerned about their own physical pleasure over the emotional or communicative aspects of sex and sexual relationships. In my results, the discourse of pleasure shifts when it concerns men: although pleasure is offered to women as a way for them to make healthy choices regarding safe sex, men's pleasure is constructed as what Lamb et al (2013) would describe as “problematic pleasure” (312). Lamb et al (2013) identify that the abstinence-only curriculum they studied presented “sexual pleasure as an impediment to self-control” to teach students that “any sexual activity is dangerous

because, once started, a student might not be able to stop” (312). The authors continue, and state that “the uncontrollability of sex is not questioned or explored as an aspect that might make sex enjoyable. Moreover, in some sense the argument that sex is overwhelming and uncontrollable implies a biological, even animal model of sex, which is problematic” (Lamb et al 2013, 312).

Pleasure is constructed as a justification for women to assume responsibility for birth control; in contrast, pleasure is constructed as a justification for men to not assume this same responsibility. Tolman and Higgins (1996) identify the gendered nature of the uncontrollability of pleasure in their discussion of good girls and desire:

Perhaps more than any other group of men, teenage boys are assumed to be least in control of their sexuality. The responsibility for making sexual choices, therefore, falls to their partners, usually teenage girls, yet these ‘choices’ are to be enacted through passivity rather than agency. Girls who attain good girlhood are at constant risk of becoming bad girls if they fail in their obligation to regulate their own sexual behaviour and that of their partners (206).

Discourses of men’s uncontrolled sexuality also appear in my results: Canadians for Choice describes coitus interruptus or withdrawal as unreliable forms of birth control because men may get “carried away” during intercourse. Trojan expands on men’s supposed limitations, indicating that withdrawal is “completely reliant on the male partner’s ability and willingness to pull his penis out of the vagina before he ejaculates”. In this construction, men are not only overcome by their own pleasure, unable to stop even if they wanted to, but they are additionally described as potentially unwilling to interrupt their own pleasure. In response, readers are told to consider alternate and additional forms of birth control, including condoms and the pill or another form of hormonal contraception. Women, then, must take on the knowledge that men’s sexuality is uncontrolled and dangerous and act accordingly by taking on the responsibility for birth control.

Tolman and Higgins' (1996) observations about women's responsibilities to control and contain men's sexuality still carry weight today: however, this patriarchal expectation is re-framed through postfeminist promises of control and sexual pleasure and a flattening of gendered hierarchies. The construction of men as unreliable and out of control is not tied to gender roles or gendered narratives in the websites in my sample, and women's responsibilities are framed in terms of pleasure, rather than explicitly as obligations. Further, women face postfeminist expectations that they should share the responsibility for birth control through self-sexualization: the responsibility for birth control is exercised through what Harvey and Gill (2011) term "sexual entrepreneurship" (52). Through this subject position, young women are "incited to be compulsorily sexy and always 'up for it', and [are] interpellated through discourses in which sex is work that requires constant labour and reskilling" (Harvey and Gill 2011, 56). My results indicate that young women are lauded for their sexual skills, and advised to employ these skills to do the work of safe sex and ensure that their male partners comply with STI testing and condom use.

A postfeminist sensibility runs through discussions on safe sex, where gendered differences are positioned as an opportunity for men and women to share the responsibility for birth control, even as this responsibility is disproportionately placed on women. The recommendation to "share" the responsibility for birth control may become a more realistic recommendation if there were more birth control options available for men. Withdrawal and vasectomies were the only two birth control options identified by the websites in my sample that men could control exclusively (and in the case of withdrawal, an option that men are supposedly not capable of controlling at all). Although vasectomies were described as highly effective and capable of facilitating spontaneous sex, the permanent nature (and difficulty of reversal) of this option makes it an impractical choice for many young men and heterosexual couples who may wish to have children in the future. Silence surrounding the lack of birth control options for men operates in the discourse to reinforce gendered responsibilities.

7.3.1 Individualizing Entitlements and Obligations for Health

One interest I have in this project is to examine how feminism and feminist ideals are reflected within contemporary, mainstream thinking about young women's sexual health, as represented through the websites in my sample. In other words, I question the extent to which feminism has been "assumed" in the discourses found in online sexual health information. I argue, like many who have written before me, that feminism has created a lasting impact on the way we talk about and understand women's health. Increasingly, women are presented as having more say and more voice in their own experiences of ill- and good-health. This presentation is a result, in part, of a demand from a range of feminist activists for increased access to information and knowledge about women's own bodies and the institutional procedures through which health care is offered. Although the attention paid to women's health issues may be occurring in a social and political climate influenced by some feminist gains, this attention is not necessarily operating in a way that contributes to feminist movements. For example, King (2006) is critical of the way that some breast cancer research and fundraising efforts operate in ways that are pro-woman but not pro-feminist. Further, medicalizing discourses have proliferated through society beyond health care and medical situations through discourses on risk, whereby individuals are understood to be singularly responsible for maintaining good health through lifestyle management. The individualization of health is at direct odds with the collective, structural critiques and approaches taken by feminists in the women's health movement.

What is clear from my analysis of the websites in my sample is that only particular aspects of feminism are incorporated into the online discourse on sexual health, and only some women are included in its imagined audience, as evidenced by the privileged presentation of certain issues as of concern to women's sexual health (e.g., the prevention of pregnancy or discussions on the physical problems associated with STI transmission). These women are presumed to be those that have benefited the most from feminism, as they are assumed to have adequate access to sexual health information and care, regardless of social class; engaging with this information is positioned as something good for women to do. Additionally, these women are assumed to have the ability to evaluate

the veracity of that information (and to continue seeking additional information if a particular source is lacking). While I do not question the ability of women to be critical consumers of health information, the expectation that women must consume this information critically offloads the responsibility of the sources of that information onto individual women, even when those sources are described as authoritative.

This individualization of responsibility means that women must negotiate competing moral and medical messages about sexuality in addition to physical health information in order to implement and execute particular choices based on that information. There are discourses advanced by some critics who are concerned that giving young women too much information (or the wrong kind of information) will make them sexual: in the introduction to this paper, I outlined how some groups that objected to some of the content in the new sexual education curriculum in Ontario cited concerns that naming body parts or different gender identities or sexual orientations will cause promiscuity or sexual confusion. From that perspective, withholding information is seen as the right and best way to protect “childhood innocence”. In the websites in my sample, withholding information is positioned as undesirable. Information, not silence, is the key to good sexual health, and readers are repeatedly encouraged to consult their parents, doctors, teachers, and other sources to seek out this information. Young women are beneficiaries of an opened discourse on sexual education, and are also responsible for taking up this benefit or of facing the consequences.

Young women are particularly subject to competing messages, as they are expected to be increasingly savvy sexual health consumers and sexual subjects. Information-seeking and knowledge acquisition is also framed as a feminist obligation: Canadians for Choice describes young women as ignorant of past struggles, particularly those surrounding abortion, and advises that they should learn about the past to better appreciate the issues affecting their current health. Being sexually healthy relies on being free from “disease, violence, injury, fear and false beliefs”, the tall order set out by the SOGC. Good sexual health seems practically unattainable, according to this standard, as many of these factors are outside of an individual’s control. How might one begin to identify false beliefs?

And, who produces the “true facts” of health? Young women are positioned as information managers who must seek out, consume, and assess information about their developing sexual health. They must reject information that is deemed inadequate or untrustworthy, and continue to pursue new sources of information in its place. The information is seemingly offered to assist women in making informed choices, based in the assumption that that there exists a direct relationship between information, knowledge, and action. Once she has the right information and knowledge, she is capable of making the “smart” choice for her health.

The task of evaluating information also applies to assessing the information and support a young woman should expect from her doctor. Not all doctors are created equal: NAHO indicates that doctors have a responsibility to support without judgement the decision young women make about continuing or aborting a pregnancy, although Canadians for Choice indicates that the education doctors receive in medical school about abortion is very brief, if present at all. In response to this anticipation of inconsistent care, Canadians for Choice advises that their readers “shop around” for doctors,¹⁸ while the SOGC similarly emphasizes the importance of finding a doctor who is supportive and “understanding” (e.g., who is capable of responding supportively to women’s experiences of vulvar pain). Young women are constructed as entitled to an informed and supportive doctor. The reader that is being addressed and privileged by the discourse is a reader who has the financial resources, the social or cultural capital, and the ‘right’ kind of social position to advocate for themselves. This subject is someone whose requests and demands will not be disregarded by health service personnel; she is a deserving citizen and patient, one who has made the right choices and is thus worthy of supportive, not merely functional, health services

The advice to shop around for a doctor assumes a consumer model of health care with a surplus of options and a client base with the agency, ability, and time to navigate, advocate, and make the right choices for their own health. It further assumes that there

¹⁸ Although Canadians for Choice offers this advice in relation to selecting a fertility clinic, they also indicate in a passage that I did not discuss in my results that youth seeking sexual health services and STI testing can call around to clinics and ask if the services offered are specifically youth-friendly.

are multiple doctors available for patients to choose from, that they are able to learn about a doctor prior to accepting health care from her, and that they have the freedom to transfer files as a patient to a new doctor. Additionally, this assumes that there are doctors available at all: The National Collaborating Centre for Aboriginal Health (NCCAHA) (2010) offers an overview of issues of access facing Aboriginal peoples in Canada. In particular, the geographic remoteness of some Aboriginal communities, particularly in Canada's North, means that there are "critical shortages of medical personnel" (NCCAHA 2010, 2). This is a strong example of the way that neoliberalism operates through the websites: although consumerism is not discussed nearly as much as I would have anticipated, the language of "shopping" when discussing the search for medical care is significant as it reflects an evolving discourse on medical consumerism in Canada. Under this model of care, patients are constructed as consumer-patients with access to particular rights (Frank 2000). This language claims to empower women seeking medical care to choose the care that is "best" for her, and is a logical extension of the postfeminist emphasis on empowerment through consumption activities. However, it is significant that consumer language appears most explicitly in the context of women's struggles with infertility: in a postfeminist context where women's "natural" roles as mothers are increasingly emphasized and where health is increasingly understood as a choice, women are discursively compelled to choose fertility by any means necessary.

