MOSQUITOES, SEX WORKERS, NUNS, AND "OUR IGNORANT FOLK": NARRATIVES OF HPV INFECTION AND VACCINATION AMONG TURKISH DOCTORS

by

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ABSTRACT

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Yaprak Sarıışık

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Keywords: HPV, gender, sexuality, medical anthropology.

Through in-depth interviews with doctors in İstanbul, this thesis explores how doctors shape the meanings of human papillomavirus (HPV) in relation to discourses about sexuality, morality, and existing social hierarchies. It examines how existing social inequalities and power relationships based on gender, socioeconomic status, and knowledge are incorporated into, shaped and reproduced by doctors' HPV narratives. Through doctors' narratives of HPV, this study examines how doctors construct their patients and the general public as uneducated masses, which they differentiate from their own social positions as educated experts. It also conveys how HPV narratives cast men and women in specific gender roles. It aims to highlight how these narratives are embedded within a broader discussion of national and traditional values, as well as assumed norms about morality and sexuality.

ÖZET

SİVRİ SİNEKLER, HAYAT KADINLARI, RAHİBELER VE "CAHİL HALKIMIZ": TÜRK DOKTORLARININ ANLATILARINDA HPV ENFEKSİYONU VE AŞISI

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Anahtar Kelimeler: HPV, toplumsal cinsiyet, cinsellik, medikal antropoloji.

Bu çalışma, İstanbul'daki doktorlar ile yapılmış derinlemesine mülakatlara dayanarak, doktorların human papillomavirüsünü (HPV), cinsellik, ahlak ve mevcut sosyal hiyerarşiler bağlamında nasıl anlamlandırdıklarını incelemektedir. Çalışmada, toplumsal cinsiyet ve sosyoekonomik konuma bağlı sosyal eşitsizliklerin ve iktidar ilişkilerinin, doktorların HPV anlatılarında nasıl ele alındığı, şekillendirildiği ve yeniden üretildiği ele alınmaktadır. Bu çalışma, doktorların HPV anlatıları üzerinden doktorların, hastalarını ve halkı nasıl cahil kitleler olarak kurguladıklarını ve kendilerini buna karşın eğitimli uzmanlar olarak nasıl konumlandırdıklarını tartışır. Ayrıca, HPV anlatılarının erkek ve kadınları nasıl farklı cinsiyet rolleriyle ele aldığını gösterir. Bu anlatıların, hem milli ve geleneksel değerler, hem de ahlak ve cinselliğe dair varsayılan normlar üzerine daha geniş bir tartışma bağlamında yer aldığının altını çizmeyi amaçlar.

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CHAPTER 1

INTRODUCTION

According to the World Health Organization, "Human papillomavirus causes cervical cancer, and is the second biggest cause of female cancer mortality worldwide with 288,000 deaths yearly."[1] One of the major causes of cervical cancer is believed to be certain types of human papillomavirus, or HPV. The virus and early stages of cervical cancer are relatively easy to detect by routine PAP smear testing, which enables high chances of recovery from cervical cancer. Both the possibility of detection at early stages and the pervasiveness of HPV make the virus and cervical cancer increasingly popular centers of attention for doctors, pharmaceutical companies, and women's health and cancer related associations. Moreover, in 2006 the first vaccine, Gardasil, which has been developed for protection against HPV infections, was approved by the U.S Food and Drug Administration (FDA).[2] The second vaccine, Cervarix also received FDA approval in 2009,[3] and for the past three years the two vaccines have been approved and used in more than 100 countries worldwide.

In the United States and Australia the vaccines have been considered to be part of mandatory vaccination programs, or to be included in state-funded immunization. In England, the department of health initiated a HPV immunization program to "routinely vaccinate girls aged 12 and 13—and up to the age of 18—against cervical cancer,

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[1] http://www.who.int/vaccine_research/diseases/hpv/en

[2] http://www.fda.gov/bbs/topics/news/2006/new01385.html

[3] http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm187048.htm

starting from September 2008."[4] With these developments about the vaccines, informational programs are mostly geared towards encouraging people to get vaccinated.

In Turkey, too, awareness about HPV and cervical cancer has been increasing. However, the "war against" cervical cancer and spreading the vaccination have not gone uncontested, especially since Gardasil's arrival in Turkey in 2007, followed by Cervarix in 2008. The following quote, taken from a news item from October 2007, demonstrates some of the initial discussions generated by HPV, cervical cancer, and the vaccine:

> Prof. Dr. Tezer Kutluk, the president of the Turkish Association for Cancer Research and Control, stated: "We recommend the cervical cancer vaccine to everyone who can afford it" while the president of the Turkish Society of Gynecology and Obstetrics Prof. Dr. Bülent Tıraş stated "If we vaccinate all female children within the age range 9-11 now, 15-20 years from now we will have significantly decreased the number of cervical cancer cases. This is a long-term and serious project." Prof. Dr. Murat Tuncer, the chairman of the Ministry of Health Department of Cancer stated that the cervical cancer vaccine is not that necessary for Turkey and said, "For us scanning programs [that highlight routine pap smear tests] are important. Because cervical cancer is not a problem for our country now. It ranks ninth among women's cancers.[5]

Such debates around HPV vaccination bring various questions to mind, which are led by but not limited by the above quote. Firstly, who does Kutluk's "everybody" in fact refer to? Tıraş's statement about "female children" and Tuncer's term "women's cancers" seem to suggest that "everybody" is not intended to include each and every body. The discussions about HPV are primarily centered on women, which may seem unproblematic considering cervical cancer affects women's bodies specifically. However, we also need to consider why men, who are equally likely to be infected by

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[4] http://www.in-pharmatechnologist.com/Materials-Formulation/Gardasil-vs-Cervarix-winner-gets-UK-supply-contract

[5] Retrieved from http://www.ntvmsnbc.com/news/422973.asp

HPV and act as carriers, are not included in the defined "everybody."[6] How are concerns about HPV shaped by existing gender hierarchies and roles? How are men and women differentially situated within narratives about HPV?

Another set of questions to be raised pertains to the possibility that information about HPV and access to the vaccine may not be equally distributed among everyone, even among women. Especially considering that the vaccination for HPV is quite costly, one wonders whether the targeted bodies of the virus equally correspond to the receivers of information and the vaccine. How do the narratives and practices around HPV vaccination shape or reproduce existing social differences based on socioeconomic status?

Moreover, if we are to go back to Tuncer's words, what does it mean for a cancer to rank ninth among other cancers? In terms of budget concerns, it makes sense for the Department of Health to allocate its resources according to statistics. However, what else might this allocation and reasoning reflect? Especially when we consider how policies and practices shape current and future policies, practices, perceptions, and meanings, what does it mean, for instance when Recep Akdağ, the Minister of Health, states that "the reason for the cervical cancer vaccine to be not included within the coverage of social security is not merely its cost, but also because the vaccine was not believed to be a priority in terms of public health [?]"[7] How is public health defined and in the particular case of HPV, how does its sexual transmission play a role on excluding it from "public" concerns?

Furthermore, what does it mean to ask these questions in the specific social and cultural context of contemporary Turkey? In Turkey a general discourse of ignorance

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[6] Especially when most of the commentators on the debate, at least in this example, are men.

[7] http://www.haberler.com/saglik-bakani-akdag-rahim-agzi-kanseri-asisinin-haberi/

(*cehalet)* is commonly used to blame individuals, especially individuals from lower social strata, claiming their own "ignorance" and "lack of information" are responsible for various social problems, including health-related issues. The emphasis on information can also be observed in campaigns about HPV; through an initial look it is possible to see that the campaigns about HPV emphasize the importance of being informed and responsible for oneself.[8] How do narratives about HPV interact with existing stereotypes about "ignorance" and reproduce meanings attached to education and health?

Within the context of HPV and HPV vaccination, women's bodies constitute a territory over which issues such as sexuality, health, immunization, cancer, state legislation, and insurance policies intersect. Various discourses on the HPV, a sexually transmitted virus, and cervical cancer not only define how people should act against the virus and the cancer but also may shape notions of acceptable sexual behavior, assumptions about individuals' sexuality and health. Doctors are significant actors in creating, shaping, and reproducing these discourses. Particularly in Turkey, where HPV vaccination is mostly based on doctors' practices and individual decisions, doctors' narratives are central to discourses on HPV.

Through in-depth interviews with doctors in İstanbul, this thesis explores how doctors shape the meanings of the virus in relation to discourses about sexuality, morality, and existing social hierarchies. I examine how existing social inequalities and power relationships based on gender, socioeconomic status, and knowledge are incorporated into, shaped and reproduced by doctors' HPV narratives.

The first chapter contains the theoretical framework for my research, a description of my study, and methodological reflections. This introductory chapter is

[8] One of the major campaigns' main slogans is "*Biliyorum Anlatıyorum*", which exemplifies the emphasis on having and sharing information about HPV.

followed by three chapters, which focus on different aspects of doctors' HPV narratives. The second chapter examines how doctors' perceive and express socioeconomic difference in their narratives. After an overview of doctors' differing practices based on their public or private work settings, I focus on the ways in which they discuss the financing for HPV vaccination. Their discourses show that, the doctors distinguish between their patients on the basis of "being able to afford" the vaccine. I examine how their notions of purchasing power normalize distinctions between those who can and cannot afford the commodified health services. Moreover, by reducing difference into a mere result of income, such explanations based on financial means overlook interdependent power relations that constitute social hierarchies. Furthermore, broader discussions about health in Turkey demonstrate how power relations are embedded within doctors' descriptions of their patients as uneducated and ignorant. In this chapter, I examine how doctors' construct their patients and the general public as uneducated masses, which they in turn oppose to their own social positions as educated experts.

In the third chapter, I demonstrate how HPV narratives often cast men and women in specific gender roles. As these narratives reproduce existing gender roles they also engage in discussions of moral values and appropriate sexualities. I also discuss how these discussions reveal various tensions between traditional moral values and sexualities on the one hand and doctors' ambivalent acknowledgement of alternative sexualities on the other.

The fourth chapter looks at issues of morality and change more closely. It examines descriptions of "change" in women's sexual behavior through a prevalent metaphor that surfaces doctors' narratives. The ways in which doctors describe HPV transmission and changes in sexual behavior suggest that they see the virus and changes as coming into our bodies and our society from the "outside". Moreover, this notion of

the "outside" is often articulated as "the west", as doctors compare Turkish society with "the west" in describing contemporary changes.

In conclusion, I review the main arguments of my research. I also suggest ways to connect the different themes in my thesis firstly by focusing on the comparisons between Turkey and "the west", and secondly by emphasizing doctors' authoritative role in shaping and reproducing norms and stereotypes about morality, gender roles, sexuality, and socioeconomic difference.

1.1 Review of relevant literatures

A critical approach towards science has been an existing concern in the social sciences. Scholars have underlined the importance of considering science as a social and cultural object, instead of presuming it to be a neutral objective realm (Latour & Woolgar 1986, Haraway 1988, Nader 1996, Downey & Dumit 1997). Downey and Dumit's co-edited volume *Cyborgs and Citadels: Anthropological Interventions in Emerging Sciences and Technologies* is a collection of works that aim to challenge perceptions of science as a "fortified citadel" with its claims of unquestioned objectivity, legitimacy, and sovereignty. The works in this volume also emphasize the increasing role of science and technology in fashioning selves.

Within this context, medical science also needs to be scrutinized. Since medicine is deeply embedded within social life and has numerous immediate implications in people's daily lives, the critical approach of the social sciences to medicine is crucial. Along these lines, examining how people construct meanings around medical practices and technologies is a key concern for the social sciences. The field of medical anthropology comprises a valuable set of contributions in forming a multifaceted understanding of medical science. Equipped with the profound understanding enabled by anthropology's ethnographic approach, medical anthropologists have contributed to

deepening our grasp of medical science as a social and cultural object (Good 1994, Hahn 1995, Sargent & Johnson 1996). Existing research has explored meanings and experiences of health, illnesses, treatments, medicines, and medical practices in various social contexts. Studies have covered a vast array of issues including understanding surveillance and regulation through medical practices (Nettleton 1991, Howson 1998), examination of how perceptions and images of body and birth are contingent on socio-historical contexts (Martin 1987, 1994), and the social and cultural trajectories of medicines that circulate around the world (Whyte et al 2002).

While there has not been any research that particularly focuses on HPV and HPV vaccination, there have been some medical studies on cervical cancer screenings as a preventive strategy (Paterson et al. 1984, Nathoo 1988, Howson 1998, Bush 2000, Todorova et al. 2006). More importantly, there is a significant body of literature that specifically focuses on reproductive health, which can encompass and contextualize discussions about HPV.[9] Rapp and Ginsburg's co-edited volume *Conceiving the New World Order: The Global Politics of Reproduction* offers a valuable collection of studies that further explore the social and political dimensions of reproduction within a transnational context. As Rapp and Ginsburg emphasize, "reproduction, in its biological and social senses, is inextricably bound of with the production of culture" (1995, 2) and therefore needs to be a central focus of social theory. Contributions like Rapp's ethnography on the social impact of amniocentesis in the United States (2000) demonstrate that reproductive health is indeed a rich area of research that reveals the social and power relations embedded in medical practices.

In the Turkish context, although there have not been similar in-depth ethnographic studies that concern reproductive health or studies that focus directly on

[9] For an extensive review of the existing literature on reproduction, see Ginsburg and Rapp's article "The Politics of Reproduction", 1991.

HPV, there are a number of studies that contextualize an exploration of the field around HPV and the HPV vaccine. Firstly, there are medical anthropological studies that have been conducted in Turkey. For instance, there are studies that explore epilepsy narratives in Turkey (Good & Good 1994); Turkish modernity through the experiences of cancer patients (Terzioğlu 2008); experiences of sickle cell anemia in Hatay (Yürür 2005); and meanings and practices of healing in a Black Sea village (Wing-Önder 2005). Although these studies do not directly concern reproductive health, by constituting examples they help to form a framework for a study that explores local understandings and experiences of health within a national and transnational context.

Secondly, studies concerning various aspects of gender and sexuality in the Turkish context also frame discussions of HPV, as they dwell on similar issues. For instance, the connections between citizenship and gender as they have been explored by existing studies around issues such as virginity examinations (Parla 2001), virginity tests and artificial virginity (Cindoğlu 1997), reproductive rights and legal reforms (Gürsoy 1996, Miller 2007) help ground the study at hand. A discussion of the official discourses about the HPV and the state interventions regarding the HPV vaccine can thus be framed within a broader discussion of the relationship between gender and citizenship. There are also qualitative studies that focus on practices of reproduction such as Delaney's ethnographic study in a Turkish village[10] (1991) and Dikmen-Özarslan's study that explores practices and meanings constructed around menstruation and their change over generations (2004). While the aforementioned works do not particularly focus on reproductive health, their contributions form the basis on which we

[10] I find Delaney's work to present the practices in the village as forming a homogenous, coherent, and unchanging entity. Although I am critical of her portrayal of the practices in this village, her work comprises one of the earliest studies that explore practices around sexuality and reproduction in Turkey.

can situate a discussion on the cultural and social dimensions of HPV and HPV vaccination.

