

NON-DECISION MAKING IN POLICY PROCESS:
THE CASE OF HPV VACCINES IN TURKEY

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DİLEK SERNUR EMİNOĞULLARI

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Approval of the Graduate School of Social Sciences

Prof. Dr. Yaşar Kondakçı

Director

I certify that this thesis satisfies all the requirements as a thesis for the degree of Master of Science.

Prof. Dr. Ayşe Ayata

Head of Department

This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Master of Science.

Assoc. Prof. Dr. Canan Aslan Akman

Supervisor

Examining Committee Members

Assoc. Prof. Dr. Savaş Zafer Şahin (Atılım Uni., KAM)

Assoc. Prof. Dr. Canan Aslan Akman (METU, ADM)

Assist. Prof. Dr. Asuman Göksel (METU, ADM)

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last name: Dilek Sernur
EMİNOĞULLARI

Signature:

ABSTRACT

NON-DECISION MAKING IN POLICY PROCESS: THE CASE OF HPV VACCINES IN TURKEY

EMİNOĞULLARI, Dilek Sernur

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Over the last decade, human papilloma virus (HPV) vaccination emerged as a public health issue, claiming to prevent HPV related diseases, in major advanced capitalist countries such as the US, Canada, and the U.K. Although the inclusion of the HPV vaccine into the expanded immunisation programme (EIP) has been considered many times in Turkey, no development was recorded about the coverage of the vaccine over the years. In this thesis, I explore the underlying reasons of non-decision making in respect to inclusion of HPV vaccine into the EIP in Turkey. To this end, public policy approaches related to the use of power in policy making process are utilised. The non-decision making strategies employed by policy makers are investigated through policy actor interviews and document based analysis. The underlying reasons of non-decision making regarding HPV vaccine has demonstrated similar characteristics to those discussed in developed countries which already have included the vaccine in their national immunisation programmes. The HPV vaccine case in Turkey has been a conspicuous example of the fact that vaccination is not only a protection against prospective diseases. Rather, HPV vaccination debate in Turkey has economic, cultural and political dimensions.

Keywords: human papilloma virus, vaccination, non-decision making, policy making process, immunisation policies

ÖZ

POLİTİKA SÜRECİNDE KARAR VERMEME: TÜRKİYE’DE HPV AŞILARI KONUSU

EMİNOĞULLARI, Dilek Sernur

Yüksek Lisans, Siyaset Bilimi ve Kamu Yönetimi

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Son on yılda insan papilloma virüsü (HPV) aşısı ABD, Kanada ve Birleşik Krallık gibi kapitalist ülkelerde bir halk sağlığı konusu olarak ortaya çıkmıştır. Genişletilmiş Bağışıklama Programı (GBP) aracılığı ile HPV aşılması Türkiye’de pek çok kez gündeme gelmiş olmasına rağmen, aşının kapsama alınması yıllar boyunca gerçekleşmemiştir. Bu tezde, Türkiye’de HPV aşısının GBP kapsamına dahil edilmesine ilişkin karar vermeme sürecinin arkasında yer alan sebepleri ortaya çıkarmayı amaçlıyorum. Bu amaçla, politikası oluşturma sürecinde gücün kullanımına ilişkin kamu politikası yaklaşımlarından faydalanılmıştır. Politika yapıcılar tarafından uygulanan karar vermeme stratejileri politika aktörleri ile yapılan mülakatlar ve dokümana dayalı analiz ile araştırılmıştır. HPV aşısı ile ilgili karar vermemenin altında yatan nedenler aşığı bağışıklama programlarına dahil etmiş olan gelişmiş ülkelerdeki tartışmalar ile benzerlik göstermektedir. Türkiye’de HPV aşısı konusu bağışıklamanın yalnızca bir hastalığa karşı koruma olmadığına çarpıcı bir örneğidir. Aksine, Türkiye’deki HPV tartışmasının ekonomik, kültürel ve politik boyutları bulunmaktadır.

Anahtar Kelimeler: insan papilloma virüsü, aşılama, karar vermeme, politika yapma süreci, bağışıklama politikaları

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LIST OF ABBREVIATIONS

ACMA	Ankara Chamber of Medical Association
CDC	Centres for Disease Control and Prevention
DGPH	Directorate General of Public Health
EIP	Expanded Immunisation Programme
EMA	European Medicine Agency
FDA	The US Food and Drug Administration
Gavi	The Global Alliance for Vaccines and Immunisation
GSK	GlaxoSmithKline
GVAP	Global Vaccine Action Plan
HPV	Human Papilloma Virus
HTP	Health Transformation Programme
IMF	International Monetary Fund
KETEM	Centre for Early Diagnosis Screening and Education for Cancer
LGBT	Lesbian, Gay, Bisexual, and Transgender
MoH	Ministry of Health
MSD	Merck Sharp Dohme
MSM	Men Having Sex with Men
NIAC	National Immunisation Advisory Committee
PAHO	Pan American Health Organisation
SAGE	Strategic Advisory Group of Experts
SAH	Society of Adolescent Health
SGO	Society of Gynaecological Oncology
SPIDI	Society of Pediatric Infectious Diseases and Immunization
SSA	Sub-Saharan Africa
SSI	Social Security Institution
TAP	Turkish Pharmacists Association
TMA	Turkish Medical Association
UHI	Universal Health Insurance System
UK	United Kingdom
UN	United Nations

UNICEF	United Nations International Children's Emergency Fund
US	United States
USCS	United States Cancer Statistics
VFC	Vaccine for Children Programme
VIA	Visual Inspection with Acetic Acid
VILI	Visual Inspection with Lugol's Iodine
WB	World Bank
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

Vaccines are valuable health interventions, blocking diseases, hampering disabilities and thus saving lives. Earlier vaccines have proved their clinical and economical effectiveness thanks to herd immunity, while newer vaccines are still expected to be confirmed as safe and effective (Schuchat, 2011). To date, at least 31 diseases are known to be prevented considerably by vaccines that are available (Stern, 2016). Some diseases have even been eliminated such as smallpox and rinderpest (Greenwood, 2014). Nevertheless, every year more than 3 million people have lost their lives due to the vaccine preventable diseases, originated from infections (CHOP, 2018).

Critical and vital aspects of vaccination for human life and the ideal of sustainable healthy generations has led to adoption of vaccination as a public health tool. The launch of national immunisation programmes in developing countries has averted many losses and disabilities (Greenwood, 2014). Early vaccines such as small pox, measles and diphtheria were developed to thwart deadly diseases killing or crippling masses. On the contrary, newer vaccines developed from the 1990s onwards targeted low incidence and less common diseases, such as cancer vaccines (Erickson et al., 2005, Mamo & Epstein, 2014).

In late 1980s, the correlation between cervical cancer and human papilloma virus (HPV), known as one of the most common sexually transmitted infections, has led to new advances in diagnosis and treatment methods with regards to the diseases related to the virus. The HPV vaccine has emerged as the strategy to prevent HPV-related diseases, specifically cervical cancer (Lowy et al., 2008; Selçuk& Engin Üstün, 2019; Ocaktan, 2012). HPV vaccines, developed by two separate pharmaceutical companies, have been authorised in the United States (US) in late 2006 and in Europe in early 2007. Canada, Australia, the US and the United Kingdom (UK) are the first countries that introduced at least one form of the vaccine into immunisation

programmes right after the regulatory authorisation (Markowitz et al., 2012). In the following years, more than 99 countries and territories have incorporated the vaccine into their immunisation programmes or pilot programmes (Bloem & Ogbuanu, 2017; Drolet et al., 2019; Cervical Cancer Action, 2018).

The HPV vaccines have also been authorised in Turkey in 2007 by the Ministry of Health (MoH) (Örenli, 2015). Given more than 10 years of availability on the Turkish market, HPV vaccination is still not available within the scope of national immunization program. The issue has been raised to the policy agenda and considered several times, but no progress was achieved. The inclusion of the HPV vaccine into the immunization program remained as a failed policy initiative. Given the widespread coverage of this vaccine in national programs across developed countries, its continued exclusion in the Turkish context is interesting from a comparative policy perspective. This non-inclusion is also interesting in the light of the sweeping health care reforms realized over the last two decades in Turkey, and many new vaccines have been introduced into the national immunization program.