Consumer language obscures the power differential between young women and medical authorities, presenting medical care as a service that an individual patient consumer is instigating and electing (Irvine 2002). Young women are advised through the websites in my sample to see doctors as a source of information meant to serve their sexual health needs. Doctors are an important source of information, and the information young women can gain from medical professionals can be used by young women to exercise control over their sex lives. Doctor-patient relationships are re-framed through a postfeminist lens in the online discourse. Traditionally marked by power differentials (and those certainly remain, even in the discourse), feminists in the women's health movement have offered decades of critique toward this dynamic, encouraging women to question the amount of control physicians (and the medical system more broadly) have

over their health.¹⁹ The online discourse incorporates this critique by obscuring the authority that medicine as an industry maintains over women's health and encourages women to shop around for doctors to find the level of care that makes them personally comfortable. This responsabilizes young women to manage the disproportionate power that a medical system holds over their lives. The institutional critique is transformed into a critique of individual doctors who are framed as being out of touch with modern medical practices that value women's experiences and/or who may simply be a poor fit for a particular woman's care.

7.3.2 Risk Groups: Capabilities for Health and Responsibilities for 'Others'

Young women are constructed as entitled to good care and support from her doctor, and as particularly responsible for making the right choices regarding her health. The websites included in my sample work to establish these entitlements and responsibilities as belonging to young women in particular through a variety of mechanisms, including the use of gender-neutral language. The language used by the websites is most often gender-neutral, inviting all readers to identify with the information offered. For example, all of the websites in my sample prioritize the use of the word "partner" rather than "boyfriend" or "girlfriend" when referring to romantic or sexual relationships. Allen (2012) warns, however, that gender-neutral language, when used in the context of sex education, is inadequate to "disrupt heteronormativity's power to constitute heterosexual pleasure as 'normal'", and she suspects "that the majority of students (particularly, although not exclusively, those who are heterosexual) 'read' the gender of partners as presumed 'opposite'" (464). The ability of gender-neutral language to be read as gender-neutral is also compromised when the websites in my sample do turn to use gendered language. Although NAHO indicates that dating violence or sexual assault "can happen to people of any age, race, sexual orientation, social class or social status, and place of

¹⁹ For example, see Morgan's (1998) analysis of the medicalization of women's health, generally; see also Haraway's (1997) and Duden's (1991) discussions of the medicalization of pregnancy via ultrasound technology.

residence”, the only time men are directly addressed as readers is when the information offered by SOGC responsabilizes perpetrators of sexual assault.

Similarly, visual images function to gender these messages; although “both partners” are identified by the written text as responsible for acquiring and using birth control, images on the Trojan website depict women holding condoms or passing them to men in their articles, reinforcing the role of women as sexual agents as previously discussed. By directly naming and addressing women through conversations about sexual assault, birth control, STI transmission, and the search for a doctor, women are constructed as the imagined audience when the language returns to being gender-neutral. Within this discursive configuration of text and image, young women are imagined to be most vulnerable to health risks, and also in the best position to make the best choices for her health. This is in direct contrast to the stated efforts of each website to offer information to “all Canadians”, and demonstrates the pervasiveness of the construction of young women as the vulnerable empowered, can-do girl through neoliberalism and postfeminism.

Although the primary emphasis is on young women, my analysis also shows that the responsibility to become informed and make the right choices for one’s health is extended to a number of different “risk groups”: Aboriginal peoples, rural, immigrant, and disabled women, and queer youth are identified by discourse as being made at risk by various structural factors (e.g., including colonization). However, there is an assumption present in the way the websites offer their information: there is an understanding across the websites that this information is equally accessible and applicable to all who might read it. The intended audience is very expansive: for example, the SOGC addresses that “all Canadians” are protected under the Canada Health Act. Power imbalances that place certain groups at risk or outside the margins of society are ignored, and as a result, all readers are presumed to be capable of first, accessing this information, and second, of effectively implementing the advice and actions recommended by the websites. Everyone is assumed to have access to doctors and medical treatment, even if that access is more difficult to attain or delayed due to their social location or identity.

Canada is positioned by the websites included in my sample as a generous and progressive nation, to its citizens at home and global populations abroad. Health is repeatedly identified as a fundamental human right, and that assertion is reinforced by information about women in other parts of the world who struggle to access this right. Canadians for Choice outlines statistics from the World Health Organization on the prevalence of unsafe abortions in “Asia, Africa and Latin America” due in part to restrictive laws on abortion in those locations, and outlines Canada’s financial commitments to sexual and reproductive healthcare globally through the Population and Development branch of the United Nations (Canadians for Choice, Sexual and Reproductive Health Issues: Abortion – Internationally). This information serves to depict women in “other” parts of the world as worse-off than Canadian women and mirrors and supports the postfeminist claim that all the hard work has already been completed in Canada. At the same time, the discussion on global health issues works to illustrate a commonality of health risk. As one example (representing many others like it from every website in my sample), NAHO indicates that “HPV is the most common STI in the world”. STI risk (and risks to sexual health more generally) is constructed as ubiquitous and unavoidable, regardless of social or global location, or of how dedicated international governments are to serving the health of their populations.

The inclusion of discussions of difference functions to democratize sexual health (risk). Identity and difference are depoliticized, where we are all susceptible to risk and thus all responsible for responding to that risk. Individuals within each of these “risk groups” are responsabilized to take individual responsibility for their own health by working to find the right doctor or care for themselves, by making the right lifestyle choices, and by finding the right community for support. This latter responsibility is particularly true for LGBTQ2 youth. In Dubriwny’s (2013) discussion of the vulnerable empowered woman, she asks where women who are “not fully engaged in the heterosexual matrix belong? The short answer: at the edge of discourse, invisible, next to the equally invisible ranks of poor women and women of color” (141). The postfeminist, neoliberal girl who must empower herself through risk management is often conceptualized as a heterosexual

subject. However, the postfeminist claim that equality has already been achieved means that sexual identity and orientation must be accounted for, and the websites in my sample, including the SOGC and NAHO, indicate that there is growing acceptance of a range of sexual identities in Canada.

Assumptions or claims of equality and acceptance are in tension with the “realities” of difference also noted by the websites, including the risk of violence, discrimination, and sexual health risks among queer youth. The choices available to queer youth are circumscribed by societal and familial responses to their identity, as the SOGC advises that those who are still financially dependent upon their parents should consider not coming out to their parents. My analysis extends Dubriwny’s (2013) discussion of the vulnerable empowered girl by showing how popular discourses on sexual health do not necessarily exclude the queer girl; similarly, the queer girl is vulnerable to the risks associated with her sexuality, and is also a girl who can choose to consume the right kind of sexual health information, and who can choose to apply that information to make the best choices for herself. In addition, she is an empowered girl who is understood as capable of living her best life by coming out (at the right time). Unlike the neoliberal, postfeminist, heterosexual girl, the queer postfeminist subject is charged with the responsibility of not only protecting herself, but also other youth like her when she is invited to act as a leader and a community member for the benefit of others in her position by participating in safe space initiatives at school.

While this call to participate in safe space initiatives may resemble collective politics, the community offered to LGBTQ2 youth does not reflect the public, political activism offered by the LGBT community during significant historical moments in Canada and the US. For example, Jennex (2015) outlines the coordinated raid by Toronto police in 1981 on four bathhouses that offered a space for men – many of whom were not “out” – to meet for sex, intimacy, and to participate in gay male culture. The raids were followed by a quickly organized and well-attended street protest where not only police violence, but homophobia as a whole was challenged. Collective action, “shared queer desires and massed bodies signalled a direct sense of political power” (Jennex 2015). Crimp and

Roulston (1990) similarly outline the importance of public action in responding to the AIDS crisis affecting gay men in the late 1980s. The authors discuss the slogan “SILENCE = DEATH”, created by ACT UP (the AIDS Coalition to Unleash Power), which “declares that silence about the oppression and annihilation of gay people, then and now, must be broken as a matter of our survival” (15). Public protest, disruption, and anger are identified as key factors to challenging the homophobia that contributed to gross government inaction during the emergence of the AIDS crisis in the United States. In contrast to these publicly political efforts, readers of the websites in my sample are encouraged to form community groups or safe spaces in the comparatively private realms of the family or at school. Although this message is for all readers, the advice to create and join safe, inclusive, queer-friendly communities both empowers and responsabilizes queer youth in particular. The SOGC and NAHO both acknowledge that youth have an influence and a say in their own lives and how they are treated and react to that treatment from others; however, it also leaves it up to youth – who are already identified by the discourse as being in a disadvantaged position – to address their own, individual oppression, as well as the oppression of others through private community engagement.