Positioned at the intersection of these existing research and theories, my work will seek to examine notions and embodiments of health and sexuality as reflected in doctors' narratives of HPV. I hope to contribute to the existing literature with a particular concentration on reproductive health in Turkey, and specifically with a focus on the impact of HPV and HPV vaccination in Turkey. I aim to examine how HPV is constructed through medical and everyday discourses, producing and reproducing social inequalities.

1.2 Research design and methodological reflections

My research is based on in-depth interviews with obstetricians and gynecologists from Istanbul. My interviews are also supported with preliminary research on media coverage of HPV and the HPV vaccine, the vaccines' website contents, pamphlets, informational booklets for doctors. Over the course of two months between April 2009 and May 2009, I interviewed fourteen doctors. I accessed my participants with the help of the snowball sampling method. Often, my participants referred me to other doctors for interviews.

As gender and sexuality is a significant part of my research, I wanted to balance the gender distribution of my interviewees as much as possible. Eight of my interviewees were men and six were women. I also tried to choose doctors who work in diverse settings and serve different socioeconomic groups of people in their practice. Six of my participants, Ali, Gaye, Sabriye, Meral, Yeliz, and Bekir, work in public hospitals, which are often overcrowded and serve the lower socioeconomic strata of the

society.[11] One participant, Salih, who now practices in his private office, has worked in public hospitals until his recent retirement. Six of my participants only work in their private offices. Among them, Haydar, Kemal, Kadir, Semra, and Suzan's practices are located in affluent neighborhoods of İstanbul. Reha and Nuri, who are also brothers, do not perfectly fit in the two groups described above. Reha practices in his private office, but he also works in a private hospital part-time. Nuri only practices in a private office, however his practice is not located in an affluent neighborhood, and he particularly serves lower socioeconomic classes. Even the admittance fee Nuri charges costs less than half of what other private practitioners' fees cost.

With the exception of one interview that lasted for 20 minutes, all of the interviews lasted about 1-1.5 hours. Except for the 20-minute interview, in which Yeliz did not want me to record, all interviews were digitally recorded and transcribed. In the case of Yeliz, instead of recording I manually took notes during and after the interview. In analyzing the transcriptions, I utilized a computer software titled HyperResearch to assist me with the coding process. All of the interviews were conducted in the doctors' offices or in their rooms at the hospital. In all but one cases, the doctors preferred to sit at their own chairs behind their office desks, while I sat at the chair where their patients normally sit.

Since my study is based on interviews with doctors, my analysis focuses on doctors' narratives. Although I have not conducted observations during doctor-patient consultations or examinations, doctors' narratives constitute a significant part of their practices overall. Moreover, because I have a small sample of doctors from İstanbul, my findings are not necessarily generalizable for all doctors practicing in Turkey.

[11] Throughout this thesis, all of the names used are pseudonyms.

Nevertheless, the common themes I examine in these narratives provide interesting insights about medical practice and HPV.

Studying HPV discourses was interesting but challenging on many levels. Firstly, studying the familiar context of "my own society" made the analysis of discourses difficult. In her work Emily Martin talks about how her interviewees' words seemed how "commonsensical" to her at first (1987, 10). In my interviews with doctors, there were times when I felt that the conversations were mainly "small talk" that we are familiar with from our colloquial experiences and where doctors' opinions sounded quite commonsensical. Going through the transcriptions multiple times, I tried to find ways to distance myself from my own cultural assumptions and question the seemingly commonsensical comments. Situating the commonsense and the small talk in the center to my analysis indeed resulted in some of the most interesting and insightful observations.

Secondly, because the HPV vaccine is a very recent development, there has not been much literature that examines social and cultural aspects of HPV. Because of this gap in the current literature and the need to familiarize myself with recent developments about HPV, I often immersed myself into the medical literature as much as I could understand its contents. Because doctors often talked about HPV in medical terms, this background was necessary in understanding their descriptions.

Being a young female social scientist also shaped my interview experiences and my position as a researcher. While "studying up" contributes immensely to understand how power is exercised and differences are reproduced, the research process inevitably introduces various challenges (Nader 1972). Aside from minor obstacles, such as convincing doctors to participate in the study and allocate an hour of their busy schedules for an interview, interviewing doctors also shifts the typical power dynamics

between the researcher and the researched. As I am in the target age group of the vaccines and as I physically sat in doctors' patient chairs in the interviews, doctors perceived me not only as a researcher but also as a woman who could have been their patient. My interviewees often commented on my research, made suggestions, or even personally asked me about my possibility of vaccination.

In the interviews, doctors mostly respond to my questions in order to "inform" me and give me scientific information about what they perceive to be purely medical issues. For them my interview questions were questions to be answered with rational, informative answers. For instance, as Suzan answered my questions, she also looked up details from the Internet, and also asked me playfully "Am I being able to answer your questions correctly?"

As they conveyed information on HPV, my interviewees also consulted books, websites, often in a didactic manner. For instance, Semra had prepared hand written notes in preparation for the interview. She also printed out information related to the HPV in preparation. As if giving me a lecture, she read from her notes while informing me about HPV. Moreover, when explaining what to do when cervical dysplasias are detected, she started drawing an image to illustrate the female reproductive organs. On a full diagram of the ovaries, fallopian tubes, and the uterus she showed me where the cervix is, and also illustrated how the cervix looks seen through a speculum. Then she explained the procedures and tools used, marking them on her diagrams. At the beginning of our interview, she also brought some sample vaccines to show me. In another interview, Salih demonstrated how a PAP smear is done using a sample cotton swab and as he held his hand in the shape of the cervix. He also demonstrated on his hand how the test does not interfere with the hymen. Like Semra who prepared notes for the interview, some doctors referred to books and websites to support their responses.

When she was telling me how many types of HPV exist, Suzan checked her information from online sources and she read them out loud for me. Nuri consulted a medical handbook, several times. As he read out loud the passage about risk factors for HPV for the third time he said, "Let's look at this one more time to reaffirm what we know."[12] As these instances suggest, doctors wanted to use these interviews also as opportunities to inform a young woman. Also thinking I would help spread this useful information, Semra and Salih gave me informative pamphlets, and they made sure I take a handful of them to share with my friends. Other doctors like Ali and Reha also offered me informational booklets about the vaccines. While Kemal shared the abstracts of conference presentations that he had recently attended, Haydar gave me as a present a book called "Sexual Education" authored by himself.

Doctors also made recommendations for my research and questioned my methods at times. For instance, after a long and distracted comment, Bekir told me that I should summarize and simplify what he has been saying when I write it up.[13] Yeliz, who did not want me to record the interview, did not answer my questions directly either. Our interview took the form of Yeliz dictating me specific answers, rather than a conversation where I took notes. She assumed that there are specific answers for my questions, since these are scientific issues there can be only one true response to such questions. In the middle of out interview, Ali also wanted to make sure I did not miss out the necessary information he was conveying; he asked me "Is this thing [the recording device] working? I'm not talking in vain here, am I?"[14] As I stated, doctors'

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[12] *Zaten en önemli sebeplerini ben size biraz önce saydım, bir daha bakalım isterseniz, pekiştirelim bilgimizi.*

[13] *Biraz böyle karışık filan oldu ama siz bunları özetleyin lütfen.*

[14] *Bu şey çalışıyor değil mi, ben boşuna konuşmuyorum?*

questions and comments were not only about the procedure of the interviews, but also about my methodology. For instance, Gaye, Sabriye, and Reha asked me who assigned my research topic and why I decided on this subject. Sabriye also commented, after the interview ended, that she believed "my parameters" and questions were wrong. She told me that I should ask better questions and decide on a more reasonable research question. Ali also asked me what my thesis is about, and what I "intended to prove."[15] While I believe these interventions were well-intentioned and doctors wanted to help me, their comments and questions also suggest how in the eyes of doctors my research did not constitute a proper "positivistic" research project.

Moreover, all these instances, where the doctors assumed the powerful position of asking the researcher questions, convey their authoritative positions as experts. These instances not only reflect the power dynamics in the interviews, but also provide instances of understanding how doctors perform their identities as experts. As experts, doctors enthusiastically educate me about the vaccine and guide me in my research methods. In this sense, my interview experiences also constitute moments of how doctors' enact their identities as experts on a daily basis.

In the following chapter, I discuss how doctors perceive their patients and the general public and how they articulate socioeconomic difference in HPV narratives. My discussion also includes how doctors set themselves apart from what they describe as "our people" or the "general public",[16] based on what they refer to as education and culture.

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[15] *Sizin tezinizin konusu ne olacak şimdi, siz neyi ispatlayacaksınız?*

[16] "The original phrases used are "*Bizim insanımız"* or *"halk"* that are used interchangeably.

CHAPTER 2

CONSTRUCTIONS OF "OUR IGNORANT FOLK"[17] IN HPV NARRATIVES

In her meticulous study of amniocentesis in the United States, Rayna Rapp reminds us that "the problems and possibilities offered by access to a specific biomedical technology fall upon social ground which is always already crosscut by prior resources and hierarchies" (2000, 10). Unlike amniocentesis, which has become a highly routinized reproductive technology, HPV vaccination is very recent and its application is only gradually taking shape. Therefore, it is not easy to map out the interactions between existing social hierarchies and the practices around the HPV vaccine. While there are not any established practices around the vaccine or mass vaccination programs in Turkey, HPV and HPV vaccination have nevertheless received attention from media and doctors. In the media, the vaccine is presented as the miracle cure for cervical cancer and recommended for all women. The HPV vaccine is yet to be subsidized by the Turkish state and it costs approximately 750 Turkish Liras, which well exceeds the minimum wage in Turkey, currently 576 Turkish liras. Yet, news stories about HPV and informational websites designed by vaccine companies do not focus on the financial aspect of the vaccine.

While the point of my study is not to advocate for equal access to the vaccine or its public subsidization, I was interested in learning about how doctors perceive the financial aspect of HPV immunization, which evidently leads to discrepancies in access

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[17] *"Cahil halkımız."*

to the vaccine. Thus, I set out to examine the ways in which the economic aspect of the vaccine is problematized, or is left unproblematized, in the doctors' narratives. I devoted a considerable part of my interviews to discuss the reasons for the high price of the vaccine, possibilities for government subsidization, the number and socio-economic status of the patients doctors' vaccinate, and how doctors feel about the unequal access to the vaccine. While I expected doctors to be critical about insurance companies that do not cover the vaccine, the pharmaceutical companies for their high pricing, or the commodification of health services that result in social inequalities overall, my questions usually led to dead ends. No matter how much I persisted on getting the doctors' to articulate their feelings and opinions about this aspect, doctors responded with short comments that resembled each other's answers. For the doctors, the price of the vaccine and the unequal access to the vaccine did not constitute an issue to problematize, or dwell on. Instead it was simply a fact that was assumed and accepted. By giving examples from other new technologies and drugs, they implied that the high price is not surprising but normal. Overall, doctors agreed that this is an unusually priced vaccine for even an average-income person, thus the vaccine is only for those who can afford its cost.

Although my questions about the vaccine did not generate the responses I expected, the way doctors accepted the distinction between people who can and cannot afford the vaccine is significant. Furthermore, when we contrast the numbers of people doctors offer the vaccine to in public hospitals as opposed to the numbers in private offices, their acceptance of difference in financial means becomes more visible. In this chapter, I begin with an overview of how doctors' use of the vaccine corresponds with their work setting. I continue by examining some interesting comparisons doctors make between the HPV vaccine and other consumer products, as they articulate the notion of

"affording" the vaccine. To complicate the narratives of "being able to afford" and of financial means that dominates these discussions, I examine doctors' depictions of their patients or the general public as "lacking education and culture."

2.1 Doctors' vaccination practices

Depending on whether they work at public hospitals or private offices, doctors' overall opinion about the unequal access to vaccination did not differ. However, their descriptions of how many people they have vaccinated seem to indicate that there is a strong connection between the number of people doctors vaccinate and where they work.[18]

Kemal, Kadir, Haydar, Suzan, and Semra are doctors who practice in their private offices. In this group, Haydar has vaccinated the least number of people, namely 40 patients. Kemal, who has vaccinated the highest number of people, reports to have vaccinated at least 1000 patients. He also adds that he would have vaccinated at least 5000 if all private insurances covered the vaccine. Semra, whose office is located in an affluent part of İstanbul, states that she vaccinated about 600 of their patients. Suzan and Kadir have prescribed vaccines to 100 patients. While he has vaccinated 100 people, Kadir notes that he is skeptical of the vaccine therefore he has not vaccinated too many people. Thus, 100 patients is a low number in his mind.

Ali, Gaye, Meral, Sabriye, Yeliz, and Bekir are the doctors who have always worked in public hospitals. Among these doctors three of them said that they have not vaccinated anyone. Similarly Nuri, who works in his private office but whose practice

[18] This is only an observation based on doctors' own responses, rather than an analysis of their actual practices. While there is not necessarily a unidirectional causal link between doctors' work places and number of people they vaccinate, the numbers they have estimated suggest a noteworthy pattern.

serves mostly lower socio-economic classes, said he has recommended it to his family and friends, but has not vaccinated anyone in his practice. Yeliz estimated that she vaccinated 20 people, which is the maximum number in this group of doctors. Although he now works in a private office, Salih could also be included in this group since he recently retired after working at public hospitals throughout most part of his career. Stating that he is quite enthusiastic about the vaccine, he guesses that he has vaccinated around 25 people, including his own daughter. While Meral vaccinated 6-7 people, Bekir who works in the same hospital with Yeliz and Meral, vaccinated 6-10 people. It was interesting that before giving a number, Bekir noted that there are "a lot of people" he vaccinated. Interestingly, while Bekir's number for "a lot" meant 6-10 people, Kadir's "not too many" referred to100 people.