This thesis aims to explore the reasons behind the non-inclusion of HPV vaccine in the expanded immunisation programme in Turkey, to identify relevant policy actors and political processes and reveal the effects of policy actors on this particular policy issue. Research questions explored are as follows: How did policy discussions about the inclusion of HPV vaccine in the national immunization programme develop in the Turkish context? What other policy alternatives were discussed during the meetings? Who were the leading policy actors? What were the effects of policy actors in HPV vaccine policy debate? What were the underlying reasons behind the inaction about HPV vaccine? What kind of non-decision methods were used?

To this end, this thesis has been divided into six chapters. The first introductory chapter provides the background, the aim and significance of the thesis, research questions, methodology and limitations encountered during the research. The second chapter lays out the conceptual and theoretical framework that will be used to explore the policy process in Turkey about the non-inclusion of HPV vaccine into the immunization program in Turkey. First, the policy process model is introduced. The different stages of the policy process identified by this model, such as problem

definition, agenda setting, policy formulation, implementation and evaluation, are discussed. This is complemented with an overview of the public policy approaches and their main assumptions about how power is exercised during policy processes to gain a broader understanding about the policy process. This thesis contends that the government showed no active policy engagement in relation to the inclusion of HPV vaccine into the immunization program in Turkey and tried to keep the inclusion of the HPV vaccine off the agenda. This chapter will therefore attach particular emphasis to non-decision making theories developed by critical pluralist theorists such as Peter Bachrach and Morton Baratz (1962; 1963; Berqvist et al., 1995; Sandberg, 2016) that explain the dynamics underpinning of failed policy initiatives. The third chapter provides information with regards to HPV virus and diseases related with HPV virus, with a special focus on cervical cancer, a common and life threatening result of HPV. Medical and clinical information about the HPV virus, and cervical cancer, their prevalence, different means fighting against the disease across different countries are important because they draw the boundaries on which policy problems are identified, and policy positions of different groups are defined and contested. The fourth chapter is organised in two parts. The first part analyses the practices related to the development and implementation of the HPV vaccination policies worldwide. The second part presents an overview of the policy issues that emerged during policy debates and processes during the inclusion of the HPV vaccines into the immunisation programmes in developed and developing countries throughout the world. The fifth chapter focuses on the Turkish case. This chapter first locates the implementation of immunization policies in Turkey within an overview of the dynamics of health care policy making in Turkey and introduces policy actors involved in policy making process and national immunisation policies. The chapter then explores the reasons underpinning the non-inclusion of the HPV vaccine into the immunization program by analysing the contestations in different stages of the policy development. Problem definition and issue framing by different policy actors are presented as well as the non-decision making strategies adopted by the government. The concluding chapter summarises the findings of fourth chapter, unveiling the reasons the behind policy inaction in respect to HPV vaccination in Turkey.

To the best of our knowledge, this is the first study analysing policy making and agenda setting processes concerning HPV vaccination in Turkey. In previous studies, researchers have conspicuously focused on level of HPV vaccine knowledge, awareness about HPV related diseases in society and medical community and attitudes towards HPV vaccine (Örenli, 2015; Hatem, 2019; Çelik, 2018; Yurtsev, 2011; Cinar et al., 2019).

1.1. Methodology

The thesis involved document based analysis, and seven elite interviews with stakeholders involved in national immunization policies. As such both primary and secondary sources of data were used in the research. Document based analysis covered the review of academic articles on HPV vaccine, vaccination and immunization policies in different health care systems, in major social science and health sciences databases, as well as the analysis of policy and technical reports prepared by public authorities in Turkey. This document based analysis prepared the ground for fieldwork, helping us to understand roles and effects of some policy actors, and dynamics of the policy making process on immunisation policies. Information gained through this document review also helped to determine the preliminary list of interviewees. Semi-structured and elite interviews were planned with key policy actors, taking part in health policy-making processes in Turkey. We used non-probabilistic, purposive sampling methods to choose individuals whose expertise and knowledge can inform our research question (Palinkas et al., 2015). In line with this purpose, key policy actors related to in particular immunisation policies, HPV vaccination and prevention of cervical cancer were identified. Authorities from public sector (Turkish Ministry of Health); professional medical associations (Turkish Medical Association, Ankara Chamber of Medical Association, Turkish Pharmacists Association); scientific medical associations (gynaecologic oncologists, public health specialists, family practitioners, infectious disease specialists and paediatricians) and vaccine unit supervisors of pharmaceutical companies who have authorised vaccines marketed in Turkey were connected to interview. We also used snowball sampling, to reach out for other respondents that our interviewees thought were active participants to the debate on immunization policies (Tansey, 2007). An ethical approval dated

28.06.2019 and numbered 28620816/293 for the research was obtained from Human Subjects Ethics Committee at METU (Appendix A). In total, 14 people from various organisations mentioned above were contacted and 7 accepted the interview invitation(Appendix B). Semi-structured interviews were conducted face to face from July 2019 to November 2019 in Ankara.

Interview questions were designed in line with the positions and specialities of respondents, which have been analysed through newspaper articles, grey literature and internet search, formerly (Appendix C and D). The foci of interviews were to understand the reasons behind the non-inclusion of HPV vaccine into Expanded Immunisation Programme (EIP), as well as to map the policy environment and policy making process concerning immunisation policies in Turkey. Additionally, factors impeding a policy initiation about HPV vaccination were questioned from the perspectives of disease burden, cost-effectiveness, safety, political ideology, culture, media influence, sexuality, affordability and socio-economic transformation of Turkish society. An emergent design research approach was used, involving inductive, continuous and exploratory inquiry methods (Given, 2008).

1.2. Limitations

There were also some limitations encountered in this study. First, difficulties of access emphasised in relation to elite interviews presented me with challenges both before and during the interviews. Building trust with them and securing a time and place to conduct interview proved difficult. The background and predisposition of interviewees had to be identified and studied before the interview. Moreover, it is not always easy to conduct interviews with public officials. Most of the time, especially when the topic being researched is sensitive as is the case with HPV vaccines, the official information they share is limited. Sometimes those in less senior positions are less constrained forthcoming with important information. Second, interview questions were emailed to respondents when there were obstacles to conduct an interview. A very busy interviewee provided written answers to the interview questions.

CHAPTER 2

PUBLIC POLICY MAKING PROCESS AND POLICY APPROACHES

This chapter will lay out the conceptual and theoretical frameworks that will be used to explore the policy process in Turkey about the non-inclusion of HPV vaccine into the immunization program in Turkey. First, the policy process model is introduced. The different stages of the policy process identified by this model, such as problem identification, agenda setting, policy formulation, implementation and evaluation, are discussed. Policy process model provides an important lens that helps us systematically analyse policy making. The policy analysis that will be conducted in Chapter five will be structured along the stages identified in this model. Yet, the linear and descriptive nature of the policy process model remains insufficient to explain why and how certain policies are identified, what determines the dynamics of agenda setting process, the processes of policy implementation. To gain a broader understanding about the policy process, and guide the analysis of the policy in the Turkish case, the second section of this chapter will provide an overview of the public policy approaches and their main assumptions about how power is exercised during policy processes. Though the literature encompasses several numbers of theories and views regarding the exercise of power, here I refer to two of them since I see them relevant to this study. Thus, pluralist approaches and critical pluralist approaches will be reviewed to inform why the policy initiative for the inclusion of the HPV vaccine into the national immunization programme failed. This thesis contends that the government showed no active policy engagement in relation to the inclusion of HPV vaccine into the immunization program in Turkey and tried to keep the inclusion of the HPV vaccine off the agenda. Particular emphasis will be given to non-decision making theories developed by critical pluralist theorists such as Peter Bachrach and Morton Baratz (1962; 1963; Berqvist et al., 1995; Sandberg, 2016) that explain the dynamics underpinning of failed policy initiatives. The section will also review

different strategies and tactic of non-decision making that may be employed by policy actors to keep issues off the agenda.

Both approaches agree that power exists, however, as observation and demonstrations of power vary so do their definitions (Cairney, 2011). Pluralist theory, emphasises the evident conflicts between parties, during the decision-making processes. This has now come to be known as the first dimension of power. Bachrach and Baratz's (1962) criticisms of the pluralist theory focuses on non-decision making characterised by hidden conflicts and issues that are not included in the policy agenda, This is now referred to as the second dimension of power. Lukes (2005) adds a third dimension of power, emphasising obscure conflicts and drawing attention to the power used to shape people's ideas and preferences (Hill, 2005). HPV vaccine example has been a specific case for non-decision making in health policy in Turkey.