One significant limitation of postfeminist discourse is that access to information is constructed as the (already accomplished) end goal of the women’s health movement. According to healthism, “good” health is accessible through lifestyle choices, and the “right” choices can be made if the individual is properly informed. The discourses on medicalization and healthism present in the websites in my sample operate on the postfeminist assumption that, because feminism has done its work, all women are equal (not only equal to men, but that all women are equal to other women) and choice is available to all, regardless of sexual orientation, ethnic background, geographic location, or socio-economic status. Further, the websites assume that access to information is all that is needed to exercise choice (and, that access to information translates directly into knowledge acquisition). However, this grossly underestimates the extent to which social determinants of health impact women’s lives. More than barriers to information, and more than barriers to the effective implementation of “good” choices, social determinants of health result in significant inequalities in health based on where or in which context an

individual (or groups of individuals) is born and raised. As such, more than increasing women's access to information and choice, (feminist) work needs to continue to change the social, economic, political, and racial climates both globally and locally. Indeed, choice operates as a regulatory discourse in a neoliberal and consumerist context by emphasizing individual responsibilities to make healthy "choices" that are presented as in women's best interests, even (and in some cases, especially) when faced with structural constraints. In lieu of this work, the online discourse on sexual health responsabilizes individual women and groups who may be otherwise disadvantaged in Canada to fill in the gaps in their health care.

7.4 Conclusion

In this chapter, I discussed the discourses of sexual health that are available to young women through a range of websites online. Healthist accounts characterize these discourses, as individuals, and women in particular, are constructed as morally responsible to incorporate care and interest about their health into their daily lives in order to support an active sex life. Control over STI risk is identified as a paramount goal, and discourses construct monogamous, committed relationships as the best option young women have to manage those risks to themselves and to their future children. Conservative relationship norms are reinforced, where the choice to commit to one person is not necessarily solely influenced by concerns over sexual morality, but by the imperatives of good health in a healthist society. Managing risk, and becoming properly informed about health, is constructed as an act of care for self and for others, namely, male partners who are depicted as incapable of or uninterested in taking on this care. Young women are promised better and more pleasurable sex, and more emotionally fulfilling relationships as a reward for taking on this work. However, this promise of good sex reinforces that there is an obligation to have sex: to decline sex, even temporarily, is to be considered unhealthy by postfeminist and healthist accounts.

In the conclusion that follows, I discuss the potential that websites, such as the ones included in my sample, have in offering health information to young women, and suggest

some directions for future research. In Canada, neoliberal influences on health policy and funding decisions mean that citizens are expected to take more initiative in responding to and managing risks to their health, including by seeking out health information. Magazines have long been established as outlets where health information is disseminated and discussed. Through its inclusion in women's magazines, health information is married with popular culture and women's every day leisure activities. Websites are a seemingly natural "new" source for this information for the postfeminist subject: young women are coming of age in an increasingly tech-savvy and connected world, and are already constructed as avid consumers of popular culture.

Websites that offer health information cannot be easily subsumed as popular culture artefacts. I included a range of websites for precisely this reason: each organization has its own mandate, purpose, and institutional truth that they operate to advance and uphold. For example, the not-for-profit organization selected, Canadians for Choice, is a pro-choice organization informed by feminist principles and a feminist mandate. Canadians for Choice emerges explicitly from the women's health movement, and calls on that legacy in some of its articles (in particular in their discussion of the history of abortion access in Canada). Likewise, Canadian-based professional or governmental organizations like the Government of Canada's Healthy Canadians, and Sexuality and U, administered by the Society of Obstetricians and Gynaecologists of Canada (SOGC), both appear to be motivated by the desire to democratize health care information by making it readily accessible and understandable to a general audience. While enhancing access is a continued goal of the women's health movement, it is also characteristic of the growing neoliberal approach to healthcare in Canada. Commercial-oriented websites such as Trojan Condom's We Know Sex also represents a distinct point in the neo-liberal development of health care, as free access to health care information finds an outlet within the context of an otherwise for-profit venture. Finally, the "special interest group or alternative voices" website, represented by the National Aboriginal Health Organization, fills an important gap by directly addressing the sexual health needs of a distinct population otherwise largely subsumed under the seemingly inclusive banner of "all people" in the other websites.

In my introduction, I considered the role that online resources could play in supplementing formal education curricula, particularly for those students who feel that the curriculum does not offer them information on the range of new issues impacting their sexual health, such as pornography or sexting. These issues are addressed, albeit briefly, by some of the websites included in my sample. For example, the SOGC provides two paragraphs of information on sexting, constructing it as a legal matter pertaining to child pornography. Trojan briefly mentions the role of pornography, constructing it as a source that contributes to unrealistic sexual performance standards. Hill and Valente succeeded in getting the issue of consent included in the newly released Ontario sex education curriculum, indicating a level of responsiveness from the Ontario government to the needs of young women. However, curriculum is a provincial mandate in Canada, meaning that the decision to include the topic of consent needs to be made by each province or territory. At the time of writing, Queens University student Natasha Kornak is hosting an online petition on change.org to lobby the Government of Alberta to include the topic of consent and sexual assault in that province's sex education curriculum (Kornak 2016). Kornak (2016) recalls learning how to prevent pregnancy and contracting STIs in her high school sex education classes, but indicates that she did not learn about what to do if someone was sexually assaulted. During her first year at university, Kornak's friend was sexually assaulted; mutual friends knew to take her "to the hospital to access what is commonly referred to as a 'rape kit' to collect DNA evidence as well as access emergency contraception and other medications". Kornak states that "the only reason I now know what to do in the event of assault is because my friend was raped, not because I learned it in my sexual education course".

Kornak's (2016) petition illustrates the need for formal sources of sexual health information to be more inclusive of topics that impact the lived realities of young women; the continued need for collective feminist efforts by women across Canada to work together for common issues of sexual assault; and the importance of friends as informal but no less accurate sources of information in times of crisis. Her petition also points to the role that the internet can play as a tool to agitate for change and to disseminate health

information; Kornak includes links to a Facebook page and a Twitter hashtag where she is promoting this campaign and the importance of the issue of consent. The ability of websites to quickly update information in response to advances (or controversies) in the social and cultural climate could be a compelling feature when compared to relying on printed material (or formal curricula) for sexual health information that may quickly become out of date. Future researchers should consider the role that social media plays in the dissemination of health information. In addition to Kornak's campaign, Action Canada for Sexual Health and Rights, the organization that Canadians for Choice folded into, also has an active presence on twitter. In August of 2016, they tweeted links to articles discussing RU-486, a medical abortion drug that was approved for use in Canada by Health Canada in July 2015 (Action Canada 2016). The drug will be sold under the name Mifegymiso and will become available in the fall of 2016 (Action Canada for Sexual Health and Rights n.d.b). This example illustrates how technological mediums can facilitate on-going, real-time conversations with an audience about emerging news related to sexual health.

However, the idea that technology is a more efficient or adaptable way to provide health information is a discourse itself, and constitutes an assumption that is not borne out by the websites included in my sample. Indeed, the websites in my sample have apparently not adapted to or incorporated new information since they were first written: despite a website redesign by Healthy Canadians, the shuttering of Canadians for Choice (where their information is no longer online), and the defunding of NAHO (where their information will be available online until 2017), the content of each website has remained markedly similar between my initial data collection and visits I have made to the websites in the years since. Limitations, or discursive silences, then, are not limited to formal curricula. In my methodology chapter, for example, I indicated that information on HPV vaccination has not been incorporated into every website, despite its controversial introduction as a magic bullet for HPV-related cervical cancer prevention in 2006.

Discursive silences are also not limited to seemingly "new" developments in sexual health. Healthy Canadians does not name or discuss any form of birth control other than

condoms. This omission is surprising: the academic literature on youth sexual health and the websites in my sample both indicate that avoiding pregnancy is a priority for health promotion campaigns directed toward this population. It is a curious oversight that websites would limit the information they provide to their audience on how they might best do this. In outlining these limitations, I do not mean to propose a comprehensive list of topics that “should” be included in all sexual health information resources going forward, nor do I proposed an ideal medium through which health information should be disseminated. Rather, I aim to demonstrate that online resources are not necessarily more advanced, inclusive, or responsive to changes in the social and cultural climate than sex education curricula or other more traditional sources of health information. Future research should examine this further: to what extent (and through what mediums) can web-based resources respond to and incorporate emerging issues related to sexual health? When considering the productive power of discourses, how does the timeliness of tweets about emerging news items related to sexual health combine with institutional authority like that from an organization like Action Canada? Does this combination of timely, institutionally-authorized information produce a new obligation of postfeminist subjectivity, one where young women are mobilized to not only consume information but to undertake a project of on-going consumption?

I take seriously the importance of having access to information, which websites and other increasingly mobile technologies facilitate. I also take seriously the discourses that are reflected and reinforced through these websites. The postfeminist subject conceptualized through discourses on sexual health is constructed as entitled to good health, good information, and good sex. Entitlement is often used as a derogative, to challenge a young woman who has not yet done the work required to earn these goods. Entitlement also functions as an extension of postfeminism, and as an extension of the genuine success of feminist and women’s health movement(s): access to information is constructed as a right, fundamental to the achievement of sexual and reproductive health. However, postfeminism is a discourse limited by conservatism, and works with neoliberalism and healthism to impose conditions on young women’s access to these goods. Young women must, according to the discourse, work to earn these entitlements

by exercising their moral responsibility to pursue good health. Young women are obligated to make smart choices and navigate competing messages about sexuality and sexual health from a range of institutional and informal sources of information; their ability to make smart choices means that the responsibility for sexual health falls to them. Men are constructed as physically incapable of making the right choices for their sexual health, and so young women are expected to be responsible for the sexuality of men, even as this expectation is framed as an opportunity for mutual pleasure. Discourses of danger, risk, morality, and responsibility weave through discussions of pleasure, control, and freedom to keep the entitled, postfeminist woman in check, and to mobilize her to manage her own life and desires in ways that are not necessarily progressive.