Given the difference in the patient profiles of private offices and public hospitals, it is expected that the number of people to be vaccinated will vary. Even though doctors state that lower socioeconomic strata need health services and preventive technologies like vaccines more, in practice public hospital doctors are able to vaccinate only a few people. In my interviews, doctors mentioned correlations between class, cervical cancer, and HPV infections. These statistics are also used in informational websites and pamphlets about HPV.[19] For instance, while she emphasized the significance of regular cervical screening Semra, stated: "While 3.9 is seen at the segment [of the society] with high socio-economic status, it's 15% in the poor segment, and that is because people with high socio-economic status go the doctor's and have pap

[19] The statistical data used in these sources are mostly for cervical cancer, but in doctors' narratives HPV and cervical cancer statistics are often used interchangeably.

smears." [20] Based on statistics and medical experience, doctors emphasize the importance of regular screening in preventing cervical cancer. They also acknowledge, aside from other causes, the lack of regular health services, including cervical screening, as a significant factor in poor health conditions of those from the lower socioeconomic strata. While they occasionally refer to this information and to statistical data, they never acknowledge the disparity in who needs the vaccine the most and who gets vaccinated.

2.2 Bananas, dresses, and being able to afford the vaccine

While doctors commented on the price of the HPV vaccine, they often compared paying for the vaccine to purchasing various other consumer products. In these comparisons, while the vaccine is equated with any other commodity, socio-economic status is also reduced to a mere function of income. For instance, when I asked her whether she suggests the vaccine to all her patients, Naciye explained that she only recommends the vaccine to families whom she think will able to afford it. She elaborates with an example: "Could you, for instance, suggest everyone to buy, I don't know, Nike sneakers for their kids? Some can buy it, and some cannot. I mean everybody makes decisions depending on their own budgets and beliefs."[21] Her example presents the vaccine as comparable to shoes. It also shows that as a doctor she distinguishes between families who can and cannot afford the vaccine and makes her recommendations accordingly.

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[20] *Sosyoekonomik durumu yüksek olan kesimde 3.9 görülürken, fakir kesimde yüzde 15, bunun da şey çevresindeki sosyoekonomik çevresi yüksek olan kimselerde doktora gidip pap smear yaptırması.*

[21] *Şöyle diyebiliyor musunuz, atıyorum, herkese teklif yapıyorsunuz siz çocuğuna, ne bileyim ben, Nike ayakkabı al? Kimisi alabilir, kimisi alamayabilir, yani herkes kendi bütçesine ve inanışlarına göre karar veriyor.*

Haydar, who describes himself as a part-time doctor, part-time painter and prides himself in having published over 20 informational books about sexual health, believes that the vaccine is not too expensive; he thinks that "Instead of eating at a restaurant twice, it would be more appropriate to get vaccinated."[22] While his comment could apply to a middle or upper class individual, it is not realistic to suggest that people who are not able to afford such health services could trade two dinners for a vaccine. Similarly, while she encourages people to get vaccinated Meral states, "I mean it is difficult, but if you have the money, if you can afford it, it's necessary to be vaccinated. Of course, if you don't have enough money to live on, you won't be able to find the money and get vaccinated, but if you have it buy two dresses less and get vaccinated."[23] Unlike Haydar, Meral recognizes that some patients cannot afford the vaccine. This may be because she has been practicing in a public hospital for 20 years, unlike Haydar who has worked in a private hospital after his retirement and who now works in his private office. However, Meral also makes a comparison between the HPV vaccine and other ways of spending money, while suggesting unessential expenses could be sacrificed to get vaccinated.

In a similar conversation, Salih speculated about the reasons for the high price of the vaccines. "When it first came out, Gardasil was the only vaccine, Cervarix came out later. I always thought the prices would fall when the second one comes out, but they didn't at all."[24] He continues this comment by explaining how free markets work for

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[22] *Yani iki defa lokantada yemek yemeyip, o aşıyı yaptırmak bence daha doğru bir şeydir.*

[23] *Yani hani, zor bir şey ama, paran varsa, gücün varsa aşılanmak lazım. Hani ne bileyim, yaşamak için paran yetmiyorsa tabi nerden bulup da aşılanıcan, ama varsa iki elbise az al, aşılan.*

[24] *İlk çıktığında Gardasil tekti. Cervarix sonradan çıktı. Ama Cervarix ucuz değil ki, o da ona yakın fiyatta. Yani.. Ben bu çıkınca biraz fiyatları düşer diye bekliyodum, düşmedi hiç yani.*

determining prices of medicine, detergent, and fridges. He thinks the free market does not work properly in Turkey and adds:

> There is only one thing the free market works for, it's bananas. When I was a kid, banana used to be very expensive, now it's an affordable fruit. Really. When bananas came from abroad it created competition, but it didn't work for these [the vaccines]. I mean I was sure the prices would be reduced when the second one comes out, but it didn't happen.[25]

In *The Woman and the Body,* Martin talks about how the application of market principles to non-commodities has been found disturbing by Marxists and Marx himself, establishing that some things like honor, courage, and conscience are not things to put a price on (1987, 66-67). Health services, medicine, and vaccines have become commodified products and it seems commonsensical to talk about them in these terms. However, we can still question whether it is problematic that we have come to see it commonsensical to compare Nike shoes, dresses, or bananas with health services and technologies.

Aside from the comparisons, another aspect of these narratives made me feel uneasy. While I agreed with doctors' comments that clearly distinguished people who can or cannot afford the vaccine, I also found our mutual agreement to be naturalizing the existing differences, instead of problematizing them. Moreover, the way health services were discussed in terms of "affording" not only frames health services in an individualized manner but also seems to reduce socio-economic differences into a sole function of having or not having money. Looking at doctors' responses regarding the price of the vaccine and being able to afford it, I initially found their descriptions of socio-economic status to be superficial and devoid of power relationships. However,

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[25] *Bir tek bu serbest piyasanın işe yaradığı bir şey var bana sorarsan, o da muz. Biz eskiden çocukken muz cok pahalıydı, şimdi muz ulaşılabilir bir meyve. Evet yani. . . Onun yurt dışından gelmesi bir rekabet ortamı doğurdu, ama bunlarda olmadı. Yani en azından ikinci aşı çıkınca muhakkak ucuzlar diye bekliyordum, ucuzlamadı.*

instead of persistently asking for what I wanted to them to express, I started examining what else doctors were saying in-between my questions. Listening to doctors' complaints about their patients and Turkish society overall, reveals that their narratives construct a certain portrayal of lower socio-economic groups. I encountered numerous references to a vague entity referred to as the "public" or "people with low culture" or "uneducated people" which were used interchangeably. In the following section, I examine doctors' portrayals of the *halk*[26] as individuals who lack education, culture, and the necessary knowledge for self-care and hygiene.

2.3 "Our ignorant folk" and lack of education in doctors' narratives

As doctors discuss the HPV vaccination, they also frequently complain about the Turkish health system and comment on the difficulties of their profession. Included in what seems to be medically relevant "small talk", are various depictions of *"cahil halkımız."*[27] As they complain about their patients or Turkish society overall, they also reproduce existing stereotypes about lower socio-economic classes in the context of health.

A common feature of these comments was their emphasis on "education" and "culture", which are used commensurately. Sabriye, who has worked in a public hospital for 28 years, describes her patient profile as "socioculturally and

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[26] *Halk* can best translated as "folk", "the people", or "the public." Moreover, in Turkish, the word *halk* mostly refers to lower socio-economic groups rather than middle or upper classes and has strong connotations of "uneducated masses" in colloquial use. Although I cannot assert this to be an overriding fact, throughout the my interviews, the word "halk" is often used when doctors want to refer to the masses of patients they have at public hospitals, and they often complain about their lack of "education" and "culture", as discussed in this chapter.

[27] "Our ignorant folk".

socioeconomically bad."[28] When I ask her to elaborate on what she means by "bad" she responds, "When I say bad, I mean everything is bad, intellectual level, economic status, cultural level, everything."[29] In her description, she portrays her patients as a group who lack education and "culture", as well as lacking financial means. Later during our interview, I ask Sabriye whether it is her or her patients who usually initiate informational conversations about HPV, she states, "If the patient's intellectual level is fine, she asks you and demands [this information]. However, if the patient's intellectual level is limited, this is not a concern for her anyway."[30] Her vague comments about "limited intellectual levels" draws a distinction between patients who are educated enough to demand information about HPV and those who are not. She assumes that her intellectually lacking patients will not even ask her about HPV and by favoring her other patients she implies that it is the patients' responsibility to be informed and demand information about health issues.

Bekir is more optimistic about his patients' levels of information about HPV. He believes, regardless of their levels of culture everyone gets informed by the help of new communication technologies. In his specific phrase, he refers to people having "crumbs of knowledge" regardless of their "cultural level".[31] Thus, even as he recognizes his patients as able to get informed, he makes it clear that what they can have amount to "crumbs of knowledge", which is probably a phrase he is unlikely to use to describe his

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[28] *Sosyokültürel ve sosyoekonomik durumları kötü hastalar bize geliyor, hasta profilimiz hayatım.*

[29] *Yani kötü dediğim her şeyi kötü; entellektüel düzeyi, ekonomik durumu kötü, kültürel düzeyi kötü, her şeyi kötü.*

[30] *Hastanın entellektüel düzeyi iyiyse, size soruyor ve talep ediyor. Ama hastanın entellektüel düzeyi sınırlıysa onun zaten öyle bir derdi olmuyor.*

[31] *Hayır ama hiç işte iletişim araçları arttıkça, insanlar, kültür seviyesi ne olursa olsun az çok bilgi kırıntılarına sahip olabiliyorlar.*

own knowledge. Bekir, who has been working in a public hospital for 30 years, sees himself in the position of recognizing his patients' crumbs of knowledge and praising them for it, despite their "low culture." His comment reveals the power hierarchy between him and his lower class patients.

As he describes the typical day for a gynecologist, Salih employs certain stereotypes about his patients from public hospitals. Explaining the number of patients he sees every day, Salih wanted to elaborate on why gynecological examinations take longer time than other examinations:

> Our patients don't know how to get undressed and lie on the table . . . most of the time we need to lay them down. The patients don't even know how to lie on the table. There are those who climb up as if they are horseback riding, those you sit backwards, those who lie with their clothes on. Whereas for us the panties need to be taken of so that we can do the examination. Because the panties cover up the genital organs. There are underpants. Therefore, we have struggled a lot, there are patients whom we had to go by three or four times so that they could get undressed and lie down.[32]

As Salih shares his experiences in a humorous manner, he assumes patients should know how to sit on a gynecological examination table and put their legs up properly on stirrups. He also indicates that he has patients who do not understand they need to take off their underwear. Here as a doctor, he describes himself as knowing the patient's body better than herself as to lay her down on the table. Ideas about the patients not knowing about their own bodies is clearer in a comment by Bekir. He complains, "Our people do not know their own bodies. Now that should be taught to them, right?"[33] He

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[32] *Bizim bir de insanlarımız soyunup masaya yatmayı da bilmezler . . . çoğu zaman biz gidip yatırırız. Hastalar masaya yatmayı dahi bilmezler. Ata biner gibi çıkan mı ararsın, ters oturan mı ararsın, üstündeki kıyafetiyle olduğu gibi yatan mı ararsın. Halbuki bizde külodu çıkacak öyle muayene edicez. Çünkü genital organları örten külot var yani. İç çamaşırı var. Dolayısıyla çok uğraşmışızdır, masaya soyunup yatırana kadar üç dört defa yanına gidip geldiğimiz hastalar vardır*

[33] *Vatandaş vücudunu bilmiyor. Yani bunu öğretmek lazım artık yani, değil mi?*

continues his comment by emphasizing the importance of sexual education in schools, highlighting the significance of education.

As he shared his opinions about Turkish society, Haydar's remarks were quite demeaning, although he stated he did not intend his words as insults. To demonstrate his belief that health problems are often not because of the state but the citizens, he told me a story about state distributing free contraceptive spirals:

> The state distributes spirals for family planning and it's even for free. But this time, some organizations spread the rumor saying that the state is eavesdropping on you, they have built in antennas in them. And the people are so stupidly ignorant, stupidly ignorant I am underlining this, it's not meant to be an insult. They are so incapable of understanding this, so they don't use the spirals, keep giving birth to babies, and cannot look after them.[34]

Here as Haydar repeatedly calls people "stupidly ignorant", he also sees himself in a position to judge whether his words are offensive or not. He believes he is making an objective and accurate observation as he calls people not only ignorant but also stupid. Following this comment he adds, "To such a population it is a fantasy to suggest PAP smears or things like that, that's like playing Beethoven's 9th symphony in I don't know where."[35] As he embellishes his description of Turkish *halk,* he complains about how people do not read books. His comments about books and Beethoven's 9th symphony indicate that he distinguishes himself very clearly from the people he describes. He positions himself as someone who can appreciate Beethoven, read books, and decide who has culture and who lacks the ability to comprehend these things.

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[34] *Devlet spiral dağıtıyor aile planlaması için, bedava üstelik dağıtıyor. Fakat bu sefer bazı örgütler, devlet seni dinliyor içine anten koyuyor filan diyor. Halk da bu kadar tabi aptalca cahil, aptalca cahil üstüne basıyorum, yani böyle hakaret değil. Bu kadar algılayamayacak bir şeyde olunca spiral kullanmıyor, hababam çocuk doğuruyor, sonra bakamıyor çocuklara.*

[35] *Yani nedir burda bir insani gelişmemişlik var. Ya bütün bunları olan toplumda da siz kanser smear testi filan dediğiniz vakit cok fantazi oluyor. Yani şeyde, bilmemnerede Beethoven'in 9. Senfonisi'ni çalmak gibi bir şey oluyor.*

As they described their lower class patients based on their lack of knowledge, education, and culture, doctors clearly distinguish themselves from them. Moreover, they also set some of their patients apart from these descriptions. For instance, as she explained which of her patients were more interested in the HPV vaccine Gaye stated, "The people who come asking for this vaccination, who are interested and want our advice, are people who are above a certain socioeconomic level, I mean they understand this."[36] Therefore, Gaye, a young doctor who has been working at a public hospital for 9 years, seems to distinguish some of her patients who are better informed and "able to understand." She marks this group by their socioeconomic status. Haydar, who has worked in a prominent private hospital until his retirement and currently practices in his office situated in a prosperous neighborhood, sees *halk* as "stupidly ignorant." However, he notes that his own patients are well educated and different from the masses he criticizes. Semra also contrasts her own patients, who attend her practice that is also situated in an affluent neighborhood, with the "general public". As she comments about how much she thinks the vaccine is known in Turkey, she states while most people may not be aware of the vaccine, her neighborhood and patients are more likely to know about it. Her comment also underlines the connotations between socio-economic status and knowledge that doctors often employ.