2.1. Public Policy Making Process

The term "policy" has been defined in various ways. Lasswell (1971) defined "policy" to indicate "important" decisions, consisting of values, instruments, stakes and outcomes. Schulman's (1988) definition of policy is "a set of concepts, axioms, and deductive inferences directed toward the analysis of a public problem". Another definition of policy is "broad statement of goals, objectives and means that create the framework for activity. Often take the form of explicit written documents, but may also be implicit or unwritten." (Buse et al., 2005). David Easton (1965) defines policy as "a web of decisions and actions that allocates values" (Nadel, 1975). The values that Easton cites are not only associated with societal values but also reflect conflicts among these values. Values with high priority prevail and turn into policies (Kraft & Furlong 2018). On the other hand, Thomas Dye (2012) summarised policy as "whatever governments choose to do or not to do".

Policy issues concern not only expressed by politicians but also public seniors, professional associations and interest groups in society (Azline et al., 2018). A policy indicates future plans and desires of an organisation and charts out to make those realise (Osman, 2002). Likewise, public policy can be regarded as preferences of government to achieve specific goals. Yet, public policy is more than governmental choices in the sense that it is designed to meet needs of the public and thus involves a

set of actions and actors, tackling problems in question (Anderson, 2003; Anyebe, 2018).

Public policy emanates from the existence of a social problem for which government is willing to take measures to solve it and therefore poises a strategy and plan to implement (Anderson, 2003; Osman, 2002). Government actors and government officials are essential actors of public policy process, the actors from private organisations may involve in and influence the process (Hill, 1997b; Anyebe, 2018). Another aspect of public policy is its binding characteristic, as it is planned and implemented by government (Nadel, 1975).

Health policy refers to governmental decisions taken with the aim of improving the level of health and population. Establishing health policy is closely related to the choice of provision of health care services, including economic, social and organisational aspects. According to Alford (1975), health policy is widely affected by the structure of a health care system (Osman, 2002).

Policy making process is dynamic in the sense that policy plans or intentions may change over time due to the feedbacks of previous policies or complete policy changes. Moreover, policy decisions require the collaboration and involvement of a myriad of policy actors from both public and private bodies (Hill, 2005; Hill, 1997b; Osman, 2002).

Policy making process can be conceptualised as consisting of different and consecutive stages in which policies are planned, developed, formulated, negotiated, implemented and evaluated (Buse et al., 2005). Though it appears like a forward moving process, policy making process may be delineated in different dimensions. First, there are institutional arenas where policy problems are defined such as executives, legislatures, regulatory agencies, specialised committees of professionals, in which every actor is responsible for specific topics and has divergent levels of policy making power. Secondly, international and national or governmental arenas shape policy environment. In international arena, transnational organisations such as the World Health Organisation (WHO) are concerned with health policies, whereas national domain includes bureaucracy, legislative and judiciary powers (Azline et al., 2018).

The policy process/cycles models are developed to make the flow of event and decisions in the policy making process more comprehensible. The models provide logical sequences of the policy process and the role of policy actors taking part in every stage (Hill, 1997b; Kraft & Furlong, 2018). The concepts and definitions in the model are general and descriptive, they can thus be adjusted to fit different political system and policy making process (Kraft & Furlong, 2018; Cairney, 2011). The nature of state-society relations, and political communities certainly change the dynamic of policy process in different stages across different societies.

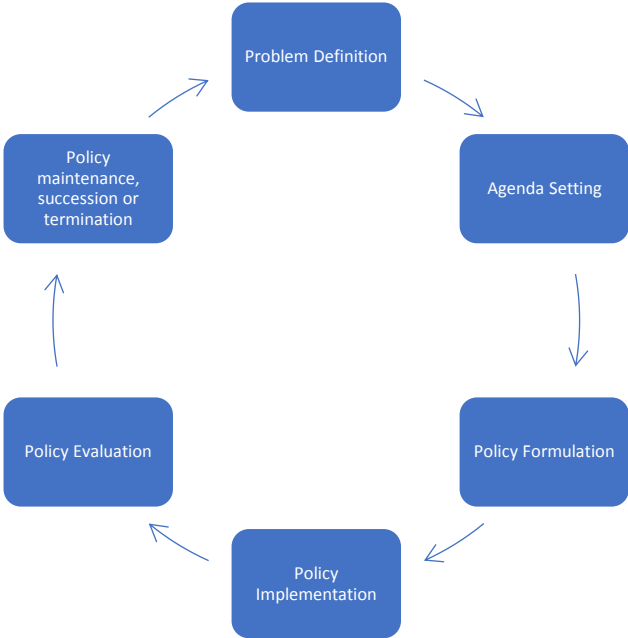


Figure 1: Policy Process Cycle

This model indicates an “implementation gap” between policy plans and policy outcomes. To understand this gap, the stages of the model need to be considered within the framework of decisions taken in each step (Cairney, 2011).

2.1.1. Problem Definition

Problem definition is the first step of policy making process. It conveys an analysis of how problems are perceived and defined by different actors in the policy process. This is also the stage where justifications may be developed by different actors for the development, or non-development of public policies to solve these problems

(Fischer et al., 2007). The identification of a policy problem precedes agenda setting and discussion of problems in political agenda (Buse et al., 2005). In modern democratic societies, power and political struggles amongst different societal actors permeate problem definition as all other stages of the policy process. The objective definitions of policy problems are therefore next to impossible. The definition of a problem also directs the trajectory of solutions offered for the issue. Kingdon (1995) states that “problem definition and struggles over definition turn out to have important consequences”. In that sense, the definition of a policy problem is of high importance as it involves biases for the solutions. Personal backgrounds, dominant ideologies, prominent cultural and political values, differences in interests are all factors that influence how problems are perceived and framed in different ways by different groups in a society and how distinct solutions are considered. The proponents and opponents of a policy problem have attitudes towards the problem from different perspectives (Kraft & Furlong, 2018).

In liberal democratic societies, problem definition is a process in which different actors and institutions are involved. This includes the executive, legislative, and judiciary organs of the state, as well as the bureaucracies associated with each one of these organs. Interest groups, organizations and individuals affected by policy may try to affect policy definition. Policy actors may also use comparisons with other policy or national contexts to define policy problems (Kingdon, 1995). Public and private authorities may develop technical and executive reports prepared to provide detailed information about the problems and its evolution over time. Interest groups are also involved in policy process by portraying problems from their perspectives (Kraft & Furlong, 2018).

2.1.2. Agenda Setting

Problem definition is not enough for a problem to be recognised as a policy problem by policy makers. Agenda setting lies at the heart of policy process (Kraft & Furlong, 2018) and is the second stage of the policy cycle. It refers to how policy problems command attention and enter into the political agenda (Kraft & Furlong, 2018, Kingdon, 1995; Birkland, 2005). John Kingdon (1995) defines agenda as “the list of subjects or problems to which governmental officials, and people outside the

government closely associated with those officials, are paying some serious attention at any given time” (Fischer et al., 2007; Buse et al., 2005). In an environment where there are plenty of policy needs, policy agenda setting is the action of allocating time, resources and attention to the most favoured policy option (Parkhurst & Vulimirib, 2013). The agenda setting process lays the ground for the adoption of public measures in response to issues identified by social forces as policy problems. An agenda demonstrates a list of topics seen worthwhile by policy participants to discuss and consider. Yet, some issues fail to rank among the list, as they are regarded as unacceptable in a particular political setting, while others achieve to be placed on the agenda due to the bias of the political system (Birkland, 2005). There may be controversies about the definition of problems and potential solutions (Fischer et al., 2007; Birkland, 2005). The rivalries and debates around the issue may affect portrayal and solution options of problem (Fischer et al., 2007).

Maintaining long-term public attention and obtaining intended solutions to the issues are also part of agenda setting process. Social construction implies the way of defining problems and managing perception about the problems in the society, which is closely related to social, political and ideological features the society based on. Kingdon (1995) stresses the importance of statistics to address the urgency of public issues. Interest groups or government officials use these indicators to attract public attention to the problem and advance their policy choices. Media reporting assists to expand the influence area of policy debate, defined as tactical means. Political elites may also mobilise masses to influence agenda setting process (Fischer et al., 2007; Buse et al., 2005; Kraft & Furlong, 2018).