Bibliography

- Abramovich, I.A. (2012). No Safe Place to Go: LGBTQ youth homelessness in Canada. *Canadian Journal of Family and Youth*, 4(1), 29-51.
- Action Canada [@action_canada] (2016, August 15). The new abortion pill will be rolled out in #Canada this fall – how much do you know about it? Srhweek.ca/caring-for-you... #prochoice #cdnhealth [Tweet]. Retrieved from https://twitter.com/action_canada/status/765333735176712192
- Action Canada for Sexual Health & Rights (n.d.a). About Us. Accessed Jul 7, 2016 at <http://www.sexualhealthandrights.ca/about-us/>
- Action Canada for Sexual Health & Rights (n.d.b). FAQ: Mifegymiso. Accessed Aug 22, 2016 at <http://srhweek.ca/caring-for-yourself/pregnancy/positive-test-pregnancy-options/mifegymiso/>
- Allen, L. (2012). Pleasure's Perils? Critically reflecting on pleasure's inclusion in sexuality education. *Sexualities*, 15(3/4), 455-471.
- Attwood, F. (2011). Through the Looking Glass? Sexual agency and subjectification online. In Rosalind Gill and Christina Scharff (Eds.), *New Femininities: Postfeminism, Neoliberalism and Subjectivity* (pp. 203-214). London: Palgrave Macmillan.
- Attwood, F. (2005). Fashion and Passion: Marketing sex to women. *Sexualities*, 8(4), 392-406.
- Bailey, B. (1997). Prescribing the Pill: Politics, culture, and the sexual revolution in America's heartland. *Journal of Social History*, 30(4), 827-856.
- Bailey, M.J. (2006). More Power to the Pill: The impact of contraceptive freedom on women's life cycle labor supply. *The Quarterly Journal of Economics*, 121(1), 289-320.
- Banet-Weiser, S. (2007). What's your Flava? Race and postfeminism in media culture. In Tasker, Yvonne and Negra, Diane (Eds). *Interrogating Postfeminism: Gender and the politics of popular culture* (Ch. 8, pp. 201-226). London: Duke University Press.
- Bay-Cheng, L.Y. (2001). SexEd.com: Values and norms in web-based sexuality

- education. *The Journal of Sex Research*, 38(3), 241-251.
- Bennett, J. (October 15 2014). Company-paid Egg Freezing Will Be the Great Equalizer. *Time*. Retrieved from <http://time.com/3509930/company-paid-egg-freezing-will-be-the-great-equalizer/>
- Best, J. and Bogel, K.A. (2014). How Legends Spread. In *Kids Gone Wild: From rainbow parties to sexting, understanding the hype over teen sex* (pp. 21-44). New York: New York University Press.
- Bielski, Z. (February 6 2015). 'We Want to Talk About Sex': Grade 8 girls push for Ontario sex-ed reforms to include the concept of consent. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/life/relationships/grade-8-girls-push-for-sex-ed-reforms-with-petition-of-40000-signatures/article22807466/>
- Bonner, F. and McKay, S. (2000). Challenges, Determination and Triumphs: Inspirational discourse in women's magazine health stories. *Journal of Media and Cultural Studies*, 14(2), 133-144.
- Boscoe, M., Basen, G., Alleyne, G., Bourrier-Lacroix, B., and White, S. (2004). The Women's Health Movement in Canada: Looking back and moving forward. *Canadian Woman Studies*, 24(1), 7-13.
- Braithwaite, A. (2004). Politics of/and Backlash. *Journal of International Women's Studies*, 5(5), 18-33.
- Brown-Bowers, A., Gurevich, M., Vasilovsky, A.T., Cosma, S., and Matti, S. (2015). Managed Not Missing: Young women's discourses of sexual desire within a postfeminist heterosexual marketplace. *Psychology of Women Quarterly*, 1-17.
- Burke, E. (2006). Feminine Visions: Anorexia and contagion in pop discourse. *Feminist Media Studies*, 6(3), 315-330.
- Cacchioni, T. and Tiefer, L. (2012). Why Medicalization? Introduction to the special issue on the medicalization of sex. *Journal of Sex Research*, 49(4), 307-310.
- Campaign Life Coalition (n.d.). Ontario's Radical Sex Ed Curriculum. Retrieved from http://www.campaignlifecoalition.com/index.php?p=Sex_Ed_Curriculum
- Minister of Justice (2012). Canada Health Act. Retrieved from <http://laws-lois.justice.gc.ca>
- Cairns, K. and Johnston, J. (2015). Choosing Health: Embodied neoliberalism,

- postfeminism, and the “do-diet”. *Theory and Society*, 44, 153-175.
- Cayen, L., Polzer, J., and Knabe, S. (2016). Tween Girls, Human Papillomavirus (HPV), and the Deployment of Female Sexuality in English Canadian Magazines. In Jessica Polzer and Elaine Power (Eds.), *Neoliberal Governance and Health: Duties, risks, and vulnerabilities* (pp. 82-107). Montreal: McGill-Queen’s University Press.
- CBC News (April 9 2012). National Aboriginal Health Organization’s Funding Cut: Organization to close at end of June. Retrieved from <http://www.cbc.ca/news/canada/north/national-aboriginal-health-organization-s-funding-cut-1.1194520>
- CBC News (October 1 2015). Ontario Sex-ed Protest 'Unlike Anything I've Ever Experienced,' Principal Says. Retrieved from <http://www.cbc.ca/news/canada/toronto/ontario-sex-ed-protest-1.3251799>
- Cheek, J. (2008). Healthism: A new conservatism? *Qualitative Health Research*, 18(7), 974-982.
- Cheek, J. (2004). At the Margins? Discourse analysis and qualitative research. *Qualitative Health Research*, 14(8), 1140-1150.
- Clarke, J. (2009). Women’s Work, Worry and Fear: The portrayal of sexuality and sexual health in US magazines for teenage and middle-aged women, 2000-2007. *Culture, Health & Sexuality*, 11(4), 415-429.
- Coleman, E. (2002). Promoting Sexual Health and Responsible Sexual Behavior: An introduction. *Journal of Sex Research*, 39(1), 1-6.
- Cook, D.T. (2004). Reconfiguring Girlhood: Age grading, size ranges, and aspirational merchandising in the 1930s. In *The Commodification of Childhood: The Children’s Wear Industry and the Rise of the Child Consumer* (pp. 96-121). Durham, NC: Duke University Press.
- Cook, D.T. and Kaiser, S.B. (2004). Betwixt and Be Tween: Age ambiguity and the sexualisation of the female consuming subject. *Journal of Consumer Culture*, 4(2), 203-227.
- Crawford, R. (2006). Health as a Meaningful Social Practice. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 10(4), 401-420.

- Crawford, R. (2004). Risk Ritual and the Management of Control and Anxiety in Medical Culture. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 8(4), 505-528.
- Crawford, R. (1980). Healthism and the Medicalization of Everyday Life. *International Journal of Health Services*, 10(3), 365-388.
- Crimp, D. and Roulston, A. (1990). "AIDS Activist Graphics: A demonstration". *AIDSDemographics* (pp. 13-26). Seattle: Bay Press.
- Davis, A. (2008). Racism, Birth Control, and Reproductive Rights. In Nancy Ehrenreich (Ed.), *The Reproductive Rights Reader: Law, Medicine, and the Construction of Motherhood* (pp. 86-93). New York: New York University Press.
- Davis, K. (2002). 'A Dubious Equality': Men, women and cosmetic surgery. *Body and Society*, 8(1), 49-65.
- De Leeuw, S. and Greenwood, M. (2011). Beyond Borders and Boundaries: Addressing Indigenous health inequities in Canada through theories of social determinants of health and intersectionality. In Olena Hankivsky (Ed), *Health Inequities in Canada: Intersectional frameworks and practices* (pp. 53-70). Vancouver: UBC Press.
- Dubriwny, T.N. (2013). *The Vulnerable Empowered Woman: Feminism, postfeminism, and women's health*. Rutgers University Press.
- Duden, B. (1991). *The Woman Beneath the Skin: A doctor's patients in eighteenth-century Germany* (Translated by Thomas Dunlap). Cambridge: Harvard University Press.
- Edwards, W.M. and Coleman, E. (2004). Defining Sexual Health: A descriptive overview. *Archives of Sexual Behavior*, 33(3), 189-195.
- Fine, M. (1988). Sexuality, Schooling, and Adolescent Females: The missing discourse of desire. *Harvard Educational Review*, 58(1), 29-53.
- Fine, M. and McClelland, S.I. (2006). Sexuality Education and Desire: Still missing after all these years. *Harvard Educational Review*, 76(3), 297-437.
- Foucault, M. (2002). *The Archaeology of Knowledge*. New York: Routledge.
- Foucault, M. (1984). The Order of Discourse. In Michael Shapiro (Ed.), *Language and Politics* (pp. 108-138). Oxford: Basil Blackwell.