In her study of how the urban poor experience the courthouse and law in general, Koğacıoğlu observes similar descriptions of the urban poor by legal professionals (2009). She also highlights the centrality of "education" in the way legal professionals distinguish themselves and individuals they deem "educated " from the urban poor. She argues that education is "a cultural term used by legal professional to

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[36] *Yani bu aşıyı zaten soran, zaten bu aşıyla ilgilenen bize danışmak için gelenler, zaten belli bir sosyoekonomik seviyenin üstündeki insanlar, yani bunu anlıyorlar.*

define their ideas and self-perceptions about law" (2009, 139). In this sense, education does not simply refer to formal education, but it encompasses broader values and characteristics. In legal professionals' narratives about the urban poor education is seen as the root of all problems; it becomes the key word that transforms the urban poor into "ignorant" (2009, 140).

Similarly, in her examination of the discourses of civil society and volunteer organizations, İpek Can notes how volunteer workers see education and ignorance as the central problem to be solved (2007). Like the doctors' complaints about Turkish society overall, İpek Can notes how volunteer workers answer questions about Turkey's problems with the comfort of having encounter a familiar question (2007, 112). According to her, volunteer workers list education among the most prevalent answers, when asked to list Turkey's most critical problems. "Overall, they emphasize lack of education and awareness as the most significant problems and state that other problems can only be solved through education and increased awareness" (2007, 112). As volunteers complain about education, they construct themselves as educated in opposition to individuals that need awareness and education. This also resembles the way the doctors distinguish themselves from their patients or the ignorant folk they describe.

Such narratives of education cite its lack as the root of various problems, as Koğacıoğlu and İpek Can also note. Putting these narratives within the neoliberal discourse, İpek Can explains "Structural problems such as inequality, poverty that leads to injustice, marginalization, are made to be 'explainable' through individuals' deficiencies" (2007, 107). Arguing for a neoliberal shift in health practices and medical discourses would require a more detailed and comprehensive study. Therefore, I cannot claim the narratives of education in doctors' narratives function in the same way.

However, we can still point out that the use of education and culture in doctors' narratives resembles İpek Can's study, as doctors define the general public based on their lack. The emphasis on patients' lack of information, knowledge, awareness suggests that the individual patients are held, at least partially, responsible for their poor health conditions.

In one of my interviews, Nuri explained that like any health issue HPV is also related strongly to education and socio-cultural status. He clarified by saying, "As people use their minds, as culture increases, they can protect themselves more easily, or they know about methods of protection. Thus, the risk of disease decreases."[37] While he enmeshes culture, education, intellect, he also employs the notion of "risk." In the following chapter, I examine how risk factors of HPV are discussed in relation to gender and sexuality. I explore how these discussions define gender roles for men and women within HPV narratives.

[37] *Tabii sosyokültürel şeyle, tabi ama insanlar şey yaptıkça, aklını kullandıkça, kültür arttıkça, kendini daha rahat koruyabiliyor, veyahut da tedbirini biliyorlar. O zaman tabi hastalıkta risk azalıyor yani.*

CHAPTER 3

SEX WORKERS, NUNS, VICTIMS, AND CARRIERS: GENDER ROLES IN HPV NARRATIVES

Because HPV is a sexually transmitted virus, conversations about HPV infection and vaccination often evoke implicit and explicit discussions of sexuality, assumed gender roles and moral norms. Informative discussions with doctors about how the virus is transmitted, who gets infected, whom the vaccination targets, and the costs of the vaccination also reveal assumptions about women and men's sexual lives and behaviors, normal and acceptable sexualities, and who is held "responsible" or considered "guilty" about HPV infections. Thus, the discourses on HPV and its vaccine not only define how people should act against the virus, but also shape notions of acceptable sexual behavior and regulate men and women's sexualities through health.

This chapter traces the assumptions about gender roles and moral discourses of sexuality as they appear in doctors' HPV narratives. Following a brief introduction of the concept of risk as it relates to my study, I first describe how men are depicted in doctors' narratives of HPV. Subsequently, I show portrayals of women's roles in HPV narratives in relation to men's roles. Following these, I focus on a metaphor of mosquitoes that was evoked multiple times in explaining HPV transmission. I discuss the mosquito metaphor in a broader context of doctors' expressions about the changes in Turkey, which they see as necessary to point out in the interviews.

3.1 Surveillance, risk, and human papillomavirus

David Armstrong observes major changes in medicine over time and argues that "a new medicine based on the surveillance of normal populations can be identified as

beginning to emerge in the twentieth century" (1995, 395). He calls this new medicine "surveillance medicine" that causes a shift in the way illnesses are conceptualized. Illness is no longer seen as confined to the physical individual body or the present. It also exists outside the body as a "possibility" for the entire population, and as a "possibility" of illness in the future. As Armstrong elaborates, "surveillance medicine turns increasingly to an extracorporeal space—often represented by the notion of 'lifestyle'—to identify the precursors of future illness" (1995, 401). Therefore, disease is no longer simply a present phenomenon pointed at by "symptoms", it becomes, even when it is not present, an ever-existing future possibility which people's lifestyles and actions can be seen to cause.

Because the vaccine for HPV is a very recent development, there are very few studies that examine its social implications. However, prior to the vaccine there have been numerous studies about cervical screening, the precursor of the vaccine for controlling cervical cancer. As regular cervical screening significantly reduces deaths resulting from cervical cancer, it is highly recommended to women and sometimes even required by national health systems. Researchers have critically analyzed such mandatory screening programs and their implications for women who participate in them (Bush 2000, McKie 1995, Todorova et al. 2006).

While HPV vaccination does not carry as strong and direct a connection with surveillance as these screening programs have, it is nevertheless very much related to "surveillance medicine" in terms of how disease is conceptualized. While HPV infection in itself is not a disease, it constitutes a strong indicator of a future possibility of cellular deformations and cervical cancer. Especially in the case of HPV vaccination, since the emphasis is on a preventive method, the illness is recognized even before it exists in the body, while it still remains as a future possibility. The strong relationship

between HPV and cervical cancer causes HPV to be seen as a sign for the future occurrence of cervical cancer. Consequently, sexual transmission of HPV leads to looking for signs to determine risk groups who are more likely to have cervical cancer through their lifestyle choices.

Searching for the causes of diseases in the body's surroundings and a person's lifestyle can also be contextualized within a greater framework of risk. Mary Douglas argues that the emergence of the risk concept secularized the way people see life. With God removed from the scene, human beings, who have the knowledge of probability of events, are seen as to be in control of their own lives. According to Douglas, this secularization enables a moral discourse on human life, which is cloaked in scientific legitimacy (Lock 1998, 10). Applying Douglas' conceptualization to the context of health and diseases, we see that the notion of risk shifts responsibility of illness to individuals and their lifestyles.[38]

As a result of the shift in medicine and the emergence of the concept of risk, individuals can be held responsible for the "health risks" of their own actions and lifestyles. Health problems resulting from a number of combined factors such as inadequate health care, environmental factors, and genetic factors can thus be condensed into individualized narratives of risk. The focus on lifestyles and the narrative of risk emphasize the responsibility of individuals and define disease as contingent on individual actions. While individual actions are indeed effective in inducing health or disease, such individualized perspectives on health can be problematic, if we consider the uneven discursive distribution of "risk" in doctors' narratives and medical discourse.

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[38] For examples of the use of "risk" in medical sociology and anthropology, see Douglas (1990), Lock (1998), Roushdy-Hammady (2004).

It has been discussed that while determination of risk groups for epidemiology are necessary for controlling diseases, they also create social stigma and aggravates stereotypes for various social groups. For instance in their discussion about the social construction of HIV and AIDS, Glick-Schiller et al. point out how risk groups developed by epidemiologists took on different meanings as they were circulated in public discourses and led to a further stigmatization of "subgroups" at risk (1994, 1338). My analysis is not primarily based on the definition of epidemiological risk groups for HPV. However, doctors frequently refer to these risk groups overtly or indirectly as they cite their textbook knowledge about sexually transmitted diseases (STD) and embed medical discourses about risk groups for STDs and specifically HPV into their responses. While my research is not limited to doctors' conceptualizations of risk groups and risks, it is still informed by the literature on risk in medical discourse.

The discourse of risk is not necessarily employed to put blame or responsibility on all individuals in the same way. My research suggests that doctors' narratives of HPV infection can involve assignment of blame, responsibility, victimhood, or innocence for different individuals. As doctors describe high-risk groups and behaviors, their reasoning suggests that the "verdict" about the infection is contingent upon one's gender and sexual lifestyle. In this sense, a loyal wife can be regarded as the victim of cervical cancer and her unfaithful husband, but a gay man will have "brought this onto himself." Moreover, the measures and actions to be taken to reduce risks do not affect everyone in the same way. For instance, while most doctors see men as "responsible" for spreading HPV, they see screening or vaccination of men as unnecessary and urge women to be screened regularly. Through similar examples that I encountered in my interviews, the following sections trace how HPV risk is differentially distributed in relation to sexuality, gender, and morality in doctors' narratives.

3.2 Men in HPV narratives

Human papillomavirus is a sexually transmitted virus that can affect both men and women, but due to the causal relationship between HPV and cervical cancer, HPV is seen as a "women's issue." Because HPV vaccine producers have highlighted the use of the vaccine for cervical cancer, the HPV vaccine is " 'feminized' in the scientific literature and news media" (Carpenter & Casper 2009, 799). Indeed, a quick glance at informational websites and pamphlets about HPV reveals that vaccine information is targeted mainly towards women. Pamphlets for informing the public feature images of women exclusively. As they list statistics for female mortality from cervical cancer and HPV incidence, they urge mothers to protect their daughters through vaccination. More detailed informational booklets about the vaccines prepared for doctors do not include images of men or references to men, either. The companies' websites, too, depict the vaccine primarily as a cure for cervical cancer and present their vaccines as intended for women.

Similarly news articles about HPV highlight the threat HPV imposes for women. Citing statistics for cervical cancer mortality in the world, which do not necessarily correspond with statistics for the Turkish population, news articles often frame HPV and cervical cancer as "Women's nightmare." Turkish newspaper article headings include, "They die every two minutes",[39] and "Four women to cancer every day",[40] "Women's nightmare: Cervical cancer"[41] while talking about the virus or the "cervical cancer vaccine." Especially headings such as "4 women to cancer every day" or "One

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[39] *"İki dakikada bir ölüyorlar."*, BirGün, 19.02.2008, retrieved from: http://www.birgun.net/life_index.php?news_code=1203389345&year=2008&month=02&day=19.

[40] *Kansere her gün 4 kadın*

[41] *Kadın Kabusu: Serviks Kanseri*

dead to cervical cancer every two minutes" depict women as victims of HPV and cervical cancer. Terzioğlu also observes such "victimizing discourse" as dominating Turkish doctors' narratives and media coverage of cervical cancer (2009).

In my interviews, doctors' approach to HPV infections paralleled this overall trend of a feminized HPV narrative, which often positions women as the victims. Unless I asked them particularly about the possibility of infection in males, doctors did not discuss the risks for male HPV infections. Men are rarely cast in the role of the victim within HPV narratives. However, this does not mean that they are invisible in these conversations; they often appear in doctors' narratives as the agents responsible for spreading HPV. When it comes to questioning where the virus comes from, doctors point directly to men. They acknowledge men as HPV carriers, who are responsible for the transmission of the virus. As Salih states, "it is us, men who spread it [the virus]"[42] while discussing whether the vaccine is an option for men. Thus women, the victims of the virus, are also the victims of their partners, who the doctors deem responsible for bringing the virus to women.

For instance, Ali, who has been practicing medicine in a public hospital for 20 years, suggests that men are more likely to be responsible for infecting their wives. As he commented on a patient who had cervical cancer he explained, "Of course this woman did not go and find HPV by herself. Her husband somehow gets it from somewhere."[43] Ali's comment also demonstrates that putting responsibility on men is complemented with declaring women as "innocent." Nuri makes a similar comment. He states:

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[42] *Çünkü bulaştıran kim, biz erkekler.*

[43] *E bu kadın HPV'yi herhalde kendi gidip bulmadı. Kocası bir şekilde bir yerden kapıyor.*

> I had once read about a research conducted on women at the age of 30, of course this is from a western source, 80 percent of the women have come across this virus. It's very interesting; this is a very high number. But how do they come across this virus, of course through their husbands, this is transmitted by sexual intercourse, that's the only explanation.[44]

Likewise, Semra says, even if you have one partner your partner could still have the virus since "For men, being with only one person is quite difficult, once they start they could even have one night stands."[45] She presumes men to be responsible in transmission depending on her assumption that men are likely to have multiple partners and short-term relationships based on sexual intercourse.

While these comments show us how men are held responsible for victimizing women, they also reveal assumed female and male gender roles. The doctors' unquestioning assumption that men are responsible for spreading HPV may put the blame on men, but it simultaneously affirms stereotypical gender roles and sexual behavior norms for men. This is more visible when we consider the reasons for their assumptions. While Semra assumes that men are more likely to have one-night stands, Ali and Nuri are sure that women are innocent, their husbands must be responsible for finding the virus "somewhere" and bringing it to their wives. Ali does not consider the possibility that his middle aged housewife patient could "go and find" HPV on her own, confidently assuming married women are not likely to have extramarital sexual relationships, but men are almost expected to have them. This is also the "only explanation" for a married woman to get HPV for Nuri. Thus, in these comments men's role as carriers is embedded within existing stereotypical gender roles for male sexuality.

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[44] *30 yaşına gelmiş, Batı kaynaklı tabi, kadınların yüzde 80'i bu virüsle karşılaşıyolar. Çok ilginç yani büyük bir rakam bu. Fakat tabi nasıl karşılaşıyorlar, kocalarından yani cinsel ilişkiyle bulaşıyor bu geçiyor, bunun tek şeyi bu.*

[45] *Erkekler çünkü bir tek kişiyle birazcık zor yani, onlar bir başlıyor ve yani onlar bir gecelik ilişkileri bile yani olabiliyor.*

Interestingly, even though doctors acknowledge men's role in HPV transmission, they rarely suggest controlling male sexuality as a solution for spreading of HPV infections. Moreover, while most of the doctors hold men as primarily responsible for having multiple partners and spreading the virus, they rarely state that men should be vaccinated. Most of the doctors do not even mention the possibility of immunizing boys or men until I ask them about it.[46] When they mention it, male vaccination is described as unnecessary, not "cost-effective", and redundant. Instead of focusing on men for solutions, they stress the need for female vaccination and regular cervical screening for women.

All of the doctors whom I spoke with believe HPV vaccination is useful and necessary for women, who are in risk groups and who fit the target age for the vaccines. Moreover, they all emphasize the importance of regular screening for women of all ages, regardless of having been vaccinated. Some doctors, like Salih and Semra, repeatedly underline the importance of having smears. They explain women should have a PAP smear test at least once a year. As Emily Martin states, "periodically, from the late teens until old age, women in this society are expected to submit their genitalia and internal reproductive organs to scrutiny by a doctor" (1987, 71). All of my participants similarly presume that women need to commit to regular gynecological examinations throughout their lifetimes.