Actors from both outside and inside of government are involved in agenda setting process. The ability of interest groups to influence policy makers are not equal, conversely some groups are stronger than others. The group who raises the most persuasive argument and solution may be more advantageous. On the other side, some policies cannot reach policy agenda due to absence of political and economic sources (Fischer et al., 2007).

The scope of policy problems, the number of people affected by them, the political strength and resources of policy actors that demand a solution to the problems are all important determinants of agenda setting process.

The problems on the agenda or not yet on the agenda might attract attention of public as a result of focusing events such as disease outbreaks or crisis. Such events may increase the chances of a problem to enter to the agenda. These big events reinforces the action of agenda setting by coupling policies and politics so long as they are linked to national priorities such as public health (Birkland, 1998; Kraft & Furlong, 2018).

All topics on the agenda run against each other to maintain the political will to be implemented. Thus, agenda setting trigger competition between groups, aiming to raise their voices and gaining public attention as no groups can address all the problems and solutions in a society (Fischer et al., 2007; Buse et al., 2005). Priority setting is used to sequence or prioritise some issues over others in an environment where all activities compete each other (Mullen & Spurgeon, 2000). Therefore, priority setting aims to make a selection among different policy options and sometimes may require a compromise among policy options considering scarce resources, especially in developing countries (Terwindt et al., 2016; Wikler, 2003). With respect to health care services, the government acts as an allocator of limited resources which entails the use of public funds. In this respect, the government may develop values or principles to decide priority setting. Some policies with low priority may be excluded from the agenda (Ham, 1997; Robinson, 1999).

2.1.3. Policy Formulation

Once a policy problem is defined and enter into the political agenda, possible solutions for the problem are developed by different actors involved often in the form of policy proposals. Policy goals and strategies to achieve these goals are also proposed by different actors at this stage (Kraft & Furlong, 2018). Still, agenda setting and policy formulation stages are difficult to distinguish as it is possible to initiate and reform a policy without visiting early stages of policy making process (Hill, 2005). At this stage, there are some dominant standards for policy acceptance such as cost or social and political acceptability. Policy actors seek out information that bolster up their arguments and pursue their goals. The arguments which have not been formulated well may fail to be implemented (Kraft & Furlong, 2018).

Hill (2005) stresses the importance of civil servants, with a consistent institutional and autonomous line for effective policy formulation. These formal and permanent personnel may influence policy process by maintaining continuity of policy agenda. Several theories have been developed to explain the role of civil servants in policy making process have been subjected to some theories. Bureaucracy theory argues that civil servants are bounded up with bureaucratic routines, conspiracy theory claims that civil servants have their own agenda and wise counsellors theory asserts that civil servants are required to ensure the policy process to be flawless (Pollitt, 2003). Besides, the influence of appointed bureaucrats who are very knowledgeable and experienced on policy process might be two-sided. On the one side, they are experienced in formulating new policies and producing arguments to support it (Kraft & Furlong, 2018). Scientific evidence, demographic parameters and personal anecdotes are regarded as the most persuasive arguments (Cohen & McKeown, 2015). On the other side, they may have a conservative approach towards policy making process and only accept gradual changes instead of innovative approaches. Interest groups also play a significant role in policy formulation process, striving to shape the process of policy formulation to serve their own interests (Kraft & Furlong, 2018).

2.1.4. Policy Implementation

Policy implementation refers the conversion of policy ideas into policy practices. It is a separate process from the earlier stages of policy making process. The absence of policy implementation stage in a policy making process indicates a potential problem limiting policy implementation (Buse et al., 2005).

The concerns of explaining public policy implementation variations and their conclusions has led to the emergence of conceptual frameworks describing the policy implementation process. To this end, top-down and bottom-up approaches have been developed (Sabatier, 1986).

Top-down approach is a process of policy implementation dividing the stages policy formulation and implementation explicitly. It is a linear and rational process, in which demands of higher levels are put into the effect on the basis of pre-determined objectives (Buse et al., 2005). This approach is based on some assumptions. Accordingly, policies include obvious policy tools for accomplishment. There is an

authoritative policy statement reflecting the wishes of highest level policy designers. Policies are implemented in accordance with an “implementation chain”, starting from the top. This high level policy designers have a comprehensive knowledge of organisation, financial and human resources and legal authority and autonomy to put policies into practice. Commitment of lower level policy implementers is of high importance for the achievements of policy goals. The problem with the top-down approach is to set an objective benchmark to decide with polices are successful and which are not. On the other hand, the presence of a single government instead of federal governments is more advantageous with regards to successful implementation of policies (Birkland, 2016).

In response to the alleged debilities of top-down approach, bottom-up approach has emerged (Sabatier, 1986). Bottom-up approach reverses the places of policy actors taking part in in top-down approach. The policy implementation process is dominated by the subordinated levels and thus results in differences in achieved policies from those planned (Buse et al., 2005). This approach has evolved out of the dissatisfaction with unsuccessful outcomes and flaws throughout the top-down policy process. According to bottom-up approach, policy is regarded as “a set of law, rules, practices and norms”. As policy goals are not as specified as top-down approach, bottom-up approach values negotiation and compliance between policy actors and groups. There is the risk of having too much expectation from lower level bureaucrats, who are bounded up with bureaucratic norms and obligations (Birkland, 2016).

2.1.5. Policy Evaluation

Policy evaluation is defined as “the assessment of the effectiveness of a public policy in terms of its perceived intentions and results”. As the last stage of policy making cycle, policy evaluation is used to check if the intended policy outcomes are achieved. At the end of policy evaluation, existing policies might be sustained, changed, terminated or replaced with newer policies (Buse et al., 2005). Policy evaluation is regarded as the last major chance to reassess and reframe the policy issue in case there are undesirable consequences. This last stage of policy process provides opportunity to check if the budget have been spent properly or assignments and rules have been implemented correctly (Gerston, 2010; Kraft & Furlong, 2018).

Cost is an important indicator to check if the policy implemented worth the money spent on it. In addition to costs and benefits of policies implemented, policy evaluation includes political judgements (Kraft & Furlong, 2018).

2.2. Power and Public Policy Approaches

Power, as a contested concept, is central to every relationship in social and political arena and subject to many interpretations (Solar & Irwin, 2010). The role of government in policy making process needs to be explained within the context of power relationships in a state, as the debate of who dominates is very contested (Hill, 1997b). The true meaning of power and the role of power in policy making process is ambiguous. In terms of being responsible for a policy action, we assume that policy makers have the power and are in charge. Power can be grasped as “capacity and potential to act”. The extent of power one possesses may not be predicted until the use of power (Cairney, 2011).

The public policy-making and agenda setting processes are closely associated with the exercise of power (Hill, 2005; Birkland, 2005). Political power, the power of making decisions and taking actions, is an outcome of political influence (Hill, 1997a). Interest groups within a society takes part in decision making processes, negotiating and trying to influence the policy implementation phases (Hill, 2005). The power relations in the society explain the reasons behind policy change or stability. Agenda setting is also a reflection of power relations in some areas (Cairney, 2011; Birkland, 2005).

The ways of power are exercised in societies has been subjected to debates between theories arguing that power can be exercised by all parties on a state and claiming that power is unequally distributed in a society. Karl Marx’s analysis of capitalism and power inequalities in society has fostered most of the theories about the latter view (Hill, 1997a). According to Neo-Marxists, the power dynamics in the society and economic strength of actors shape political arena and so policy outcomes (Kitschelt, 1986). According to top-down model power is exercised by authorities who are at the top of the organisations, seeking to implement previously decided policy objectives. Power may be used to achieve someone’s interests or preferences over the others (Erasmus & Gilson, 2008).

2.2.1. Pluralism

Pluralism argues that individuals in a society are connected to the state by means of intermediary groups, referred as ‘democratic elitism’ (Hill, 1997a). Schumpeter (1942) and Lasswell (1936) have contributed to studies of democracy in early 20th century by defining power structures in a society. They have identified power holders or ruling elites in different ways (Cairney, 2011). According to Schwartzmantel, pluralism is “both as normative theory and a way of explaining and analysing the power structure of the liberal democratic system” (Hill, 2005).