- Foucault, M. (1978). *The History of Sexuality: An Introduction*. New York: Vintage Books.
- Frank, A.W. (2000). All The Things Which Do Not Fit: Baudrillard and medical consumerism. *Families, Systems and Health*, 18(2), 205-216.
- Friedman, J. and Valenti, J. (2008). *Yes Means Yes: Visions of female sexual power and a world without rape*. California: Seal Press.
- Gamble, S. (2004). *The Routledge Companion to Feminism and Postfeminism*. New York: Routledge.
- Genz, S. and Brabon, B. (2009). *Postfeminism: Cultural texts and theories*. Edinburgh: Edinburgh University Press.
- Giami, A. (2002). Sexual Health: The emergence, development, and diversity of a concept. *Annual Review of Sex Research*, 13, 1-35.
- Gill, R. (2009). Mediated Intimacy and Postfeminism: A discourse analytic examination of sex and relationships advice in a woman's magazine. *Discourse & Communication*, 3(4), 345-369.
- Gill, R. (2007). Advertising and Postfeminism. In *Gender and the Media* (pp. 73-112). Cambridge: Polity.
- Gill, R. (2000). Discourse Analysis. In Martin W. Bauer and George Gaskell (Eds.), *Qualitative Researching with Text, Image and Sound: A Practical Handbook* (pp. 172-190). London: Sage.
- Goetzinger, L., Park, J., Jung Le, Y., and Widdows, R. (2007). Value-Driven Consumer E-Health Information Search Behavior. *International Journal of Pharmaceutical and Healthcare Marketing*, 1(2), 128-142.
- Goldin, C. & Katz, L.F. (2002). The Power of the Pill: Oral contraceptives and women's career and marriage decisions. *Journal of Political Economy*, 110(4), 730-770.
- Government of Canada (2016). About Canada.ca. Retrieved from http://www1.canada.ca/en/newsite.html?_ga=1.105804547.1030583600.1375300125
- Gunn, J. and Douglas Vavrus, M. (2010). Regulation through the Postfeminist Pharmacy: Promotional discourse and menstruation. In Lori Reed and Paula Saukko (Eds.), *Governing the Female Body: Gender, health, and networks of power* (pp. 112-132). New York: Suny Press.

- Gupta, K. (2011). "Screw Health": Representations of sex as a health-promoting activity in medical and popular literature. *Journal of Medical Humanities* 31, 127-140.
- Hankivsky, O. and Christoffersen, A. (2008). Intersectionality and the Determinants of Health: A Canadian perspective. *Critical Public Health*, 18(3), 271-283.
- Haraway, D.J. (1997). The Virtual Speculum in the New World Order. *Feminist Review*, 55, 22-72.
- Harding, K. (2015). *Asking For It: The alarming rise of rape culture – and what we can do about it*. Da Capo Press.
- Harris, A. (2004a). The "Can-Do" Girl Verses the "At-Risk" Girl. In *Future Girl: Young Women in the Twenty-First Century* (pp. 13-36). New York: Routledge.
- Harris, A. (2004b). Jamming Girl Culture: Young women and consumer citizenship. In *All About the Girl: Culture, Power and Identity* (pp. 163-172). New York: Routledge.
- Harvey, L. and Gill, R. (2011). Spicing It Up: Sexual entrepreneurs and *The Sex Inspectors*. In Rosalind Gill and Christina Scharff (Eds.), *New Femininities: Postfeminism, Neoliberalism and Subjectivity* (pp. 52-67). London: Palgrave Macmillan.
- Health Canada (2014). About Health Canada. Retrieved from <http://www.hc-sc.gc.ca/ahc-asc/index-eng.php>
- Henderson, J.M. (October 15 2014). Why We Should Be Alarmed that Apple and Facebook are Paying for Employee Egg Freezing. *Forbes*. Retrieved from <http://www.forbes.com/sites/jmaureenhenderson/2014/10/15/dont-work-for-or-trust-a-company-that-pays-you-to-freeze-your-eggs/#3cb2632f7487>
- Henderson, S. and Peterson, A. (2002). Introduction: Consumerism in health care. In *Consuming Health: The Commodification of Health Care* (p. 1-10). New York: Routledge.
- Hollows, J. (2003). Feeling Like a Domestic Goddess: Postfeminism and cooking. *European Journal of Cultural Studies*, 6(2), 179-202.
- Irvine, R. (2002). Fabricating "Health Consumers" in Health Care Politics. In Saras

- Henderson and Alan Peterson (Eds.), *Consuming Health: The Commodification of Health Care* (p. 31-47). New York: Routledge.
- Jennex, Craig (2015). No More Shit!: Complicated collectivity, past and present. *Guts: Canadian Feminist Magazine*. Retrieved from <http://gutsmagazine.ca/issue-three/no-shit>
- Jones, A. (2003). Feminism, Incorporated: Reading “postfeminism” in an anti-feminist age. In Amelia Jones (Ed), *The Feminism and Visual Culture Reader* (Ch. 36). Routledge: New York.
- Kilbourne, J. and Jhally, S. (Director) (2010). *Killing Us Softly 4: Advertising’s Image of Women* [Motion picture]. United States: Media Education Foundation.
- King, S. (2006). *Pink Ribbons, Inc: Breast Cancer and the Politics of Philanthropy*. Minneapolis: University of Minnesota Press.
- Kinser, A. (2004). Negotiating Spaces For/Through Third-Wave Feminism. *National Women’s Studies Association Journal*, 16(3), 124-153).
- Kornak, N. (2016). Reform Alberta's Sexual Education Curriculum to Encompass Consent and Sexual Assault. Retrieved from https://www.change.org/p/government-of-alberta-reform-alberta-s-sexual-education-curriculum-to-encompass-consent-and-sexual-assault?source_location=discover_feed
- Lamb, S., Lustig, K., and Graling, K. (2013). The Use and Misuse of Pleasure in Sex Education Curricula. *Sex Education: Sexuality, Society and Learning*, 13(3), 305-318.
- Lazar, M. (2009a). Entitled to Consume: Postfeminist femininity and a culture of post-critique. *Discourse and Communication*, 3(4), 371-400.
- Lazar, M. (2009b). Communicating (Post)feminism in Discourse. *Discourse & Communication*, 3(4), 339-344.
- Lazar, M. (2007). Feminist Critical Discourse Analysis: Articulating a feminist discourse practice. *Critical Discourse Studies*, 4(2), 141-164.
- Levy, A. (2005). Raunch Culture. In *Female Chauvinist Pigs: Women and the Rise of Raunch Culture* (pp. 7-45). New York: Free Press.
- Lippman, A., Melnychuk, R., Shimmin, C., and Boscoe, M. (2007). Human

- Papillomavirus, Vaccines and Women's Health: Questions and cautions. *Canadian Medical Associations Journal*, 177(5), 484-487.
- Loe, M. (1999). Feminism for Sale: Case study of a pro-sex feminist business. *Gender & Society*, 13(6), 705-732.
- Lottes, I. (2000). New Perspectives on Sexual Health. In Ilsa Lottes and Osmo Kontula (Eds.), *New Views on Sexual Health: The case of Finland* (pp. 7-29). Finland: The Population Research Institute.
- Lupton, D. (2015). Quantified Sex: A critical analysis of sexual and reproductive self-tracking using apps. *Culture, Health and Sexuality*, 17(4), 440-453.
- Lupton, D. (2014). Apps as Artefacts: Towards a Critical Perspective on Mobile Health and Medical Apps. *Societies*, 4, 606-622.
- Lupton, D. (1994a). Consumerism, Commodity Culture and Health Promotion. *Health Promotion International*, 9(2), 111-118.
- Lupton, D. (1994b). *Medicine as Culture: Illness, Disease and the Body in Western Societies*. London: Sage Publications.
- Mace, D.R., Bannerman, R.H.O., and Burton, J. (1974). *The Teaching of Human Sexuality in Schools for Health Professionals*. Switzerland: The World Health Organization.
- Mancuso, F. and Polzer, J. (2010). "It's Your Body But...": Young women's narratives of declining Human Papillomavirus (HPV) Vaccination. *Canadian Women's Studies*, 28(2-3), 76-81.
- Martin, E. (1991). The Egg and the Sperm: How science has constructed a romance based on stereotypical male-female roles. *Signs*, 16(3), 485-501.
- Massoni, K. (2006). "Teena Goes to Market": Seventeen magazine and the early construction of the teen girl (as) consumer. *The Journal of American Culture*, 29(1), 31-42.
- Mills, S. (1998). Post-feminist Text Analysis. *Language and Literature*, 7(3), 235-253.
- Morgan, K.P. (1998). Contested Bodies, Contested Knowledges: Women, health, and the politics of medicalization. In Susan Sherwin (Ed.), *The Politics of Women's Health: Exploring agency and autonomy* (pp. 83-121). Temple University Press.
- Morrow, M. (2007). 'Our Bodies, Our Selves' in Context: Reflections on the women's