While regular screening has been proven to significantly reduce mortality caused by cervical cancer, the emphasis on regular screening of women's bodies has not gone

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[46] There were a few exceptions. For instance Salih, when I had asked him about the vaccine and the virus said "So, this is more often transmitted from one's partner, therefore maybe these vaccines should also be applied to men. Australia has already included this vaccine in their program. They also vaccinate male children."[46] Salih is one of the two male doctors who thought that men should also be vaccinated. In the case of female doctors, all but one women thought that men should be vaccinated as well.

unquestioned. For instance, Bush's study on cervical screening programs points out how such programs require constant surveillance of the body (2000). She notes that while women used to be under medical surveillance during pregnancy and menopause, the regular cervical screenings recommended for preventing cervical cancer put women's bodies under surveillance almost throughout their entire lives. Todorova et al. point out that the legitimacy and necessity of screening are often taken for granted and not questioned (2006). Pointing out that such regular screening puts women under the medical gaze, Kaufert discusses "the implications for women of a definition of the female body as an object in constant need of monitoring, evaluation and surveillance, a body for screening" (2000, 166-167).

Some scholars see cervical screening as a means of surveillance of women's bodies and sexualities. Kaufert describes PAP smears as one of the "prime examples of intimate invasions of the female body by the medical gaze" (2000, 167). Bush argues that "cervical screening is not just about surveillance of the cervix and women's sexuality but it also encompasses getting women to behave in a particular, prescribed way. Cervical screening is built upon medical discourses concerning the need for *regulation* of women's bodies" (2000, 441). Bush also notes that not attending cervical screening programs is usually considered deviant and irresponsible. Todorova et al.'s findings from the interviews they conducted with health-care providers are also in line with this notion of irresponsibility. They state that when women did not participate in cervical screening programs they were labeled as irresponsible. Similarly, Kaufert argues "Being screened is a duty; evasion is tagged as irresponsible behavior, a moral dereliction" (2000, 167). These studies suggest that not participating in cervical screening programs was perceived as irresponsible and this responsibility or its lack is presented in moral terms. As Kaufert states, "Women are told that being screened is an

expression of virtue and that the punishment for those who resist is death and disfigurement" (2000, 181). Thus, screening becomes not only a personal responsibility for one's health, but also a virtuous behavior.

In my interviews, I asked doctors whether there is a similar need for screening men for HPV or other aspects of sexual health. Doctors usually explain that men do not need such screenings until they are old enough to have prostate problems. In the case of HPV, they often emphasize the rarity of penis cancer and state that screening men for HPV would be unnecessary. In elaborating why men are not influenced by HPV, Ali explains that men are simply "lucky" by way of their anatomy and that they do not suffer from HPV infections like women do. Thus, unlike women, men are not seen as the victims of the virus, HPV is a nightmare for women only. Interestingly, occasionally "some" men are cast in these victim roles. While doctors typically dismiss the threat HPV imposes for men, stating the stakes are too low, they mention higher risks and more serious dangers for homosexuals and transsexuals.

A recurring theme in the interviews is the designation of homosexual men and transvestites as male risk groups for HPV. For instance, when I ask Suzan, a young doctor who has worked in the United States for four years before coming to Turkey in 2004 to initiate her private practice, whether there is a similar test like women's PAP smear for detecting HPV in males, she states that "specific populations" are possibly at higher risk; therefore PAP smears can be run on homosexual males for anal cancer.[47] While my question was intended to inquire about a procedure for all men, Suzan's response specifically addresses homosexual men, rather than aiming to detect the virus across the entire male population. Also, when I asked her whether men are only carriers

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[47] *Homoseksüel popülasyonda vesaire yapılabilir, anüsten smear almak için vesaire, hani anüs kanseri için, anal kanser için, orda o hani spesifik popülasyonlarda olabilir diye düşünüyorum.*

or if they are affected by the virus, she said: "I mean, you could get penis cancer or anal cancer; homosexuals might get it through intercourse."[48] Similar to her previous comment, although the question refers to all men, Suzan's response particularly distinguishes homosexual men and suggests that getting penis and anal cancer is more likely for them.

After explaining that although of low probability, penis cancer might afflict men, Bekir adds, "Moreover, there are men who are referred to as transsexuals or homosexuals who have different sexual preferences. [Condilomas] are also seen in certain body parts of these men, around their anuses or between their legs if they have had a surgery."[49] Like Suzan, Bekir depicts homosexual men as more likely to suffer from HPV. He also groups transvestites and homosexuals together in the same male risk group.

Interestingly, while doctors go into detail about the danger HPV poses for transsexuals or homosexuals', they rarely spend any time on discussing the risks for the wider male population. Doctors do not discuss the consequences of men's HPV infections for their bodies or for the bodies of their partners. They seem to include men in the narratives of HPV only when men are outside the conventional definitions of masculinity. Men are situated within the feminized HPV discourse as victims, only when they are in the margins of "masculinity", or seen as "feminized."

In my interview with Kemal, he also included another group of men as being at risk for HPV infections. Kemal's office is located in an affluent İstanbul neighborhood, and he prides himself on having a high number of patients from very diverse

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[48] *Yani penis kanseri olabilirsiniz, ya da anüs kanseri, hani homoseksuellerde mesela ilişkiyle olabilir.*

[49] *Erkeklerin içinde de bir takım transseksüel tabir ettiğimiz veya homoseksüel diye tabir edilen farklı cinsel tercihi olan insanlar var. Bunlarda da, maalesef yani, bir takım bölgelerinde anüs civarında veya bir operasyon falan geçirmişse bacak arasında o bölümlerinde görülür.*

backgrounds. When I asked Kemal whether men also get infected with the HPV, he responded, "People like gigolos, who work professionally, might" get infected.[50] While men who are involved with female sex workers were never mentioned as being at risk in any of my interviews, it was interesting that Kemal brought up "gigolos" as being at risk. While defining gigolos as a risk group was only mentioned by Kemal, referring to female sex workers as a high-risk group was a recurrent theme. In the following section, I discuss the references to sex workers as risk groups in more detail. This section overviewed how men appear in doctors' HPV narratives and the roles they were assigned in these narratives. In the following section, I complement this discussion with how women are situated in these narratives.

3.3 "Rare in nuns, but common in prostitutes"

Various informational pamphlets and websites about HPV present it as a highly pervasive and common virus that presents a significant danger for individuals. According to the Center for Disease Control and Prevention, "At least 50% of sexually active men and women acquire genital HPV infection at some point in their lives."[51] Websites in Turkish, that are sponsored by the Turkish Society of Gynecology and Obstetrics and the two vaccine companies, also highlight the ubiquity of the virus, underlining that the risk is greater for women. GlaxoSmithKline's website asserts that "Since HPV infection is highly common and since it can happen at any age, all women who are sexually active can face this risk throughout their lives."[52] Similarly, Merck's

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[50] *Onlarda da tabii penis kanserini, daha çok işte bu işte jigolo grubu vesaire falan, yani bu işten, daha doğrusu profesyonel çalışan erkekler.*

[51] http://www.cdc.gov/std/HPV/STDFact-HPV.htm

[52] http://www.servikskanseri.com

website informs that "Cervical cancer is caused by HPV (Human Papillomavirus), which is a pervasive virus. Every 5 women out of 10 face this virus throughout their lives."[53] The Turkish Society of Gynecology and Obstetrics, citing data from WHO and CDC, underlines "approximately 1 out of 10 people have HPV" and that "a woman has 80% risk of getting an HPV infection until she is 50 years old."[54] Employing an abundance of numbers and statistics, these websites aim to demonstrate the prevalence of the virus, thus the magnitude of the threat it imposes for women.

Despite the underlined pervasiveness of the virus, when I ask my participants "Who is likely to get infected with HPV?" they list specific groups of people as being likely to get the virus. While the vaccine companies reach out to mothers and urge them to vaccinate their teenage daughters, doctors' first responses to this question do not involve mothers or daughters. Instead they immediately list particular risk groups. Strikingly, the most common risk group identified by doctors is that of "sex workers."

For instance, Nuri states that condilomas, also caused by HPV, are more often seen among women with multiple partners. His subsequent sentence clarifies what he means by multiple partners: "Nowadays the westerners call it 'sex workers,' they changed it in the medical textbooks. The books used to state 'prostitutes,' now it goes by sex workers."[55] I came across a similar example when Kadir was explaining the factors that increase people's possibilities of getting HPV, and he said: "People who

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[53] http://www.rahimagzikanseri.org *"Rahim ağzı kanserine yaygın bir virüs olan HPV (Human Papillomavirüs) neden olur. Her 10 kadından 5'i yaşamları boyunca bu virüsle karşılaşmaktadır."*

[54] http://www.tjod.org *"WHO verilerine göre yaklaşık her 10 kişiden 1'inde HPV vardır. CDC'ye göre bir kadının 50 yaşına kadar HPV enfeksiyonuna yakalanma riski %80'dir."*

[55] *Batılılar şimdi seks işçileri diyorlar, adını değiştirdiler tıp kitaplarında, eskiden prostitute falan kelimeleri geçerdi şimdi seks işçileri diye geçiyor.*

earn money by selling their bodies, because of having multiple partners."[56] Here Kadir does not only suggest that sexual intercourse causes a greater risk, but specifically points out "people who sell their bodies" are at risk. While arguing that people need to be informed, possibly through informative campaigns organized by the state, Gaye stated: "Starting from the brothel, going down to orphanages, then from there to the normal public; it's necessary to tell everyone."[57] Interestingly, she sets "brothels" as the first place to start informing or vaccinating people. In a similar manner, while elucidating to whom she is likely to recommend the vaccine, Suzan says: "For example, if it's a decent family with a 12 year old daughter, I don't insist on the vaccine . . . but if she is at a more critical age like 18, say she sings at a night club or doesn't have a family, she can have more contacts easily, so I recommend [the vaccine]."[58] While Suzan does not make an overt reference to sex workers in comparison to the previous examples, her reference to "working at a night club" might be seen as suggesting promiscuity or even a euphemism for prostitution.

These responses show that doctors often associate HPV with brothels, sex workers, prostitutes, promiscuity, and working at nightclubs. They see it less likely for daughters of "decent families" to be infected with HPV. Doctors' examples suggest that they do not associate HPV with the "general public" but rather see particular parts of the population as being at risk for HPV. They do not simply list behaviors as being risky, but identify groups of people as being at risk. Instead of explaining the risks of having multiple sexual partners, it is striking how doctors talk about sex workers as a high-risk

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[56] *Yani vücudunu satarak para kazanan insanlar, çünkü multipartneri var.*

[57] *Genelevden başlayarak, yurtlara inip, ordan da normal halka, anlatmak gerekiyor herkese.*

[58] *Mesela kızları 12 yaşında, düzgün bir aileyse hemen aman aşı olun diye ısrar etmiyorum . . . ama belki kritik yaşlarda 18 yaşında, işte gece kulübünde şarkı söylüyorsa, bir ailesi yoksa falan, onda daha çok kolay temas olabilir, öneriyorum.*

group. As Glick-Schiller et al. state, identifying subgroups of population as "at risk" lead to pitting high-risk groups against the "general population" (1994, 1338). It seems that through these examples, doctors clarify the boundaries of the "general population" by excluding promiscuity and sex workers from it. Despite their medical knowledge about the prevalence of HPV and the various statistics for all women they list for me in other parts of the interview, doctors are not immune to stereotypical connections between HPV and promiscuity and prostitution.

It can be argued that the references to sex workers could result from actual statistics and the higher probability of other sexually transmitted infections among sex workers. However, complemented with the various references to nuns—usually in opposition to sex workers—which I encountered in my interviews, the discussion of sex workers can elucidate the moral subtext of these narratives. Even though nuns are not a familiar part of daily life in Turkish society, being a nun or leading a nun's life are expressions used to imply extreme chastity and abstinence. Moreover, a common vulgar Turkish phrase defines the ideal role for women to be "a prostitute in bed, and a nun in public" and in this context prostitute and nun seem to constitute two opposite images of female sexuality. Just like the stereotypical image of the "prostitute", the "nun" also appears in doctors' narratives.

Doctors employ "nuns" to denote virginity and chastity in discussions about HPV transmission. When I asked Ali whether HPV could be seen among people who haven't had sexual intercourse, he responded:

> No no, not in real nuns. When I say real nuns, I mean real nuns. Just like this: years ago cervical cancer was seen in one nun, and they investigated it. It turns out, she was once a prostitute and then she converted. So, what I call real nun is really truly someone whose hand hasn't been touched by any men, that's what I mean.[59]

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[59] *Gerçek rahibelerde yok. Hani gerçek rahibe derken hakkaten rahibe olanlarda. Aynen şöyle, yıllar önce rahibelerde bir kişide görülüyor serviks kanseri, onu da araştırıyorlar. Kadın hayat*

Although I avoid even the word "virgin" in my question, Ali immediately associates "not having had intercourse" with being a nun and thus engages a mental image of "real nuns" as a reference point for HPV infections and risk groups. Similarly as Suzan explains, although a small possibility, the virus can be transmitted by means other than sexual intercourse, she says, "So, it's not possible to say that cervical cancer is never seen in virgins or nuns who have never had contact."[60]

In the first instance, Ali is referring to a study that was conducted "years ago." The mentioned study was conducted by an Italian surgeon named Rigoni-Stern in 1842.[61] Although this study has been criticized and refuted later (Griffiths, 1991), it seems to have been highly influential on various subsequent studies and doctors' overall understandings of cervical cancer.[62] As Griffiths states, "Almost any paper on the epidemiology of cervical cancer mentions the work of Rigoni-Stern, a surgeon in Padua in the mid-nineteenth century, who appears to have had an amateur interest in epidemiology" and "it is some-what surprising that his work is quoted as being authoritative. It is alarming that it is almost universally misquoted" (1991). This often referenced but misunderstood study has been a pioneer in relating cervical cancer with sexual intercourse, but it has also helped create the myth that cervical cancer is "rare in nuns and common in prostitutes." The doctors' remarks about nuns and the imagined

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kadınlığından dönüp rahibe olmuş, yani gerçek rahibe dediğim hakkaten gerçekten eline erkek eli değmemiş, kastettiğim o.

[60] *Şey hani bakirelerde ya da işte rahibelerde hiç teması olmamış, serviks kanseri hiç olmuyor demek mümkün değil.*

[61] Rigoni-Stern (1842). "Fatti statistici relativi alle malattie Cancerose" *Giornale per servire ai progressi della patologia e della terapeutica*, 2: 507-517.