In the post-World War Period, pluralism has been restricted into the sphere of economy and interest groups with economic motivations competing against each other. Robert Dahl, Charles Lindblom, Nelson Polsby, and David Truman contributed to pluralist approach in this era. Compared to the earlier works of pluralism and radical empiricism, second generation pluralists have embraced visible actions as determinants of decision-making processes in an environment where all beliefs and ideas conflict. Their focal point was the actions in the economic realm (Schlosberg, 2003). Pluralism concentrates on the existence of interest groups, both elites and non-elites, to understand the policy making process (Buse et al., 2005). These interest groups basically represent occupational groups. They have reoriented the focus of pluralism from plurality in social identity to plurality in consensus . As such, David Truman identifies pluralism as the interest or pressure groups with common attitudes, conflicting with other groups in an environment where the state is neutral (Schlosberg, 2003).

Robert Dahl, the most prominent proponent of pluralism, claims that power is distributed throughout the society and groups in western democracies. There are multiple power centres within a society with different and contending interests. In his famous book “Who Governs?”(1961), in which Dahl analysed by whom important decisions are taken on controversial problems in New Haven, the US, he supposes that pluralism can be achieved with no group or person gaining the dominance in society (Hill, 2005; Buse et al., 2005). Power is observable and has a meaning when it is used over others. He claims that the statement “A has more power than B” is meaningless as long as their preferences and achieved outcomes do not contradict. Rather, Dahl proposes the statement “A has power over B to the extent that he can [or

does] get B to do something that B would not otherwise do”, indicating problems when putting power into operation (Cairney, 2011). Groups or individuals who exercise power over the others have the privilege to get their interests done and influence policy decisions (Buse et al., 2005). A pluralist state is a neutral mediator between fragmented groups for some pluralists, while Dahl sees the government as another interest group among all groups in society, both responding the needs from outside and pursuing its own interests (Hill, 2005). According to Dahl (1961), there are processes starting with the move from oligarchy to pluralism in 18th century and followed by democratic but still unequal relationship between policy actors. He identifies political preferences as a result of a conflict between parties (Cairney, 2011).

Pluralism asserts that every group or individual has different power and the ability of influencing decision making is not the same for every group. Money, information and expertise are seen as sources of power, which are not dispersed cumulatively. Individuals or groups can raise their voices and make an impression at some point in the decision-making process. There is no group or individual who is absolutely powerless. The superiority of voices raised, and diversity are the determinants of achievements in a pluralistic environment (Hill, 2005; Buse et al., 2005). With this regard, pluralism is against the unitary and monolithic conceptions in the political and philosophical sphere and insists on the plurality in social sphere. Pluralism promotes the existence of diverse groups having different background and experiences coming from the past (Schlosberg, 2003).

2.2.2. Critical Pluralism

Pluralism has encountered some objections. First, diverse groups with unlike interests in a society are brought together under the same classification, which might be a deceptive comment on democracy. Second objection claims that pluralist theory pays no attention to the organised state power, instead concentrates on democratic political system. Pluralism assumes that all groups within a society are satisfied in any way. In connection with this, another rejection suggests that pluralism constructs an optimistic portrait of power relations in a society (Hill, 2005; Hill, 1997a). Pluralist theory also excludes low-income countries, where governmental influences and power relations originated from personal relations and nepotism (Buse et al., 2005).

According to critical pluralists, power may take many forms and does not necessarily involve domination or oppression. Rather, it may appear in covert forms (Solar & Irwin, 2010). Power may be exercised through influencing interests and concerns of people in an implicit way to great extent (Hill, 2005). Else, power may be used to maintain policies of dominant actors and refrain other actors from engaging in key decisions, only if their policy interests jeopardise the interests of people who are more powerful (Bachrach & Baratz 1962; Cairney, 2011).

The power asymmetry between policy actors has led to some issues to become a policy decision, while some others cannot get into the agenda (Sandberg, 2016). Public policies develop in an environment where competing interests, influences, opinions and motivations conflict (Marchbank, 2000). Therefore, key decisions should have the characteristic to challenge “the authority of those who regularly enjoy a dominant position in the determination of policy outputs” (Cairney, 2011).

The actors who are in disadvantaged positions may be kept down and their distresses may not be taken into account by dominant parties and thus they need to spend more effort to be considered. Power may also be used to intimidate people to think that an issue is a policy problem (Cairney, 2011).

Powerful actors subordinate the values and procedures which are favoured by less dominant actors. As decision making process is manipulated by elites, generally accepted “set of values, beliefs, rituals and procedures” gather strength in society. This process termed as “mobilisation of bias” (Cairney, 2011) may prevent the discussion of some issues, preclude their entry into the decision making process and thus limit policy making practices (Hill, 2005; Bonal, 2012). In this context, the issues which are not favoured by the dominant values are excluded from the agenda (Bonal, 2012).

Peter Bachrach and Morton Baratz (1963) claim that a power relation entails the existence of “conflict of interests or values between two or more persons or groups” one group may keep other groups or policy makers to act for the interests of others. They assert that pluralist kind of representativeness is difficult to display since it is subjective (Bachrach & Baratz, 1962; Cairney, 2011). They believe that Dahl’s theory is incomplete and partial. To them, power is more than decisions taken in the political process. In this context, they stress the significance of non-decision making as “the practice of limiting the scope of actual decision making to ‘safe’ issues by

manipulating the dominant community values, myths and political institutions and procedures”. Non-decision making is an action of power holder to inhibit some issues to develop and need to be differentiated from negative meaning of decision making (Hill, 2005). According to Marchbank (2000), non-decision making is a way of preserving status quo without any debate or conflict. She defined methods used to maintain status quo. Accordingly,

threats to prevent an issue being raised, intimidation of challengers, co-option of challengers, branding of issues in such a way as to delegitimise them, modification or perversion of the issues, burying of demands in committee, incomplete implementation, and the creation of a bias within society to suppress opposition, to socialise people into acquiescence.

are the tactics employed by policy makers. (Sandberg 2016).

Bachrach and Baratz (1963) attributes importance on the issues which are not on the policy agenda, as well as those that are on the agenda. They noted that a non-decision making-the second dimension of power- may be explored by revealing disguised problems and disputes among the groups in policy arena. In case of absence of problems or disagreements, non-decision making cannot be in question. In some instances, policy expectations of groups or individuals may be deterred by policy makers. Similarly, maintaining status quo demonstrates the use of power, resulting in non-decision making (Hill, 2005; Nadel, 1975). The exercise of power can be gauged when power elites achieve to keep some issues out of the agenda (Nadel, 1975).

Though critical pluralist analysis contradicts pluralist thinking on policy making process, Bachrach and Baratz (1963) agree with the pluralists on the limitations of empirical analysis, meaning that power struggle should be recognised at least from one party. Non-decision making is not always in question in cases where there is a consensus and no grievances (Cairney, 2011). Critical pluralists do not deny the diverse characteristic of the world and acknowledge differences in social realm. They acknowledge the existence of others, meaning that acceptance of recognition of others, understanding of the view and positions of others and communication with others (Schlosberg, 2003).

Since pluralist approach focuses on observable actions, the impossibility of observing non-decision making is seen as an insufficiency of critical pluralist view. In

response to this argument, Bachrach and Baratz (1963) claim that non-decision making can be observed when some policies are favoured over others.

Steven Lukes (2005) asserts that Bachrach and Baratz were unsuccessful to reveal the non-intentional sides of use of power. He criticizes Bachrach and Baratz ignoring another aspect of power: shaping ideas (Bernhagen, 2002). He defines power as the situation where “*A exercises power over B when A affects B in a manner contrary to B’s interests*” power (Hill, 2005). This third dimension of power is built on the basis of second dimension of power, the works of Bachrach and Baratz (Robinson, 2006).