- health movement in Canada. In Marina Morrow, Olena Hanikivsky, and Colleen Varcoe (Eds.), *Women's Health in Canada: Critical Perspectives on Theory and Policy* (pp. 33-63). Toronto: University of Toronto Press.
- McGregor, S. (2001). Neoliberalism and Health Care. *International Journal of Consumer Studies*, 25(2), 82-89.
- McRobbie, A. (2011). Beyond Postfeminism. *The Atlantic Public Policy Research*, 179-184.
- McRobbie, A. (2007). Postfeminism and Popular Culture: Bridget Jones and the new gender regime. In Tasker, Yvonne and Negra, Diane (Eds). *Interrogating Postfeminism: Gender and the politics of popular culture* (pp. 27-39). London: Duke University Press.
- McRobbie, A. (2004). Postfeminism and Popular Culture. *Feminist Media Studies*, 4(3), 255-264.
- Mihalcik, C. (January 19 2016). Apple Pushes Diversity, Progress is Slow: Despite minor improvements, the tech giant's US workforce overwhelmingly white and male. *CNET*. Retrieved from <http://www.cnet.com/news/apple-pushes-workforce-diversity-but-progress-is-slow/>
- National Aboriginal Health Organization (April 5, 2012). Announcement. Retrieved from www.naho.ca/wp-content/uploads/2012/04/NAHO-Announcement-5-APR-12.pdf
- National Collaborating Centre for Aboriginal Health (2010). *Access to Health Services as a Social Determinant of First Nations, Inuit and Métis Health*. University of Northern British Columbia.
- Negra, D. (2009). *What a Girl Wants? Fantasizing the reclamation of self in postfeminism*. New York: Routledge.
- Phelan, P. (2003). Broken Symmetries: Memory, sight, love. In Amelia Jones (Ed), *The Feminism and Visual Culture Reader* (Ch. 15). Routledge: New York.
- Philpott, A., Knerr, W., and Boydell, V. (2006). Pleasure and Prevention: When good sex is safer sex. *Reproductive Health Matters*, 14(28), 23-31.
- Polzer, J. and Power, E. (2016). Introduction: The governance of health in neoliberal

- societies. *Neoliberal Governance and Health: Duties, risks, and vulnerabilities* (pp. 3-42). Montreal: McGill-Queen's University Press.
- Polzer, J. (2010). Caring for the Self, Caring for Others. *Canadian Woman Studies*, 28(2/3), 71-76.
- Polzer, J. and Knabe, S. (2009). Good Girls Do...Get Vaccinated: HPV, mass marketing and moral dilemmas for sexually active young women. *Journal of Epidemiology and Community Health*, 63(11), 869-870.
- Randall, M. (2011). The Treatment of Consent in Canadian Sexual Assault Law. Retrieved from Theequalityeffect.org
- Reinharz, S. and Kulick, R. (2007). Reading Between the Lines: Feminist content analysis into the second millennium (Ch. 12). In S. Hesse-Biber (Ed.), *Handbook of Feminist Research: Theory and Praxis*. Thousand Oaks, CA: Sage Publications.
- Reinharz, S. (1992). Feminist Content Analysis. In *Feminist Methods in Social Research* (pp. 145-163). New York: Oxford University Press.
- Richardson, L. (1989). Gender Stereotyping in the English Language. In Laurel Richardson and Verta Taylor (Eds.) *Feminist Frontiers*. New York: McGraw Hill.
- Riordan, E. (2001). Commodified Agents and Empowered Girls: Consuming and producing feminism. *Journal of Communication Inquiry*, 25(3), 279-297.
- Rose, G. (2012). *Visual Methodologies: An Introduction to Researching with Visual Materials* (3rd Edition). Sage: Los Angeles.
- Roy, S. (2008). Taking Charge of Your Health: Discourses of Responsibility in English-Canadian Women's Magazines. *Sociology of Health and Illness*, 30(3): 463-477.
- Rushowy, K. (May 13 2016). Toronto School Offers Sanitized Sex-ed Amid Parent Concern. *Toronto Star*. Retrieved from <https://www.thestar.com/yourtoronto/education/2016/05/13/toronto-school-offers-sanitized-sex-ed-amid-parent-concern.html>
- Sandfort, T.G.M. and Ehrhardt, A.A. (2004). Sexual Health: A useful public health paradigm or a moral imperative? *Archives of Sexual Behavior*, 33(3), 181-187.
- Savage, B. (2013). Large Numbers of Natives Were Sterilized by Province. In

- Margaret Helen Hobbs (Ed.), *Gender and Women's Studies in Canada: Critical terrain* (pp. 487-488). Toronto: Women's Press.
- Segal, J.Z. (2012). The Sexualization of the Medical. *Journal of Sex Research*, 49(4), 369-378.
- Seidman, S. (1989). Constructing Sex as a Domain of Pleasure and Self-expression: Sexual ideology in the sixties. *Theory, Culture and Society*, 6, 293-315.
- Sex Information and Education Council of Canada (2016). Welcome Page. Retrieved from <http://sieccan.org/wp/about-us/>
- Shoveller, J., Knight, R., Davis, W., Gilbert, M., and Ogilvie, G. (2012). Online Sexual Health Services: Examining youth's perspectives. *Canadian Journal of Public Health*, 103(1), 14-18.
- Simon, L. and Daneback, K. (2013). Adolescents' Use of the Internet for Sex Education: A Thematic and Critical Review of the Literature. *International Journal of Sexual Health*, 25(4), 305-319.
- Sturken, M and Cartwright, L. (2001). *Practices of Looking: An Introduction to Visual Culture*. New York: Oxford University Press.
- Sunderland, J. and Litosseliti, L. (2008). Current Research Methodologies in Gender and Language Study: Key Issues (Ch. 1). In Kate Harrington, Lia Litosseliti, Helen Sauntson and Jane Sunderland (Eds.), *Gender and Language Research Methodologies*. New York: Palgrave Macmillan.
- Tang, S.T. and Browne, A.J. (2008). 'Race' Matters: Racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context. *Ethnicity and Health*, 13(2), 109-127.
- Tasker, Y. and Negra, D. (2005). In Focus: Postfeminism and Contemporary Media Studies. *Cinema Journal*, 44(2), 107-110.
- Tolman, D.L. and Higgins, T.E. (1996). How Being a Good Girl Can Be Bad for Girls. In Nan Bauer Maglin and Donne Perry (Eds.), *"Bad Girls"/"Good Girls": Women, sex, and power in the nineties* (pp. 205-225). New Brunswick: Rutgers University Press.
- Tone, A. (2012). Medicalizing Reproduction: The pill and home pregnancy tests. *The Journal of Sex Research*, 49(4), 319-327.

- Tran, M. (October 15 2014). Apple and Facebook offer to freeze eggs for female employees. *The Guardian*. Retrieved from <https://www.theguardian.com/technology/2014/oct/15/apple-facebook-offer-freeze-eggs-female-employees>
- Valente, L. and Hill, T. (2015). Make Consent a Topic in the 2015 Ontario Health Curriculum. Retrieved from <https://www.change.org/p/ontario-ministry-of-education-make-consent-a-topic-in-the-2015-ontario-health-curriculum>
- Van Dijk, T.A. (1993). Principles of Critical Discourse Analysis. *Discourse Society*, 4(2), 249-283.
- Wilton, J. (2015). HIV Prevention within Serodiscordant Couples: A changing paradigm. *Catie: Canada's source for HIV and hepatitis C information*. Retrieved from <http://www.catie.ca/en/pif/spring-2015/hiv-prevention-within-serodiscordant-couples-changing-paradigm>
- Wodak, R. (2008). Controversial Issues in Feminist Critical Discourse Analysis (Ch. 13). In Kate Harrington, Lia Litosseliti, Helen Sauntson and Jane Sunderland (Eds.), *Gender and Language Research Methodologies*. New York: Palgrave Macmillan.
- World Health Organization (2006). *Defining Sexual Health: Report of a technical consultation on sexual health 28-31 January 2002, Geneva*. Switzerland: World Health Organization.
- World Health Organization (1975). *Education and Treatment in Human Sexuality: The training of health professionals*. Switzerland: The World Health Organization.

Appendices

Appendix I: List of Websites Offering Sexual Health Information

<i>#</i>	<i>Organization Name and Website URL</i>
1	AIDS PEI, aidspei.com
2	Always (US and CAN), www.always.com/en-us/home.aspx
3	Boston Women's Health Book Collective, ourbodiesourselves.org
4	Brant County Health Unit, bchu.org/index.php?option=com_frontpage&Itemid=565
5	Calgary Sexual Health Centre, cbca.ab.ca
6	Canadian Federation for Sexual Health, cfsh.ca
7	Canadian Living Magazine, canadianliving.com/relationships/sex/
8	Canadian Women's Health Network, cwhn.ca/en
9	Canadians for Choice, canadiansforchoice.ca
10	Chatelaine Magazine, chatelaine.com/health/sex-and-relationships/
11	Come as You Are sex shop, comeasyouare.com/sex-information
12	Durex Canada, durex.com/en-CA/Pages/default.aspx
13	Gurl (US), Gurl.com
14	Health Canada, hc-sc.gc.ca/hl-vs/jfy-spv/women-femmes-eng.php
15	Healthy Canadians, healthycanadians.gc.ca/index-eng.php
16	Island Sexual Health Society (BC), islandsexualhealth.org
17	Kotex (US and CAN), kotex.com/NA
18	Manitoba Sexuality Education Resource Centre, serc.mb.ca
19	Middlesex-London Health Unit – Sexual Health, healthunit.com/sexual-health
20	National Aboriginal Health Organization, naho.ca/firstnations
21	Native Women's Association of Canada, nwac.ca/home
22	Native Youth Sexual Health Network, nativeyouthsexualhealth.com
23	North West Territory's Respect Yourself, respectyourself.ca
24	Nunavut's I Respect Myself, irespectmyself.ca
25	Ontario Public Health, sexualhealthontario.ca