[62] Griffiths describes the study as "poor by modern standards" and adds, "His paper is littered with errors of arithmetic. He adduces importance to differences which we would not now regard as being statistically significant."

binary of nuns and prostitutes in the context of cervical cancer may indicate how this study's assumptions influenced other studies and how these studies influence medical knowledge on this subject. The "commonsensical" assumptions of these studies that pit "nuns" against "prostitutes" are incorporated into epidemiological and medical knowledge.

While the second comment about nuns might also be indirectly referring to this study, there was another reference to nuns that did not evoke Rigoni-Stern's study. This was when Kemal asked me whether I was considering being vaccinated or not, at the end of our interview. When I told him I did not see it as necessary at the time, he responded by saying "Why not, are you leading a nun's life?"[63] In this case, the reference is more of an analogy to refer to chastity and sexual abstinence. Kemal's question also demonstrates the power relations embedded in the interviews that I discussed earlier. Although he is the interviewee, as a doctor Kemal feels comfortable about asking me such a question. Although he is an older male and I am not his patient, by way of his medical expertise he feels that he can ask me a question about my intimate life and sexuality.

I was perplexed by these references to sex workers and nuns that complemented each other. While I expected HPV to bring about discussions of female sexuality and morality, I did not expect nuns and prostitutes to be literally and symbolically present in these discussions. It is intriguing how doctors, instead of talking about female sexuality in a more broad or diverse way, employ these two images that represent two extreme ends of female sexuality.

In their comparative study of circumcision and HPV vaccination, Carpenter and Casper observe a similar role casting for women as either innocent or fallen. Carpenter

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[63] *Ne o rahibe yaşantısı mı yaşıyorsun?*

and Casper comment on how these roles for women compare to men's roles as simply "sexually driven" and ask "Why have attempts to mandate HPV vaccination activated concerns about female promiscuity, whereas talk of promoting circumcision as HIV preventive for boys has not (at least regarding U.S. boys)?" (2009, 792). They believe that this "double standard" regarding female and male sexuality depends on the existing "double standards" in cultural constructions of female and male sexualities. They assert that "Beyond actual public health successes (and failures), provaccination and containment practices work to intensify extant structural relations, extending hierarchies and inequalities" (2009, 809). They remind us that sexual health is used to discipline certain bodies in order to ensure immunity for all.

Carpenter and Casper's discussion applies existing notions of surveillance and discipline through health to the case of HPV and HIV and their comparative analysis is very insightful. However, their comparison between representations of male and female sexualities does not necessarily explain why women are presented as either innocent or fallen. At a first glance, the two roles of female sexuality may suggest that HPV is caused by uncontrolled female sexuality and prevented by its complete absence. However, the last comment by Kemal actually reveals a tension; there is a binary of nuns and prostitutes, but as he asks me this question, Kemal implicitly acknowledges that I am not a part of this binary and assumes an unmarried young woman could and even perhaps should have an active sexual life. While there were no references to nuns in them, I experienced similar moments when my interviewees asked me if I considered the vaccination or gave me advice about safe sex practices to protect myself from HPV.

Juxtaposing such comments with the frequent use of the prostitute/nun imagery points to an interesting tension. On the one hand, my interviewees see themselves as "modern" educated individuals as doctors, especially as gynecologists they see

themselves as particularly open-minded in discussing sexuality as part of sexual health. Yet, they resort to stereotypical images of female sexuality and often utilize moral discourses of sexuality when they talk about HPV. On the other hand, they express that they see changes in Turkey and in people's sexual behaviors in recent years. In the next chapter, I discuss these moral discourses and "changes" as described by doctors in more detail.

In this chapter, I overviewed recurring images of female and male sexuality as they appear in doctors' discussions of HPV. Comparing the differences in men and women's roles provide valuable insights into understanding the gendered inequality of these discourses. However, my aim is not only to contrast them, but also to combine them in order to look beyond gender inequality. The way doctors employ moral discourses and the images they utilize invite us to look beyond the gender story within the HPV narrative.

As much as doctors reproduce existing gender roles and moral values in their narratives, as the mentioned tensions show they also recognize changes in sexualities. The following chapter explores the "changes" doctors express that they observe in Turkish society. Beginning with an examination of a striking metaphor concerning mosquitoes that was often used to describe men's role in HPV transmission, the next chapter traces doctors' understanding of where HPV comes from and how Turkey is changing.

CHAPTER 4

MOSQUITO INVASIONS AND WESTERNIZED SEXUALITIES

As discussed in the previous chapter, doctors often refer to men as the "carriers" of HPV. In these descriptions and discussions about vaccinating men against HPV, an interesting mosquito metaphor came up several times. Doctors' regarded men as "the mosquitoes of HPV" and suggested ways to control HPV by elaborating this metaphor. Overall, the use of this metaphor was in line with men's roles in HPV narratives. The commonsensical portrayal of men as mosquitoes helps legitimize and naturalize men's roles as only carriers but not victims of HPV, as well as the stereotypical assumptions about male sexuality.

Examining this metaphor further and locating it within a broader framework of doctors' comments about "changes" that they observe suggest that it may carry additional meanings as well. For instance, by way of this metaphor doctors underline how HPV is brought into the body from "outside". In a similar manner, throughout our conversations doctors describe changes in Turkish society and people's sexual lifestyles, which are also perceived to be coming from "outside". I begin this chapter by a close look at the mosquito metaphor that doctors utilize. Subsequently, I trace doctors' comments about changes in Turkish women's sexual lives and habits.[64] Through doctors' uses of the mosquito metaphor and expressions about "changes", I explore how they discuss HPV infections, viruses, and changes as coming from "outside", which in turn defines the boundaries between "inside" and "outside".

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[64] Interestingly, the comments I discuss in this chapter are not answers to questions I asked; yet in most of my interviews doctors felt the need to express these changes that they observe.

4.1 Keeping mosquitoes out

While talking to doctors about HPV transmission and infections, I was intrigued by a metaphor of mosquitoes that was used several times. As we discussed the possibility of vaccinating men, Suzan recalled: "In fact at a meeting I heard some people say that we should dry the swamp. You know, dry the swamp, I mean vaccinate the men. It might be reasonable."[65] She invokes a narrative that is typically used for preventing malaria and applies it to the case of HPV as a metaphor.

Interestingly, the mosquito metaphor came up in another interview, although with different points of reference. Ali, when asked if men are affected by the HPV, responded: "Well, men are the mosquitoes. They are the carriers of this thing."[66] While he affirmed the matter-of-fact role of men in spreading the virus, as discussed before, he also utilized the mosquito metaphor. At a different instance, he detailed his use of the metaphor:

> It's much more practical to vaccinate the target female population, or the unprotected female population before vaccinating the men . . . I mean, think about it; perhaps you can't handle the mosquitoes, but you can always keep the mosquitoes away by some repellents or setting a mosquito net.[67]

Ali's explanation also shows how the metaphor is used to legitimize and normalize men's role in the infection and spreading of the virus. Unlike Suzan's use of the metaphor, here mosquitoes are used to illustrate cost-benefit calculations of optimal vaccination according to Ali. While the quotes suggest different solutions for the

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[65] *Bir toplantıda söylemişlerdi, "Bataklığı kurutsak ya" falan diye. Bataklığı kurutsak ya, erkekleri aşılasak, hani onlar genellikle taşıyıcı oluyor ya. Yani mantıklı tabi.*

[66] *Erkekler zaten olayın sivrisinekleri, yani taşıyıcıları.*

[67] *Çünkü erkekleri şey yapana kadar, aşılayana kadar, hedef kadın kitleyi ya da şey, korunmasız kadın kitleyi aşılamak daha pratik . . . Yani şey gibi düşün, sivrisineklerle baş edemiyorsun, ama cibinlik takıp ya da bir ilaç sürüp sivrisinkeleri yaklaştırmıyorsun.*

"mosquito problem", they refer to similar points within the narrative of infection. They all point out men's roles in spreading a threatening agent and they suggest solutions to keep this problem under control and to keep the virus out of our boundaries somehow. Suzan suggests "drying the swamp", which is the typical solution suggested for mosquitoes that implies trying to eliminate the original cause of the problem. While he also sees men as the "carriers", Ali suggests a different solution. He thinks using mosquito nets is the most efficient solution, and later in the interview as he jokes with a colleague, they take the metaphor further and say that the net refers to using a condom during sexual intercourse. Thus, instead of targeting the cause, he focuses on avoiding the nuisance. His use of the metaphor parallels the doctors' overall statement that women should be vaccinated and people should practice safe sex.

The mosquito metaphor is not only used to legitimize the gender inequality in existing vaccination practices. They also point to the threat posed by harm that is brought by an uncontrollable agent. Mosquitoes carry a dangerous parasite and they need to be controlled, kept outside of our homes to protect our bodies from the disease they help transmit. They can penetrate into our homes and through them the parasite causing malaria can penetrate our bodies. Thus, their presence in our homes and aoround our bodies threaten our well-being. The parallels that doctors make between HPV vaccination and protection from malaria may suggest that HPV raises similar anxieties. The mosquito is a reification of the feeling of threat posed by a virus that can invade our private spaces and healthy bodies.

It is also important to see how the extracorporeal nature of the causes of illnesses is underlined with this metaphor; the illness does not originate within the body but mosquitoes are inconvenient outsiders that bring it in from outside. The following passage's comparisons with other diseases and explanation of their causes show how

the body is seen as under threat of outside microbes and how HPV is positioned within this narrative:

> For instance let's say, chicken pox that spreads via respiration, or say jaundice that can be passed on from the water I drink, or mumps that is transmitted through respiration, you may not be able to protect yourself from these microbes. Because, you ride the public bus, you go to the mall, that microbe, someone sneezes and you get it. Here you don't have any guilt. I mean you can't prevent this with your own behavior. Therefore, these are microbes that spread fast, and concern the public. HPV is not such a microbe. You can protect yourself from HPV by having one partner, having a closed sexual relationship, with a condom. Do I make myself clear? Through global mobile tourism, I mean if you don't do sex tourism you can be protected. Today, if you go to Bangkok there are prostitutes who are 11 years old. Now, someone who goes to Bangkok for this, is going to the swamp of the mosquitoes, it's impossible for them not to get it. I mean the government isn't obligated to protect you just because you went to Bangkok (Ali).[68]

Ali's explanation establishes the extracorporeal nature of diseases, including HPV infections. Illnesses come to us from the water we drink or the air we breathe. However, he also points out that HPV is not an easily transmitted virus; according to Ali you cannot get it through regular daily activities like riding the public bus or going to the mall, or by drinking water. His reasoning reveals, in contrast with "easily transmitted" common diseases, because HPV is sexually transmitted individuals are held responsible for getting this infection. Moreover, the comparison between jaundice, mumps, chicken pox and HPV seems to point to a finer distinction between guilt and responsibility. While anyone can innocently get chicken pox from riding a public bus, only certain

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[68] *Mesela diyelim ki solunum yoluyla bulasan su çiçeği, ya da atıyorum içtiğim sudan bulasan sarılık gibi, ya da kabakulak gibi solunum yoluyla bulaşan bir mikroptan korunamayabilirsin. Çünkü belediye otobüsüne binersin, alışveriş merkezine gidersin, o mikrop, hapşırır birisi sen de kaparsın. Burda senin suçun yoktur. Yani davranışınla da bunu engelleyemezsin. Dolayısıyla bu toplu, çok hızla yayılan mikroplardır, toplumu ilgilendiren mikroplardır. HPV öyle bir mikrop değil. HPV'den tek partnerli olmakla, kapalı cinsel ilişkide korunabilirsin, prezervatifle korunabilirsin. Analatabiliyor muyum? Beynelmilel gezici turizm yoluyla, yani seks turizmi yapmazsan korunabilirsin. Bugün Bangkok'a git, 11 yaşında fahişe var. Şimdi Bangkok'a bu iş icin giden adamın, yani artık o sivrisineğin bataklığına gidiyor, kapıp gelmemesi mümkün degil. Yani şimdi devlet de sen Bangkok'a gittin diye seni korumak zorunda değil.*

individuals get HPV as a consequence of their own irresponsible actions. Ali states that you do not have "any guilt" in getting such a common microbe like mumps or measles, which implies that you are guilty if you get HPV. While he blames the "microbes" for diseases like chicken pox, it is the human beings and their deserving actions that are responsible for HPV infections.

Ali also makes a reference to "sex tourism" in this passage. As discussed in the previous chapter, doctors' references of sex workers suggest that they do not see HPV as concerning the "general public." This quote also supports this pattern, as Ali clearly distinguishes between "diseases that concern the public" and HPV. It is also striking that he jumps to a very extreme example of global sex tourism as a way of putting HPV in contrast with "riding public buses or going to the mall" for getting other microbes that "concern the public." He delineates HPV from the general public as he distinguishes between innocent and guilty individuals. For instance, following these comments, as he explains his reasoning for not supporting government subsidization of HPV vaccine, he states there are other viruses that are more dangerous, that can spread with just a sneeze and that "endanger everyone, including innocents and children, too."[69] It is noteworthy that the "11 year old prostitutes" he mentions are not acknowledged as innocent or children.

Ali's use of the mosquito metaphor in the context of global sex tourism shifts the metaphor to a different level. As he depicts sex tourism in Bangkok as the swamp of the mosquitoes, Ali does not only situate HPV "outside" of the physical space of the human body. He also situates it outside the boundaries of moral and appropriate sexuality. Engaging in global sex trade is as threatening as the virus itself. Outside the boundaries

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[69] *Çünkü herkesi tehlikeye atıyor, masumları da çocukları da.*

lie the harmful HPV subtypes and global sex trade, which are perceived to threaten healthy bodies and pure moral values. As Douglas describes the expressive levels of "pollution ideas" in societies, she reflects on how transgressions that threaten the ideal order of society are guarded by dangers (1966, 3). Because beliefs about these dangers also serve to encourage the members of the society to hold on to their righteousness, "the laws of nature are dragged in to sanction the moral code: this kind of disease is caused by adultery, that by incest" (1966, 3-4). Thus, beliefs about dangerous contagions are used to establish and affirm moral values and social rules. In a sense, the mosquito metaphors signify a similar threat of pollution that threatens not only the body but also the moral code of a society.

Furthermore, the swamp of immoral sexuality and HPV is located in Bangkok, far away from Turkey. Thus, the "inside" is demarcated with our national boundaries, where viruses are brought in through travelers. I found it interesting that while we were discussing individual HPV infections, the point of reference automatically shifted to Turkey as a whole. However, this shift was not unique to Ali's aforementioned comment. I often encountered such generalizations and references to Turkish society at large when doctors talked about the changes they observe in individuals' sexual lives. In the following section, I focus on doctors' doctors' perceptions of "changes in Turkey" as they discuss it within the context of HPV vaccination. As the mosquito metaphor construct a threatening "outside" to locate the virus, disease, dangerous subtypes, and immoral sexualities, doctors' narratives of change similarly portray change as coming from "outside." The next section examines changes in individuals' sexualities as articulated by doctors and how they interpret the changes in relation to "western" countries.