This chapter aimed to lay out the theoretical and conceptual framework that will guide the analysis of non-decision making processes in Turkey in relation to the inclusion of HPV vaccine into the immunization program. According to Dahl (1961), we can see power only if it is exercised by actors over each other while making decisions on important issues. The critique of Bachrach and Baratz (1962) of Dahl added non-observable behaviours to the power debate. The second dimension of power emphasises the importance of invisible or less visible interventions in decision making process. Unlike Dahl, they suggest that people may not have the opportunity to express their views on matters and thus not strong enough to influence key decisions. Simultaneously, their analysis indicates that some mighty actors, (i.e. groups, elites, or governments) can exercise power in ways that prevent certain issues from emerging on the policy agenda. Keeping in mind how policy process cycle works and the two approaches related to power use in policy making process, the following chapter will give general overview about HPV and HPV vaccination policies.

CHAPTER 3

HUMAN PAPILLOMA VIRUS CASE

This chapter provides information with regards to HPV infection and diseases related with HPV, with a special focus on cervical cancer, a common and life threatening result of HPV. Medical and clinical information about the HPV virus, and cervical cancer, their prevalence, different means fighting against the disease across different countries are important because they draw the boundaries on which policy problems are identified, and policy positions of different groups are defined and contested. In relation to this, I introduce brief information about diagnosis and screening methods for cervical cancer and HPV vaccines to elucidate the role of these prevention strategies in the management of HPV related diseases. This chapter also discusses the role of international actors in HPV vaccine introduction.

3.1. Human Papilloma Virus

HPV is the most common sexually transmitted infection and affects people from both sexes worldwide. HPV infection is transmitted through sexual contact (skin to skin, genital to skin, and oral to genital). People who have at least one sexual partner in their life have encountered the infection, with 85% rate in women and 91% rate in men, proving that HPV does not cause diseases pertaining to one gender. HPV is a persistent but not dangerous virus with more than 100 types having been detected to date. 13 of those types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59 and 66) are regarded as high-risk types which may cause cervical, anogenital or oropharyngeal cancers (Crosbie et al., 2013; WHO, 2011; Daley et al., 2017). Nearly 50% of all cervical cancers are originated from type 16 and 15%-20% of cervical cancers are caused by type 18. Besides, the most common two HPV types associated with cervical cancer, types 45 and 31 are responsible for another 10% of all cervical cancers. Low risk HPV types, 6 and 11, hardly cause cervical cancer, only creating benign cells or low-grade lesions on cervix (WHO, 2011; McIntyre, 2005).

The prevalence of HPV is at the highest point in developed countries in young women and this number drops after the age of 35 (Franceschi et al., 2006). HPV is thought to lead approximately 5% of all new cancers every year, more than 80% of which arises in developing countries (De Martel et al., 2008).

3.2. Diseases Related to Human Papilloma Virus

It is believed that HPV is acquired in the early years of becoming sexually active and then cleared spontaneously. People may acquire the virus in the following years, which corresponds to second peak of HPV prevalence, coinciding with the age 55 or older (Franceschi et al., 2006). The prevalence of HPV in men is much higher compared to women, however, the persistence of infection is low. Having many sexual partners, smoking, early debut of sexual activity, oral contraceptive use, low socio-economic status increases the risk of acquiring oncogenic HPV types in men and women (Bruni et al., 2018; Gdc et al., 2012; ınar zen, 2019).

HPV leads several types of cervical cancer including adenocarcinoma and squamous cell carcinoma, responsible for almost 80%-95% of all cervical cancer types (WHO, 2011; Grimes, 2006). Harald zur Hausen analysed the connection between HPV and cervical cancer in early 1970s. A couple of studies also confirmed this connection by 1991 (McIntyre, 2005; Grimes, 2006). The process of developing cancer from HPV virus takes many years after having encountered with HPV infection (Grimes, 2006). HPV infections do not necessarily result in cancer, most of them are asymptomatic and may disappear by itself. HPV infection remains unnoticed for two years for almost 90% of the cases in women. However, some genotypes of HPV are risky. When infection persist in people, the possibility of persistent infection to cause cancer arises. 16, 18, 31 and 45 are the most common subtypes of HPV generating cervical cancer, of which types 16 and 18 lead to 70% of cervical cancers (Bloem & Ogbuanu, 2017; Crosbie et al., 2013; WHO, 2011; Mahdavi & Monk, 2005).

Globally, it is estimated that 569.847 new cervical cancer cases occur every year, ranking cervical cancer in the fourth place among cancer types affecting women (Bray et al., 2018). As presented in Figure 2, Sub-Saharan Africa and South America have the highest incidence rates worldwide with about 35 per 100.000 women, while the incidence in North America is 7 per 100.000 women (Cecilia et al., 2017). On the

other hand, Western Europe, North America, Australia and Eastern Mediterranean are regions with low prevalence of cervical cancer, while Latin America, Sub-Saharan Africa and South Eastern Asia are areas with high rates. The maps illustrating the incidence and prevalence rates throughout the countries show similarity. Turkey is among the countries with lowest cervical cancer incidence and prevalence rates (Figure 2, Figure 3).

According to Globocan (2018), 311.365 people died of cervical cancer in 2018 (Howard et al., 2017; Bray et al., 2018; Bruni et al., 2019). As shown in Figure 4, approximately 90% of deaths from cervical cancer appeared in developing regions such as Africa, Latin America and Caribbean. On the other side, the US, Canada, Australia and western European countries have lower rates of mortality rates of cervical cancer. Despite the lower incidence and prevalence rates, mortality rates of cervical cancer in Turkey is close to the rates in developed countries (Cecilia et al., 2017).

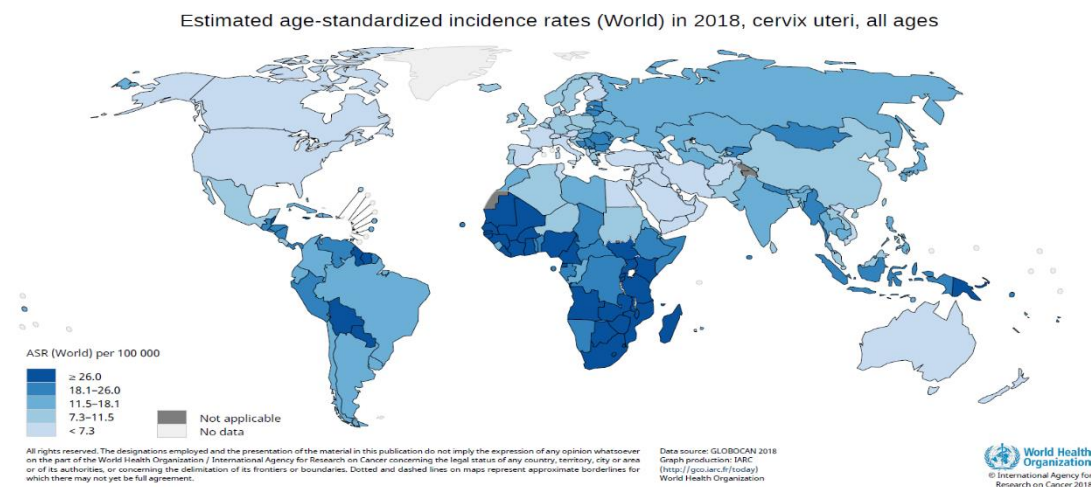


Figure 2: Global Incidence of Cervical Cancer (2018)

Source: WHO Cancer Today, 2019

Estimated number of prevalent cases (5-year) as a proportion in 2018, cervix uteri, all ages

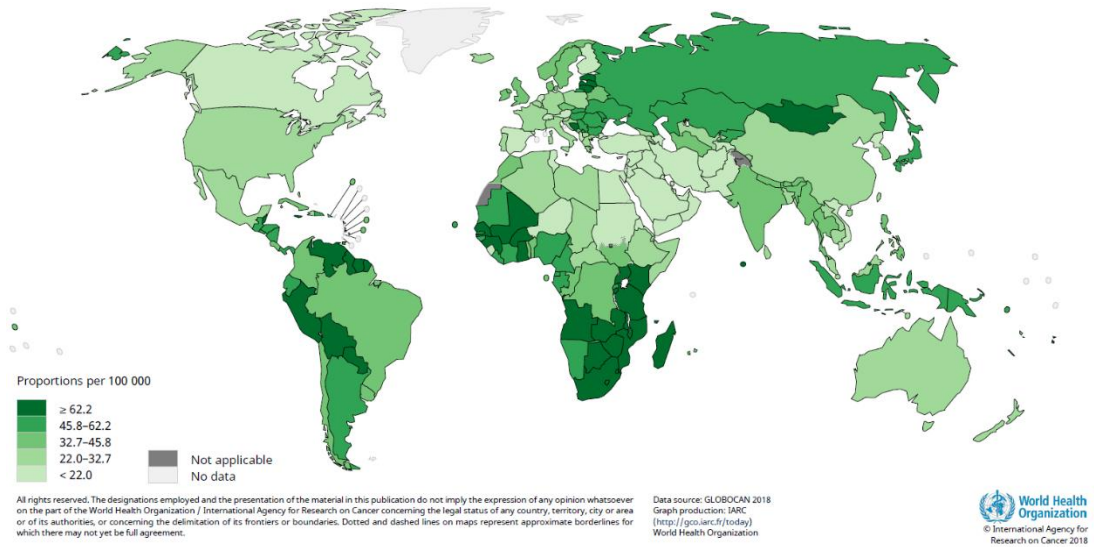


Figure 3: Global Prevalence of Cervical Cancer (2018)