26	Options for Sexual Health (BC), optionsforsexualhealth.org
27	Peterborough Health Unit – Sexual Health Clinic, pcchu.ca/clinics-classes/clinics/sexual-health-clinic
28	Planned Parenthood Newfoundland and Labrador Sexual Health Centre, nlsexualhealthcentre.org
29	Public Health Agency of Canada, phac-aspc.gc.ca/index-eng.php
30	Rainbow Health Network (ON), rainbowhealthnetwork.ca
31	Scarleteen (US), Scarleteen.com
32	Sex Information and Education Council of Canada, sieccan.org
33	Sexual Health Centre (Nova Scotia), lunco.cfsh.info
34	Society of Obstetricians and Gynaecologists of Canada’s Aboriginal Sexual Health, aboriginalsexualhealth.ca/index_e.aspx
35	Society of Obstetricians and Gynaecologists of Canada’s HPV Info, hpvinfo.ca
36	Society of Obstetricians and Gynaecologists of Canada’s Sexuality and U, SexualityandU.ca ,
37	Tampax (US and CAN), beinggirl.com
38	Tel-Jeunes (QB), en.teljeunes.com/home
39	Thunder Bay Sexual Health Unit, tbdhu.com/sexualhealth
40	Toronto Public Health – Sexual Health, toronto.ca/health/sexualhealth
41	Trojan Canada, weknowsex.ca
42	U by Kotex (US and CAN), ubykotex.com
43	Women’s College Hospital Research Institute, womensresearch.ca
44	Yukon’s Better to Know, bettertoknow.yk.ca

Appendix II: Sexual Health Topics by Website

Legend:

✓ Indicates that a full article was dedicated to this item

(✓) Indicates that this item was included in an article on a separate topic

	Canadians for Choice	Healthy Canadians	National Aboriginal Health Organization	Sexuality and U (SOGC)	We Know Sex (Trojan)
Aboriginal Health	(✓)	(✓)	✓		
Abortion	✓		(✓)	(✓)	
Alcohol and/or Drugs	(✓)	(✓)	✓	✓	✓
Birth Control (hormonal)	✓	(✓)	(✓)	✓	✓
Birth Control (natural)	✓		(✓)	✓	✓
Birth Control (non- hormonal)	✓	✓	(✓)	✓	✓
Body Image			✓	(✓)	✓
Dis/ability	(✓)				
Emergency Contraception	✓		(✓)	✓	
Erectile Problems	(✓)			(✓)	✓
Global or International	✓	(✓)	(✓)	(✓)	(✓)

	Canadians for Choice	Healthy Canadians	National Aboriginal Health Organization	Sexuality and U (SOGC)	We Know Sex (Trojan)
HPV Vaccination	(✓)	(✓)	(✓)	(✓)	
In/fertility	✓	(✓)	(✓)	(✓)	(✓)
Masturbation			(✓)	✓	(✓)
Orgasm		(✓)		✓	✓
Pap Smears	(✓)	(✓)	(✓)	✓	(✓)
Pregnancy	✓	(✓)	✓	✓	✓
Puberty				✓	
Relationships	(✓)	(✓)	✓	✓	✓
Seniors and Sex		✓		✓	
Sexual Assault	(✓)		✓	✓	(✓)
Sexuality (LGBTQ2)	(✓)	(✓)	✓	✓	(✓)
STIs	✓	✓	✓	✓	✓

Appendix III: Code Book

<i>Code Name</i>	<i>Description</i>
<i>About us</i>	Website mandate, mission statement, non-profit status, funding.
<i>Abuse and Assault</i> <i>Abusive Relationship, Date Rape, FGM, Financial Dependence, Hierarchy of Rape, No means no, Opportunity, Perpetrator, Rape Culture, Rape Prevention, Resistance, Safety in Numbers, Stranger Danger, Survivors, Victim, Violence</i>	Rape, sexual assault, or abusive relationships; discussion of rape prevention and safety tips, situations where rape or abuse is described as likely to occur, discussion of the aftermath for "victims" or "survivors"
<i>Age</i>	Discussion of age, including youth as a vulnerable and sexually active population; seniors and sex
<i>Seniors</i>	
<i>Ailments and Procedures</i> <i>Andropause, Breast exam, Cervix, Depression, Endometriosis, Gardasil, Hormone Therapy, Hysterectomy, Immunization program, Mass Inoculation, Menopause, Paps, Pelvic Exam, Physical Therapy, Physiotherapy, Speculum, Surgery, Vaccine, Yeast Infection</i>	Health issues, conditions, or interventions that impact sexual health or experiences (excluding STIs or pregnancy)
<i>Alcohol and Drugs</i>	Discussion of alcohol, drugs, or smoking/tobacco use and its impact on sexual health, decision-making, and as a risk factor for sexual assault; use of intravenous drugs and STI transmission risk
<i>Audience</i>	When websites address a specific audience: information

<p><i>Female Audience, Male audience, Man, Speaking to the Victim, Where is the Perpetrator, Youth Audience</i></p>	<p>directed toward youth, to men only, to women, to victims of assault, etc.</p>
<p><i>Authority Government, Researchers</i></p>	<p>Mentions of researchers or other authority figures such as professional organizations to support claims</p>
<p><i>Birth Control Abstinence, Basal Body Temperature, Birth Control Pill, Calendar Method, Cervical Cap, Contraceptive Ring, Contraceptive Sponge, Depo- Provera, Diaphragm, Douching, Emergency Contraception, Essure, Family Planning, Fertility Awareness Method, IUD, IUS, Lactational Amenorrhea Method, Latex Gloves, Lea Contraceptive, Menstrual Suppression, Norplant, Ovulation or Billings Method, Patch, Rhythm Method, Sterilization, Subdermal Contraceptive Implants, Symptothermal Method, Tubal Ligation, Vaginal Contraceptive Film, Vasectomy, Withdrawal</i></p>	<p>Discussion of contraception in general, or specific examples and types of contraception along with benefits and drawbacks for pregnancy and STI prevention. Includes discussion of non-contraceptive benefits of birth control use, e.g. menstrual suppression. Condoms listed below.</p>
<p><i>Body Parts Biological basis, Biological Sex, Brain, Breasts, Clitoris, Genetics, Hormones, Hymen, Immune</i></p>	<p>Discussion of the biological body and processes.</p>

<i>system, Penis, Piercings, Puberty, Reproductive Organs, Semen, Sexual Organs, Skin, Testicles, Vulva</i>	
<i>Canada</i>	Specific mentions of Canada and other global locations.
<i>Global, Society</i>	
<i>Choices</i>	Choice and decision-making.
<i>Benefits, Change behavior, Changing Minds, Impact of Decisions, Informed Choice, Life is Changed, Mistake, Regret, Smart</i>	
<i>Communication</i>	Talking with partners or medical professionals, friends, parents, etc. about sexual health issues or STI disclosures; includes guidelines for how to initiate conversations.
<i>Disclosure, Guide, Negotiation, Scripts, What to expect</i>	
<i>Condoms</i>	Barrier contraception including condoms, dental dams, and female condoms and related products; see also hierarchy of contraception code, below.
<i>Barrier, Dental Dam, Female Condom, Lubrication, Spermicide</i>	
<i>Consent</i>	Consent in the context of sexual assault and as integral to healthy sexual relationships; also covers medical consent.
<i>Consent and Pressure, Consent to Medical Treatment, Withdraw Consent</i>	
<i>Consequences</i>	The unwanted consequences or symptoms of STIs or untreated STIs.
<i>Cancer, Death, Fertility, Harmless, Hidden, Infertility, Invasive, Pain, Permanent, Rare, Side Effect, Symptoms, Visible</i>	
<i>Conservative</i>	Sexually conservative values, waiting for sex.
<i>Morals</i>	
<i>Consumerism</i>	Language that indicates that any cost may be involved in

	a health or sexual decision (e.g. OTC medication, experimenting with different styles of condoms).
<i>Control</i>	Exercising control through choice, through particular
<i>Action</i>	(female-managed) contraceptives, managing STIs with medication (e.g., herpes outbreaks), etc.
<i>Diversity</i>	The embarrassing etc.: where websites specifically call on
<i>Aboriginal, Acceptance, All people, Alternative, Colonization, Common, Comparison, Disability, Exclusion, Homelessness, Identity, Immigration Status, Language, Low Income, Most, Mother Earth, Natural, Normal, Oppression, Othering, Race, Reclaim, Religion and Culture, Residential Schools, Role Model, Rural, Same, but different, Socio-Economic, Spiritual, Tapestry of Faces, Together, Trend, Unique</i>	(or contribute to) difference such as socio-economic status, ability, racial or ethnic origin, etc. This could be to demonstrate their own attempts at inclusion or to describe discrimination in society. See also LGBTQ.
<i>Doctor</i>	Medical professionals, nurses, pharmacists, or medical
<i>Anonymous, Confidential, Counseling, Doctor-Patient Relationship, Paperwork, Patient, Pharmacy, Professional, Shop for doctors, Support Group or Community</i>	clinics or organizations.
<i>Ease or Difficulty</i>	Whether a particular conversation, STI treatment, or
<i>Convenient, Effective, Realistic, Reliable, Work</i>	contraceptive method was described as easy or difficult to engage
<i>Emotion</i>	Any discussion of a range of emotional states, including