4.2 Us and them: Westernization of Turkish sexualities

HPV vaccination is recommended for women of ages 9-26 by the vaccine companies and FDA. This age range is determined by optimal immune responses and prevalence of HPV in this age range. It is also emphasized that vaccination works ideally if the patient has not had any contact with the virus, thus has not had any sexual contact prior to vaccination. When I ask doctors the age range for vaccination, doctors usually refer to the ages recommended by the vaccination companies with slight variations. They also elaborate on how this age range is determined, as well as how they interpret the recommended ages and apply them to their own practices.

Not all doctors explained the basis of the recommended age range in the same way. For instance, when I ask him to clarify why ages 10-12 are the best ages for vaccination, Salih states "It's very simple, they look at the best immune response of the body, it emerges at ages 10-12, if it happened at age 5 they would say age 5, if it were 17, they would say 17 [is the best age for vaccination]."[70] Likewise Kadir states "Biologically we accept that the best immune response a human can give to such a vaccine is around age 12."[71]

While Salih and Kadir focus on the body's immune responses, other doctors suggest that the determination of the recommended age range depends on when sexual activity begins. As he explains that the best time for vaccination is prior to beginning of sexual activity, Nuri states, "Every country has determined the respective age group for this, in Turkey this is suggested as 11-12 for us . . . For cultural reasons, they move this

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[70] *Oradaki sebep çok basit, vücudun, şey yapmışlar, bakmışlar, en iyi immün yanıtı 10-12 yaşında çıktığı için 12 yaş, yoksa 5 yaşında olsaydı 5 yaş denirdi, 17 yaş olsa, 17 yaş denirdi.*

[71] *Biyolojik olarak bu tür bir aşıya bir insanin verebileceği güzel yanıtın 12 yaş civarında olduğunu kabul ediyoruz.*

to earlier ages in western countries, for instance the British has moved this to the age of 9."[72] Thus, Nuri believes the best age depends on "cultural reasons" and different countries can determine appropriate ages based on their particular "cultural" characteristics. What he means by cultural reasons is clarified in a similar comment by Ali. When I asked Ali for whom the vaccine is recommended, he responded "When the vaccine first came out and also in its prospectus, it is recommended for all women between the ages of 10 and 26. If you ask why 10, in western societies because it is so common to have sexual intercourse at ages 13-14, it was recommended from age 10 and on." [73] According to Ali, the age recommendations are based on the sexual behaviors of individuals in "western" societies.

Although Kadir and Ali disagree about how vaccine companies determine the age range for their product, they agree on one aspect; neither of them recommends the vaccine to 8-9 year olds in their own practice. Kadir believes the companies suggest age 9 as the lower limit based on immune responses, but he also adds "I mean, I don't recommend it to my patients' 8-9 year old children, my daughter is 8, too, I don't think she should be vaccinated yet. Because, in our country sexuality does not begin as early as it does abroad."[74] Similarly Ali states, "In Turkey, I don't recommend it to a 10 year old, usually after 14-15. Because for us there aren't many relationships at ages 14-15,

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[72] *Her ülke bu yaş grubunu tayin etmiş, biz Türkiye olarak 11-12 olarak teklif ediliyor bizde, 11-12 yaş olarak. . . Yani bu kültürel sebeplerden dolayı batı ülkelerinde daha erkene çekiyorlar bunları. İngilizler 9 yaşa aldı bunu.*

[73] *Aşı ilk çıktığında da, prospektüsünde de 10 yaş ile 26 yaş arası herkese öneriliyordu. Neden 10 yaş derseniz, Batı toplumlarında 13 - 14 yaşında cinsel ilişkiye girmek cok sık olduğu için 10 yaşından itibaren öneriliyordu.*

[74] *Yani artık, kendi hastalarımdan da ben hiç kimseye 8-9 yaşındaki çocuğuna önermiyorum. Benim kızım da 8 yaşında yani, aşılanmasını ben henüz önermiyorum yani, çünkü bizim ülkemizde cinsellik halen yurt dışındaki kadar erken başlamıyor.*

it's very rare (Ali).[75] In these two comments, doctors interpret the age recommendations as they apply it to their practice based on their assumptions about the "typical" age for beginning sexual life in Turkey. Moreover, it is interesting that their discussion of vaccine age shifts to assumptions about sexuality, including not only individual sexual behaviors but also assumptions about "our" sexuality or sexuality in Turkey. They do not merely talk about deciding on vaccination based on individual lifestyles or specific high-risk behaviors, but they refer to a broader description of sexuality "for us" or "in our country." Another interesting point about these comments is how doctors' descriptions of the typical ages for "our" society are defined in opposition to other countries. Kadir compares "our country" with "abroad" and Ali's states early sexuality is "rare for us" while it is "so common in western societies."

Other doctors find ages 8-10 to be too early for their own practices, too. As they explain why they think so, other doctors also comment on what they believe to be the "typical" age at first intercourse in Turkey. Interestingly, Ali and Kadir were not the only doctors who discussed this age in collective, or even national, terms instead of talking about individual behaviors. Moreover, other doctors, too, expressed their presumptions about sexuality in our society with the help of comparisons with "abroad."

For instance, Semra comments that pediatricians also vaccinate children and that "they even say 9 years" is the best age for vaccination. She adds:

> I think 11 years of age is early for Turkey. If it were me, I would not have my 11 year old child vaccinated, I would wait until he/she is 15 because in Turkey, for a girl to have sexual intercourse when she is 14 or 15 might be possible but it's very rare. I would think university period is possible, 15 is too early, I mean in Germany they start sexual relationships when they are 13. They bring friends over to their houses,

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[75] *Türkiye'de ben on yaşındakine pek önermiyorum, genellikle 14 - 15'ten sonra. Çünkü bizde 14 - 15 yaşında ilişki pek daha henüz yok, yani çok nadir.*

> they stay over, at their parents' house. They are a little different, aren't they?[76]

She also adds that she has vaccinated her own daughter at the age of 25 after this explanation. It is interesting to observe how the age increases from 9 to 25 in her narrative. More interestingly, when she is justifying the appropriate sex age for Turkish youth, she automatically makes a comparison with Germany, where she has lived and worked before.

Kemal also compares Turkey with another country. He said, "In some countries this is at very early ages, for example in England sexuality has gone down to ages like 14. Many women at the ages of 12, 13 are no longer virgins, like a 13 year old girl is not a virgin, she's just 13."[77] When I asked him at what age he thinks women in Turkey begin their sexual lives, he responded: "It should be 20, 18, 19, 22's or something like that, as you see it's not that low." Because in other interviews doctors shared anecdotes with me about their young patients who gave birth as teenagers or complained about early marriages in rural parts of Turkey, in this interview I followed up Kemal's comment with another question. I asked him how early marriages would factor into his age approximations, he said "In that case it would be lower, 18's 19's maybe, I have had many patients at the ages of 17 or 16,"[78] which suggests that he associates the

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[76] *Çocuk dokları [sic] da yapıyorlar ama bence öyle 9 yaşından, 9 yaşında bile diyen varmış ama 11 yaş falan Türkiye'ye göre erken bence diye düşünüyorum. Hem yani 11 yaşında ben olarak düşünsem, çocuğuma yaptırmam, hem daha bu aşı daha çok yapılıp hani şeyleri görülmüş olur, 15 yaşını beklerim diye çünkü Türkiye'de 14-15 yaşında bir kız cinsel ilişkiye girmesi olabilir de, çok seyrektir diye düşünüyorum. Yani şey olsa bile bir üniversite cağı falan olur hiç olmazsa diye düşünüyorum yani 15 yaş falan çok erken, Almanya'da ama 13 yaşında başlıyorlar cinsel ilişkiye. Çünkü eve de getiriyorlar arkadaşlarını, evde de kalıyorlar, annesinin babasının evinde, onlarda daha bir şey, değişik [gülüyor].*

[77] *İşte birkaç ülke böyle cok erken yaşta, mesela İngiltere'de 14 yaşlara düştü şey, cinsellik. 12 yaşında, 13 yaşında falan artık birçok kadın bakire değil, mesela 13 yaşında kız bakire değil. 13 yaşında.*

[78] *E tabi o zaman düşüyor yine 18'lere kadar düşer, 19'lara kadar düşüyor. Yani benim mesela öğrenci çok hastam var. 16'larında, 17'lerinde hani. Ondan önce de hatırlamıyorum, 15 belki*

decline in the age for initial sexual relationship with premarital or extramarital sex. Interestingly, most doctors give examples of their married patients who give birth as teenagers, but they do not seem to include these examples in their guesses about the initial sex age in Turkey.[79]

Kadir also observes a decline in the age for first sexual contact, but unlike Kemal who sees this change in England, Kadir thinks that Turkey is undergoing similar changes and becoming "westernized":

> In our country sexual life still doesn't start as early as it does in other countries. But if you consider cities like Istanbul, or the three major cities, the age for sexual life has dramatically declined. I mean, from the 25-30's in our time, it has decreased to 13, 14, 15, therefore we have westernized very rapidly. . . The society is changing; now our society is probably equal with New York, the Istanbul society. I mean the same, they have the same risks.[80]

His remark is interesting in the way it frames risks. Kadir compares Istanbul and New York in terms of "the risks they have." Although Kadir has been living and working in İstanbul since 1996, in our interview he also emphasized that he is originally from a village in Çorum. He expressed that he is familiar with both the circumstances in village life in Çorum, and the social life in the affluent neighborhood where his current private

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birkaç tane olmuştur ama 14 yaşında, 13 yaşında benim şeyim olamdı hiç. Olmadı yani. 15-16 belki bir tane olmuş olsa, 16-17 yaşlarında çok hastam var.

[79] In these quotes as doctors try to suggest the ideal age for vaccination and the ages for first sexual contact, I was struck by how the age keeps shifting as they talk. They are trying to define the age neatly, but they keep changing their responses. This may be a manifestation of how early they find the ages suggested; they start with ages 8-9 and throughout their responses they almost count up, and for them the ending number is also too early. The shifting numbers also show how arbitrary these numbers are in a way, and how strange it is that they are trying to find an accurate estimate of "the" average age in by engaging in an interesting mix of "science" and commonsense.

[80] *Bizim ülkemizde cinsellik halen yurt dışındaki kadar erken başlamıyor, ama özellikle İstanbul'u önplana alırsan, ya da üç büyük şehiri önplana alırsan, ani çok radikal bir şekilde cinsellik yaşı düştü Yani 25-30'lardan bizim çağımızdaki, cinsellik yaşı şimdi herhalde 13, 14, 15 düşmüş durumda, o yüzden biz hızla batılılaştık.. . . ama şimdi bu toplumun dönüşmesi, yani bizim toplumumuz da şu anda herhalde New York'la eşit oldu İstanbul toplumu. Yani aynı, aynı riske sahipler.*

clinic is situated. In a sense, he sees that Istanbul has "caught up" with New York's risks of sexual health due to changes in people's lifestyles. He describes changes in Turkey with a New York comparison in a similar manner with Kemal and Nuri who make references to England and Semra who compares Turkey with Germany. Like Ali, who differentiates Turkey from "western countries", Kadir suggests Turkey is becoming "westernized." These frequent comparisons with European counties or a vague entity named "western countries" help establish "Turkey" in contrast. Doctors' commentaries about "their" sexualities in turn define and affirm who "we" are and our sexual norms.

Kadir's comment is also significant because he does not only establish Turkey as being different, but also acknowledges contemporary transformations. I came across similar comments about perceived changes in Turkey, regarding lifestyles and sexualities. As discussed in the previous chapter, while it is almost expected for men to have multiple sexual partners, women are not imagined as getting HPV through having multiple partners, unless they are sex workers. However, although they were rare, there were instances when doctors recognized changes in these patterns. For instance, when talking about having multiple sexual partners as risk factor for HPV, Semra first referred to men's multiple partners. In the middle of her sentence, she paused and added "Or it's the same in ladies, now in Turkey [laughs] it's not like as it used to be, because of having multiple partners."[81]

Similarly, while talking about insurance coverage of HPV vaccination in other countries Kemal commented "But having multiple partners is much more common for them, then again, having multiple partners has increased for us very significantly,

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[81] *Yani hanımın veya eşin yirmi yaş öncesi cinsel ilişkide bulunmaya başlaması, veya erkeklerin çok eşlilik, bir çok kimseyle, veya hanımlarda da aynı şekilde, Türkiye'de de şimdi [gülüyor] eskisi kadar şey degil, çok eşlilikten.*

too."[82] In this case Kemal does not emphasize the gendered aspect of the changes, however his comment underlines the difference between the sexual practices of "our country" and "other countries", like the various comments on the age for first sexual intercourse. Moreover, similar to Kadir who observes Turkey's "rapid westernization" in cities like Istanbul, Kemal recognizes that incidence of having multiple partners has increased for "us", too. Thus, these comparisons and perceptions of change in relation to "the west" also serve to define who "we" are and how "we" are changing.

In the previous section, I discussed how the use of the mosquito metaphor works to situate HPV as a threat that originates "outside" of the individual body as well as the national body. I described Ali's portrayal of global sex tourism in Bangkok, which locates the source of the virus as outside of Turkey. Kemal also had a remark that strongly resembled Ali's comment:

> Now in Turkey we see all these weird types coming out, for instance the patient goes abroad, spends a few months in a foreign country, obviously has some relationships there and as a results new types [of the HPV] started to arrive here.[83]

At first I was confused when Kemal referred to "weird types coming out", thinking he was referring to people and sexualities. However, his explanation of "weird" subtypes of HPV coming to Turkey from abroad was still perplexing for me. While Kemal probably makes this comment from his experiences, there is no scientific study that details the origins and routes of the more than 100 subtypes of HPV. Kemal imagines the harmful types of HPV to be originating elsewhere, just like Ali who describes Bangkok sex tourism as the HPV "swamp" where Turkish men may get infections. Both

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[82] *Ama onlara da çok çok eşlilik bizden daha fazla ama bizde de çok eşlilik ciddi şekilde arttı.*

[83] *Türkiye'de de böyle tuhaf tuhaf tipler çıkmaya başladı. Mesela hasta gidiyor beş ay altı ay yurt dışında başka bir ülkede kalıyor, farklı bir ülkede kalıyor, orda muhakkak bir takım ilişkileri oluyor, ordan da boyle farklı tipler gelmeye başladı.*

these comments clearly locate the origins of the dangerous infection and virus abroad. In this sense, these comments resemble the mosquito metaphor, which builds on the contrast between inside and outside. Just as the mosquito brings danger and illness from "outside", the harmful subtypes of HPV are imagined to be brought into Turkey by traveling individuals.