Source: WHO Cancer Today, 2019

Estimated age-standardized mortality rates (World) in 2018, cervix uteri, all ages

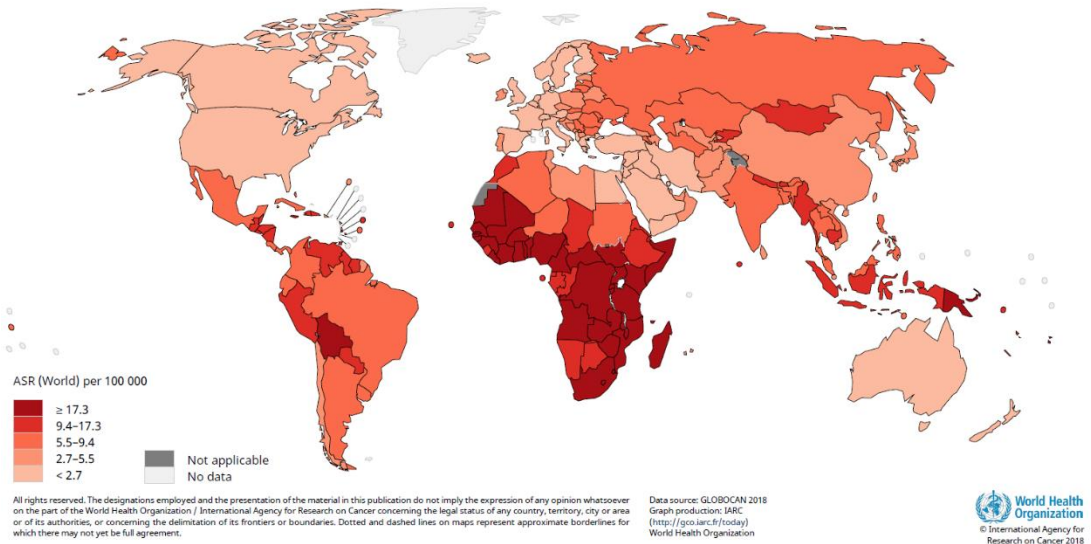


Figure 4: Global Mortality of Cervical Cancer (2018)

Source: WHO Cancer Today, 2019

Having been the most common cause of cervical cancer, HPV also leads to sexually transmitted diseases such as genital warts (Bloem & Ogbuanu, 2017). Anogenital warts, the result of another two HPV types (6 and 11), are a clear indication

of HPV infection in young men and women. Anogenital warts' incidence vary between 160 to 289 per 100,000 overall. Anogenital cancers such as vaginal, anal, penile, vulvar cancer as well as oropharyngeal cancer (head and neck) are other types of cancers linked with HPV infections (Bloem & Ogbuanu, 2017; Bruni et al., 2018; Bruni et al., 2019, Forman et al., 2012).

Though HPV is the leading cause of cervical cancer, other co-factors such as smoking, contraceptive use, HIV infection, dietary deficiencies, herpes virus type 2, suppression of immune system contribute to cervical cancer development in women. HPV virus spreads by sexual contact primarily (Bruni et al., 2019). Changing trends in sexual behaviours increase the possibility of having genital cancer (Guo et al., 2018).

Anal cancer is a rare disease with a prevalence of less than 2 in 100.000 people (Machalek et al., 2012). Overall, 24,000 cases in 27,000 cases of anal cancers originated from HPV infections, specifically types 16 and 18 (Bloem & Ogbuanu, 2017; Bruni et al., 2018; Forman et al., 2012). HPV 16 is responsible for 73%, while HPV is responsible for 5% of all tumours (Bruni et al., 2018). Risk of developing anal cancer is higher in women with cervical HPV history, individuals with HIV positive, immune suppressed transplant receivers and men having sex with men (Machalek et al., 2012).

Vulvar cancer, observed mostly in developed countries, constitutes 4% of all gynaecologic cancers with 27.000 new cases worldwide, of which basaloid/warty types are related with HPV. The overall prevalence of vulvar cancer attributable to HPV is 43% worldwide, especially the HPV types 16 and 33 (Bruni et al., 2018; Bruni et al., 2019).

Contrary to vulvar cancer, vaginal cancer emerges in developing settings with 13.000 new cases worldwide, about 90% of those are ascribed to HPV infections. HPV 16 is the leading factor for high grade vaginal lesions with 70% (Bruni et al., 2018, Bruni et al., 2019).

Penile cancer has 22.000 new cases worldwide, mostly in developing countries affecting men aged 50 to 70. More than 60% of all penile cancers are caused by HPV types 16, 18, 6 and 11 (Bruni et al., 2018; Bruni et al., 2019).

The risk factors of head and neck cancers are alcohol and smoking as well as the high-risk HPV types. 30-60% of all oropharyngeal cancers, 3% of oral cancer and %12% of pharyngeal cancer are caused by HPV infection, specifically HPV type 16 (Bruni et al., 2018; Bruni et al., 2019; Kobayashi et al., 2018).

3.3. Diagnosis and Screening Methods for Cervical Cancer

Screening methods are employed as a means of prevention from cervical cancer (Ocaktan, 2012). Cytology based screening (conventional cytology- Pap Smear test and liquid based cytology), visual inspection (with acetic acid-VIA or with Lugol's Iodine-VILI) and HPV DNA test are methods used to detect cervical cancer and its indicative lesions (WHO, 2014a; Sankaranarayanan et al., 2005).

The removal of abnormal cells from the cervical tissue prevents the possibility of developing cancer up to 90%, which highlights the importance of early detection of cancerous lesions (Mahdavi & Monk, 2005).

The commencement of screening methods to detect precancerous lesions and cervical cancer has contributed to the reduction in cervical cancer rates in developed countries, but not helpful in developing countries (Bruni et al., 2018; Mahdavi & Monk, 2005). There are disparities in cervical screening programmes between countries. Some screening programmes cover all target population, intended to check regularly, while some screening programmes require the individual's request or doctors' offer during medical examination, namely "opportunistic screening" (Bruni et al., 2018).

Cytology is the most commonly used method. In some countries, HPV DNA testing is accompanied by cytology screening (co-testing) or followed by cytology screening, providing specific examination (Bruni et al., 2018). High income countries enjoy cytologic screening and monitoring since 1950s and thus drop the morbidity and mortality rates of cervical cancer to a great extent, while poor countries still suffer lack of expertise, technical knowledge and capacity (Jones & Davey, 2000).

Cytology based screening methods, mostly used in Europe and North America, have led substantial drops in HPV related diseases (Sankaranarayanan et al., 2004). Pap smear testing, detecting precancerous lesions and infections in cells, is highly effective and decreased the incidence and mortality rates of cervical cancer in most of

the industrialised countries, however, the test has no effect in defending against anal cancers and genital warts (Parkhurst & Vulimirib 2013; Zimet et al., 2013; Sankaranarayanan et al., 2001). The problem with Pap-Smear test is it needs to be repeated due to the false negatives, in addition to repeatability and sensitivity problems (Graham & Mishra 2011; Gultekin et al., 2018). There are several criteria for cytological screening programs to be successful; a comprehensive program targeting high coverage and follow up of population, well-trained personnel, satisfactory laboratory services, quality control services and good cytology (Sankaranarayanan et al., 2004).