<p><i>Brave, Comfort, Danger, Embarrassed, Fear, Happiness, Humour, Judgement, Panic, Shame or Discomfort, Stigma, Threat</i></p>	<p>shame, discomfort, stigma, or fear surrounding a particular relationship, conversation, sexual experience, or medical procedure or status (e.g., STI status).</p>
<p><i>Feminism</i></p>	<p>Explicit or implied invocation of feminism; feminist- and post-feminist related terminology like freedom, privacy, entitlement, etc.</p>
<p><i>Body image, Empowerment, Entitled, Equal, Female Body, Freedom, Fun, Independence, Mind-Body, Pamper, Post-feminism, Power, Privacy, Respect, Right for You, Rules, Self-confidence, Sexism, Voices, You do you</i></p>	
<p><i>Gender</i></p>	<p>Gender comparisons (e.g. in listing STI symptoms),</p>
<p><i>Battle of the sexes, Gendered Language, Girl, Stereotypes, Stereotypical Depictions of Women, Women</i></p>	<p>gendered language (e.g. in discussions of conception), representation of gender roles in images.</p>
<p><i>Health</i></p>	<p>Discussions or definitions of health or what constitutes</p>
<p><i>Access, Assuming Health, Definitions, Health Care, Health Insurance, Health Record, History, Medical, Medication, Mental Health, Physical Problems, Public Health, Records, Reporting, Reproductive Health, Sexual Health, Stay Healthy, Taking Care, Un-health,</i></p>	<p>health, including reproductive health, mental health, and well-being; health care management including advice to maintain good health</p>

<i>Well-being, WHO</i>	
<i>Hierarchy of Contraception</i>	Arguments or evidence presented that depict a preference for certain types of birth control over others for reasons related to efficacy, pleasure, etc.
<i>Backup, Condom Breaks, Condoms decrease pleasure, Non-Contraceptive Benefits, User failure</i>	
<i>Images</i>	
<i>Importance</i>	When article text emphasizes the importance of a particular behaviour (e.g. STI screening) or the consequences of ignoring a particular sign or symptom.
<i>Ignore, Priority, Recommendations</i>	
<i>Knowledge</i>	Sources of information; Knowledge of self, sexual health information, knowledge, or education.
<i>Aware, Computer, Education, Fact, Friends, Information, Media, Misinformation, Myths, Outdated information, Resources, Take for granted, Tips, Truth, Website</i>	
<i>Law</i>	References to the legality of sexual behaviour, crimes, reporting to the police (including sexual assault).
<i>Age of Consent, Child Pornography, Crime, Internet Luring, Legal, Prison, Prostitution</i>	
<i>LGBTQ</i>	
<i>Activists, Asexual, Bisexual, Coming Out, Confusing, Discrimination, Gay, Gender Identity, Heterosexism,</i>	References to LGBTQ audiences, identities, or behaviours.

<i>Heterosexual, Homosexuality, Intersex, Lesbian, Queer, Sexual Diversity, Sexual Identity, Sexual Orientation, Transgender or Transsexual, Two-Spirited</i>	
<i>Not just intercourse</i>	References to sexual activity that is not defined only as p-in-v intercourse.
<i>Anal Sex, Foreplay, Kissing, Masturbation, Missionary, Oral Sex</i>	
<i>Partner</i>	References to sexual or romantic partners and relationships, including discussions of monogamy, relationship problems or imbalances, marriage, love, and intimacy.
<i>Assumption of non-monogamy, Break up, Cheating, Expectations, Family, Healthy Relationship, Intimacy, Love, Marriage, Monogamy, Promiscuity, Rejection, Relationship Imbalance, Relationships, Romance, Sexual Intimacy, Sexual Relationship, Significant Other, Single</i>	
<i>Period</i>	Menstruation, bleeding as a symptom of STIs, and menstrual management
<i>PMS, Toxic Shock Syndrome</i>	
<i>Pleasure and Arousal</i>	Physical and emotional sources of and responses to sexual stimuli; issues that impede "proper" or normal sexual response.
<i>Desire, Erectile Problems, Fantasy, Give pleasure, Libido, Lust, Mood-killer, Orgasm, Painful Intercourse, Performance Anxiety, Porn, Satisfaction, Wet Dreams</i>	
<i>Pregnancy</i>	Discussions of pregnancy, whether planned or unplanned.

<p><i>Abortion, Adoption, Anti-Choice, Body is for pregnancy, Breastfeeding, Children, Custody, Delaying pregnancy, Fatherhood, Miscarriage, Motherhood, Oops, Parent, Post-baby, Pregnant Body, Pro-Choice, Splash Pregnancy, Teen Pregnancy, Unintended pregnancy, Voluntary Childlessness</i></p>	
<p><i>Prevention Planning, Preparation, Protect, Protecting partner</i></p>	Prevention and planning to protect self and partner from pregnancy and STIs.
<p><i>Responsibility Blame, Cleanliness, Diet, DIY, Exercise, Guilt, Individual, Instincts, Lifestyle, Self-care, Stress, Weight, Worry</i></p>	Where individual responsibility for health is explicitly or implicitly stated; involves lifestyle choices and self-care as factors impacting health and well-being.
<p><i>Rhetorical Devices Discredit, Euphemisms, Exaggerating for Effect, Fight, Ideal, List, Machine, Metaphor, Narrative, Need, Personification, Statistics</i></p>	Use of metaphor, statistics, or other linguistic efforts to persuade readers or add emphasis to a particular discussion.
<p><i>Rights Paternal Rights, Reproductive Rights, Sexual Rights</i></p>	Discussion of sexual or reproductive rights
<p><i>Risk Safer Sex, Safety, Unprotected Sex</i></p>	Identification of sources of risk, risk factors, and risk activities as well as discussion of safety and safer/protected sex.

<p style="text-align: center;"><i>Sex</i></p> <hr/> <p><i>Ask for sex, Bad sex, Casual Sex, Encouraging Sex, Experience, Good sex, Problem, Reasons for having sex, Sex as an experience, Sex Drive, Sex Fog, Sex Life, Sex position, Sex to save a relationship, Sex Toys, Sexting, Sexual, Sexual Activity, Sexual Appetite, Sexual Being, Sexual Chemistry, Sexual Desire, Sexual dysfunction, Sexual Experience, Sexual Expression, Sexual History, Sexual Initiation, Sexual Potential, Sexuality, Sexy, Teen sex, Thinking about sex, Uninterrupted sex, Virginity</i></p>	<p>All things sex-related: sexual health and well-being, activity, experience, problems, etc.</p>
<p style="text-align: center;"><i>STIs</i></p> <hr/> <p><i>Acute, Bacterial, Chlamydia, Chronic, Democratic STIs, Gonorrhoea, Hepatitis B, Herpes, HIV-AIDS, HPV, LGV, Non-Sexual Spread, Parasitic or Fungal, Pelvic Inflammatory Disease, Pubic Lice (Crabs), Scabies, Superbug, Syphilis, Trichomoniasis, Viral</i></p>	<p>STIs as a general term/concern, STI categories (acute, bacterial, viral, etc.), and specific STIs (including HIV-AIDS).</p>
<p style="text-align: center;"><i>Surveillance</i></p> <hr/> <p><i>Routine, Self-Diagnosis, Self-Surveillance, Vulnerable</i></p>	<p>Anything to imply scrutiny of body or sexual behaviour; medical exams, self-diagnosis, and self-surveillance.</p>
<p style="text-align: center;"><i>Tests</i></p>	<p>Pregnancy or STI testing and procedures; process of</p>

<i>Diagnosis and Detection</i>	diagnosing or detecting STIs.
<i>Time</i>	Any reference to length of time (e.g. of recovery from infection) or discussions where readers are urged to act.
<i>Last chance, New, Urgent</i>	
<i>Transmission</i>	Transmission or spread of STI or other infection, including possibility of re-infection after treatment.
<i>Carrier, Exposure, Infected, Recurrence or reinfection, Spread</i>	
<i>Treatment</i>	
<i>Clear Infection, Cure</i>	STI treatment through medical means or immune system response.
<i>Trust</i>	Discussion of trust and honesty (e.g. in discussions with doctors or sexual partners)
<i>Honesty</i>	

Curriculum Vitae

- Name:** Laura Cayen
- Post-secondary Education and Degrees:** University of Windsor
Windsor, Ontario, Canada
2007 B.A.
- The University of Western Ontario
London, Ontario, Canada
2008 M.A.
- The University of Western Ontario
London, Ontario, Canada
2016 Ph.D.
- Honours and Awards:** Province of Ontario Graduate Scholarship
2012-2013
- Social Science and Humanities Research Council (SSHRC)
Joseph-Armand Bombardier Canada Graduate Scholarship
2009-2012
- Related Work Experience**
- Instructor
The University of Western Ontario
2012-2016
- Instructor
King's University College, The University of Western Ontario
2016
- Teaching Assistant
The University of Western Ontario
2007-2014
- Publications:**
Cayen, L., Polzer, J., & Knabe, S. (2016). Tween girls, human papillomavirus (HPV) and the deployment of female sexuality in English-speaking Canadian magazines. In Jessica Polzer and Elaine Power (Eds.) *Neoliberal Governance and Health: Duties, Risks and Vulnerabilities* (pp. 82-107). Montreal: McGill-Queen's University Press.