These comments also highlight the parallels between how the virus and changes in sexuality are perceived. In a sense, since engaging in sex tourism, having multiple partners, starting sexual life at an early age are risk factors for getting HPV infections, changes in sexual lifestyles are also seen as threatening like the virus. In her examination of HPV narratives in Turkish media, Terzioğlu discerns:

> Several Turkish doctors interpret such sexual activities as major deviations from the "traditional" and mainstream gender identities and sexual patterns in Turkish society. Some doctors go even further, by saying that the increase in cervical cancer rates indicate that the moral and religious values, which regulate sexual interactions, are forgotten or ignored in Turkey, and that the new generations copy the decadent life in Western countries (2009, 1).

Thus Terzioğlu also observes doctors' perceptions of deviations from "traditional" sexual patterns in Turkish society. In my interviews, none of the doctors drew a causal link between increase in cervical cancer and decline in moral or religious values. However, they see the changes in sexual behavior patterns as increasing risks for HPV infections. Terzioğlu also points out the contrast between Turkey and western countries, which is in line with my study (2009). While doctors observe changes, they feel the need to articulate these changes through comparisons between Turkey and western countries. This may suggest that they see change as coming from "outside", just like the mosquitoes and dangerous HPV subtypes. Although none of the doctors openly make a statement about "decadence in Western countries" or new generations copying Western lifestyles, their comments about becoming "more like them" and "rapid westernization"

suggest that they see “the west” as a source of these changes, as well as the direction these changes are leading us. In the previous section I argued that the mosquito metaphors clearly locate the threat of illness as outside the individual body, morality, normal sexuality, and national boundaries. The narratives of change in this section reveal that the distinctions between inside and outside are specifically referring to differences between Turkey and the west.

CHAPTER 5

CONCLUSION

Conversations about HPV are never merely about the virus, but also about sexuality, morality, and the reproduction of existing social inequalities. Inspired by Emily Martin, who aimed to get at "what *else* people are talking about" when they describe menstruation and birth, and Rayna Rapp, who utilized anthropological tools "in the service of telling another story" within expert discourses and practices of biomedicine, in this thesis I aimed to explore what *else* doctors were telling me as they talked about HPV infections and vaccines. Through doctors' depictions of HPV, I examined how they shape the meanings of the virus in relation to discourses about sexuality, morality, and existing social hierarchies.

Although my study was based on doctors' narratives, their answers to the interview questions provide a general impression about their practices as well. The number of people doctors vaccinate for HPV is strongly related to whether they work in public hospitals or private settings. Despite the higher rates of incidence and mortality from cervical cancer for lower socio-economic groups, which is cited by doctors and the media, it is often doctors' middle or upper class patients who get vaccinated. Because patients either pay for the vaccine themselves or use their private insurances for the expenses, it is quite unlikely for public hospital patients to be able to access the vaccine. Doctors often accept this reality and perceive the vaccine as a luxury item that is intended for those who can afford it. While their acceptance normalizes the commodification of health services and the distinction between those who can and cannot afford the commodified health services, their practices of vaccination reproduce social hierarchies by offering the vaccine to more privileged patients.

Moreover, doctors' understanding of socioeconomic difference in terms of financial means reduces difference into a function of income, devoid of interdependent power relationships. However, this does not mean doctors do not acknowledge or engage power dynamics that make up social differences. Their general descriptions of their patients or the overall Turkish population reveal stereotypical depictions of lower socioeconomic groups as uneducated and ignorant masses. Through these portrayals, they differentiate themselves from these masses and construct themselves as educated experts in contrast, who have the authority to categorize their patients as uneducated and educated. Furthermore, their emphasis on lack of education also individualizes health problems experienced by lower socioeconomic groups. As they complain about their patients who do not know how to take care of themselves, ask for information about the vaccine, or make use of contraceptive methods offered to them, they present them as responsible for their health problems.

Like the narrative of education that is used to individualize health problems, the narrative of risk is also utilized to depict diseases as outcomes of individual lifestyle choices. While the notion of risk transforms disease into a set of future possibilities and threats, as well as physical suffering, lifestyle choices and behaviors become central to shift responsibility of diseases towards individuals. In doctors' narratives, risk factors are employed differently according to gender of individuals, moral values, and norms for appropriate sexual behaviors.

Moreover, narratives of HPV are shaped around existing "traditional" gender roles. Because doctors assume men to be likely to have multiple sexual partners, they see men as responsible agents in carrying and transmitting HPV. However, despite men's role in spreading HPV, they believe that women should be vaccinated and regularly screened for cervical cancer. Women, who take the center stage in HPV

narratives, are often cast in victim roles; they are infected because of their partners' multiple partners. Men are cast in similar victim roles, only if they are homosexuals or transsexuals.

As doctors' discuss risk groups for HPV, they also mention sex workers quite frequently. The use of this imagery may suggest women are only imagined to have multiple partners if they are sex workers, unlike men, who are expected to have multiple partners by definition. This imagery also shows that by associating HPV in women with sex workers, doctors want to place HPV and women having multiple partners outside of "the general public" who abide by the traditional moral codes.

The prevalent metaphor of mosquitoes that was invoked in doctors' HPV narratives also works in a similar way. As the doctors evoke the mosquito metaphor, they emphasize how disease is conceptualized as originating outside of the body and assumed moral norms of sexuality. Moreover, the ways the metaphor is used suggest that in the case of HPV, the infection is not only situated outside of individual bodies but also outside the borders of the country. Thus, just as HPV invades bodies and brings the danger of cervical cancer, deviant sexual behaviors that originate elsewhere come into our society and transform us. As the mosquito highlights the boundaries between inside and outside of the individual and the national body, it also serves to define the boundaries of "our society" in opposition to outside threats of pollution and disorder that disturb our moral code and purity (Douglas 1966, Malkki 1995).

Interestingly, the mosquito metaphor and further discussions about changes in sexualities in Turkey are often based on comparisons between Turkey and the "west". Both by defining sex workers as the high-risk group and by imagining mosquitoes and harmful HPV subtypes to originate outside national borders, doctors define what they

assume to be "our" identity in contrast. Their exclusions of HPV and deviant sexualities can be interpreted as what Rose calls "we-intentions". Rose states that morality is a matter of "we-intentions", through defining immoral actions that can only be done by "others", personal and collective identities get affirmed through moral discourses (23). Interestingly, in doctors' narratives the "we-intentions" are defined specifically in relation to the west. In order to define "our" values as opposed to "what we normally did not do", doctors frequently referred to specific European countries or a vague entity titled "the west", suggesting they interpret the changes as "westernization" of Turkish values and sexualities.

In doctors' narratives of change, westernization is not seen in a positive way. Doctors assume that women who live by traditional gender norms are not high-risk groups for HPV, but women who become "westernized", who have sex at earlier ages, with multiple partners invite risk factors into their lives.[84] Thus, westernization of sexualities is a threat to sexual health, as well as an imagined moral and pure essence that makes up "our" identity. As these narratives of change look at western values critically, in a way they define "us" with a respect for traditional values of the public. However, when we complement these narratives with doctors' portrayals of *halk* as ignorant, uneducated and lacking culture, we end up with an interesting contrast. On the one hand, doctors praise "our" traditional values in contrast with westernization, on the

[84] Fears of moral decay and eroding values has a long history, and interestingly these fears have often been discussed in relation to uncontrolled female sexuality, female promiscuity, female bodies (Rose 1999, 223). While the narratives I examined reveal various issues that transcend the gender dimension of HPV, it is striking that even broader debates of national identity and change are articulated though observations about female sexuality and changes in women's sexual lives in Turkey. In her theoretical reflections about morality and identity, Rose asks, "why have women's open expressions of sexuality recurrently been linked in public discourse with images of societal and moral decay and family breakdown?" (1999, 227). While she comes up with explanations about why morality is often evoked, I do not think she is able to explain the centrality of women in these discourses. In my study, while I observed similar a focus on women's sexualities in narratives of change, I do not think I am able to explain the puzzle that Rose presents, either.

other hand they exclude themselves from the "public" and demean "our people" based on their lack of education, culture, and proper conduct of health. In these narratives, they position themselves as neither a part of the public, nor "western values". Yet, in other discussions about the conditions of hospitals in Turkey and state of medical technologies, "the west" signifies different things. For instance, Reha stated, "Turkey is well 40-50 years behind Europe" in development of its health system. In such instances, westernization carries different meanings, which contrast with its uses in doctors' narratives of change.

Ahıska argues defining Turkish identity has always been a process of continuous contrast between the east and the west. As Turkish identity is negotiated through these contrasts, she notes "The West" has either been celebrated as a "model" to be followed or exorcised as a threat to "indigenous" national values" (2003, 353). The doctors' conflicting ideas about westernization are perfectly captured in Ahıska's comment. Likewise İpek Can describes Turkish identity's complicated relationship with the west. As deciding on "what is 'unique' to us and what can be 'taken from them' " have characterized debates about westernization, the distinction between Turkey and the west is asserted. Nevertheless, a desire to become modern and western, while remaining true to ourselves has always remained (İpek Can, 99). Particular to the Turkish context, these conflicting desires of wanting to remain true to our imagined essence while adopting positive qualities of the western world are also visible in doctors' narratives of HPV.

APPENDIX: Interview Questions

-Kendinizi tanıtabilir misiniz?

Meslek ve eğitim / muaynehane hastane / kaç hastanız var

Çocuğunuz var mı?

-Hastalarınızın profili nasıldır?

-Human papilloma virüsü nedir? Kanserle ilişkisi nedir? Biraz bilgi verebilir misiniz?

-Bu virüs hakkında ne zaman bilgi sahibi olundu? Yakın bir zamana kadar pek duyduğumuz bir şey değildi HPV, hala bile çoğu insanın bildiği söylenemez.

-Kaç türü var? Her tür kansere yol açıyor mu?

-Tespit edildiğinde hangi tür olduğu, kansere yol açıp açmayacağı da tespit edilebiliyor mu?

-Kanser ve HPV'nin bağlantısı nasıl tam olarak?

-HPV taşıyan insanlar, özellikle kansere yol açan tiplerini, kesinlikle kanser olurlar mı?

-Bu durumda kanseri tetikleyen başka unsurlar var mıdır?

-Mesela sigaranın ne gibi bir etkisi var?

-HPV nasıl bulaşır?

-Kan? Havlu vs. Gibi temas?

-Bulaşmadan da HPV vücutta oluşabilir mi? Örneğin ilişkisi olmamış birinde rastlanır mı?

-Kimler HPV virüsünü kapabilir? Kimlerde bu olasılık daha yüksektir?

-Erkeklere de HPV bulaşabilir mi?

-Yaşam tarzı virüsü kapma olasılığını veya kanser olasılığını artırır mı?

-HPV'den korunma yolları, bulaşmasını engelleme yolları nelerdir?

-Korunmak için cinsel ilişkide prezervatif kullanmak etkili midir?

-Düzenli olarak smear yaptırmak gerekir mi?

-Devlet/SSK smear ücretini karşılıyor mu?

-Erkekler için benzer bir yöntem var mı?

-HPV aşısı korunmak için ne kadar etkili?

-Bu aşı tam olarak nasıl etki ediyor? Bildiğimiz aşılardaki gibi vücuda virüs mü enjekte ediliyor? Aşı olunca enfeksiyon riski var mı?

-Bu aşıyı kimler olabilir? Kimler olamaz?

-26 yaşa kadar deniliyor, neden? Daha sonra olunamaz mı?

-Kaç yaşındaki kadınlara öneriliyor?

- Bu aşıyı erkekler de olabilir mi?

-Aşının etkisi ne kadar sürüyor? / yan etkisi var mı? Güveniyor musunuz?

-Sizce kimler olmalı, kimlere öneriyorsunuz, neden?

-Kimlere öneriyorsunuz, ne gibi tepkiler alıyorsunuz?
-Hastalarınız duymuş oluyorlar mı? Siz mi anlatırsınız?
-Nerden duymuş oluyorlar?
- Peki insanlara bu aşı nasıl duyuruluyor? Örneğin jinekoloğa gitmeyen kadınlar veya erkekler bu virüs ve aşı hakkında nasıl bilgi sahibi olurlar?

-Kaç kişiyi aşıladınız? Önerdiğiniz ama olmak istemeyen, veya önerdiğiniz ama başka yerde olan?
-Kendi kızınız, oğlunuz?
-Aşı olan bir kadın hala smear olmaya devam etmeli midir? Neden?

-Aşı olmaya karar veren biri ne yapmalı? Aşıyı nerden temin etmeli, nasıl olmalı?
-Nerelerde uygulanıyor?
-Sigorta karşılıyor mu?

-Aşının ücreti hakkında ve sigorta kapsamları hakkında ne düşünüyorsunuz?

-Maddi sebeplerle olamayanlar ne yapmalı? Ne düşünüyorsunuz?
-Olmak isteyip olamayana doktor olarak siz ne söylüyorsunuz?
-Ne düşünüyorsunuz bu ikilem hakkında?

-Sizce herkes aşı olmalı mı? Olamayanlar?

-Sağlık Bakanlığı henüz gerekli görmedi, ancak başka ülkelerde uygulandığı gibi toplu aşı kampanyaları olmalı mı sizce?
-Zorunlu aşılara dahil edilmeli mi? Neden?
-Zorunlu aşı olursa kimler dahil olmalı? Neden?

-Sağlık nedir? Devletin sorumluluğunda mıdır? Bireyin sorumluluğu mudur? Finansal kısmı?
-Kadın doğum sağlığı, cinsel hastalıklar ve HPV toplumsal sağlığa dahil midir?

Doktorlar nereden bilgi edinirler? Yayın takip eden etmeyen?
-Bu firmaların tanıtım kampanyaları var mı?
-Doktorları aşı ile ilgili bilgilendiriyorlar mı?

-Aşı firmaları dışında, virüs ve aşı ile ilgili bilgiyi bir doktor olarak nereden ediniyorsunuz?
-Kongrelerde aşı konuşuluyor mu?
-Erkeklerin aşılanması konuşulur mu?
-Fiyat konuşulur mu?

-Bu bilgiyi yaygınlaştırmak için ne yapıyorsunuz?
-İnsanlar nereden bilgi edinebilir?
-Siz sitelere baktınız mı hiç?

-Siz kendiniz aşı oldunuz mu? Çocuğunuz varsa onun aşılanmasını istiyor musunuz?
-Hayır ise, neden?

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