On the other hand, studies demonstrate that HPV DNA test gives more accurate results compared to conventional and liquid based cytology and visual inspection (Zhao et al., 2010). The US Food and Drug Administration (FDA) has recognised HPV DNA testing as the primary screening strategy in April 2014 (Ouh & Lee, 2018). However, there are controversies around the implementation of HPV DNA testing whether to conduct the test without using cytology. HPV test necessitates more laboratory work and money compared to Pap Smear test and developing countries may find it difficult to achieve (Sankaranarayanan et al., 2004; Zhao et al., 2010; Lew et al., 2017).

VIA and VILI methods are uncomplicated to apply and affordable and thus, more suitable for developing countries (Zhao et al., 2010; Sankaranarayanan et al., 2004). Nevertheless, the specificity of VIA and VILI tests are low with a rate of 15% false positives, resulting in unnecessary treatment and cost (Sankaranarayanan et al., 2004).

The absence of cervical screening in developing countries takes the rate of deaths from cervical cancer up to second rank (Mahdavi & Monk, 2005). Factors impeding screening are discomfort and sense of shame about sexuality and gynaecological checking (Graham & Mishra, 2011). Additionally, routine screening may not be sustainable for low- and middle-income countries by virtue of insufficient financial resources, lack of media awareness, incapable healthcare facilities, deficiency in follow up mechanisms and not paying enough attention to public health issues (Bloem & Ogbuanu, 2017; Ekwunife et al., 2017; Bosch et al., 2013).

Another aspect of screening programmes is that they might have differentiated screening procedures for vaccinated and unvaccinated females (Ouh & Lee, 2018; Rossi et al., 2017).

3.4. HPV Vaccines

HPV vaccination has emerged as a prevention mechanism against cervical cancer and other diseases related to HPV (Lowy et al., 2008). However, vaccination is not the only prevention mechanism against cancers originated from HPV. As there are more than a hundred types of HPV, cervical screening mechanisms need to be used to enable protection thoroughly (WHO, 2014a).

To date, 3 types of HPV vaccines (GlaxoSmithKline's Cervarix and Merck's Gardasil 4 and Gardasil 9) have been marketed worldwide. Merck's quadrivalent vaccine Gardasil is developed using recombinant yeast technology, guarding against HPV types 6, 11, 16 and 18 and genital warts. Gardasil 4 has been approved by the FDA in June 2006 and by European Medicine Agency (EMA) in September 2006 (EMA, 2019; FDA, 2019). Bivalent vaccine Cervarix marketed by GSK designed to protect against HPV types 16 and 18 (WHO, 2014a). Cervarix has been launched by GSK in September 2007 in Europe and in October 2009 in the US following approvals of EMA and FDA (EMA, 2019; FDA, 2019). The HPV types 45 and 31 are not intended by Gardasil 4 and Cervarix directly (Graham & Mishra, 2011). These two vaccines developed against HPV has claimed to prevent cervical cancer with nearly 70-80% chance (Howard et al., 2017; Simms et al., 2019).

Merck's nonavalent vaccine Gardasil 9, offering protection against five genotypes (31, 33, 45, 52, and 58) in addition to 6, 11, 16 and 18, have been licensed in December 2014 in the US and in June 2015 in Europe (EMA, 2019; FDA, 2019). The quadri- and nonavalent HPV vaccines are also authorised for use in men. Gardasil 9 is estimated to avert nearly 90% of cervical cancers (Bloem & Ogbuanu, 2017; Simms et al., 2019). The suggested population, age and dosages of the HPV vaccines which are authorised by the FDA and the EMA are summarised in Table 1.

Table 1: Population, Age and Dosage Details of the HPV Vaccines

	Vaccines	Population	Age	Dosage
FDA	Cervarix	Women	9- 25 years	3 doses: 0, 1 and 6 months
	Gardasil 4	Women and Men	9-26 years	3 doses: 0, 2 and 6 months
	Gardasil 9	Women and Men	9-14 years	2 doses: 0, 6 to 12 months 3 doses: 0, 2 and 6 months
			15-45 years	3 doses: 0, 2 and 6 months
EMA	Cervarix	Women	9-14 years	2 doses: 0, 6 months
			15 years and older	3 doses: 0, 1 and 6 months
	Gardasil 4	Women and Men	9-13 years	2 doses: 0, 6 months
				3 doses: 0, 2 and 6 months
	Gardasil 9	Women and Men	9-14 years	2 doses: 0, 6 to 12 months
				3 doses: 0, 2 and 6 months
	Gardasil 9	Women and Men	15 years and older	3 doses: 0, 2 and 6 months
				3 doses: 0, 2 and 6 months

Sources: <https://www.fda.gov/media/78013/download>

<https://www.fda.gov/files/vaccines,%20blood%20&%20biologics/published/Package-Insert---Gardasil.pdf>

<https://www.fda.gov/media/90064/download>

https://www.ema.europa.eu/en/documents/product-information/gardasil-9-epar-product-information_en.pdf

https://www.ema.europa.eu/en/documents/product-information/gardasil-epar-product-information_en.pdf

https://www.ema.europa.eu/en/documents/product-information/cervarix-epar-product-information_en.pdf

All HPV vaccines are supposed to be administered healthy people before the first sexual intercourse to achieve full effectiveness and protection (Graham & Mishra, 2011; WHO, 2014b). The vaccines are for prophylactic use and need to be administered intramuscularly.

In 2014, WHO revised the recommendation of HPV vaccination schedule. Accordingly, the two-dose vaccine are effective in adolescents aged 14 or younger when administered with and intervals of at least 6 months and up to 15 months (Bloem & Ogbuanu, 2017; WHO, 2014b).

The cost of Gardasil per dose changes between \$100 and \$233 in high income settings and \$30 and \$100 in low income settings (Castro et al., 2017). In 2011, Merck has declared that the vaccine is provided to the Global Alliance for Vaccines and Immunisation (Gavi) at \$US5 per dose with a 67% reduction (Nguyen et al., 2011).

3.5. HPV and Cervical Cancer in Turkey

In Turkey, the annual incidence of cervical cancer is reported 4.5/100.000 by the MoH, while recent sources note the incidence as 5.7/100.000 (Sağlık Bakanlığı, 2016b; Bruni et al., 2019). 55% of cervical cancer patients are diagnosed in late phases of the disease and the mortality rate is 2/100.000 (Brotherton et al., 2016; Gultekin et al., 2017a). Annual number of new cervical cancer cases is 2356 and 1280 of those die each year (Bruni et al., 2018; Bruni et al., 2019). In the early phases of the disease, treatment can be maintained with surgery while in the advanced stages and the case of distant metastasis, chemo or radio therapy are treatment options, with decreasing survival. Overall 5-year survival rate is 62% for Turkey (Gultekin et al., 2017b). It is estimated that approximately 31 million female aged 15 or older are at risk for cervical cancer in Turkey (Bruni et al., 2019).

The annual prevalence of genital warts in women is 154/100.000. Recurrence rate is about 15%-37% and the estimation of annual incidence is between 97 and 131 per 100.000 women (Özgül et al., 2011).

The incidence rates per 100.000 for anal cancer 0.1-0.4 both in men and women, for vulvar cancer is 0.3 to 0.8, for vaginal cancer is 0.1 to 0.5, for penile cancer is 0.0 to 0.1 and for oropharyngeal cancer is 0.4 in men and 0.1 for women (Table 2).

The prevalence of low-grade cervical lesions is 24.1%, high grade cervical lesions 30.2% and cervical cancer is 67.6% (Bruni et al., 2018).

Özgül et al., (2011) observed outstanding differences between regions in Turkey. Aegean Region has the top annual HPV prevalence rates, while south eastern region has the lowest annual HPV prevalence rates. Identified HPV cases in Turkey are akin to those in Europe (Brotherton et al., 2016). The prevalence of HPV is at the highest point in the age group of 30-39 (Demirci et al., 2018).

Table 2: HPV Related Cancer Incidence Rate per 100.000 in Turkey (2018)

	Men	Women
Cervical Cancer	–	5.7
Anal Cancer	0.1-0.4	0.1-0.4
Vulvar Cancer	–	0.3-0.8
Vaginal Cancer	–	0.1-0.5
Penile Cancer	0.0-0.1	–
Oropharyngeal Cancer	0.4	0.1

Source: Bruni et al 2019

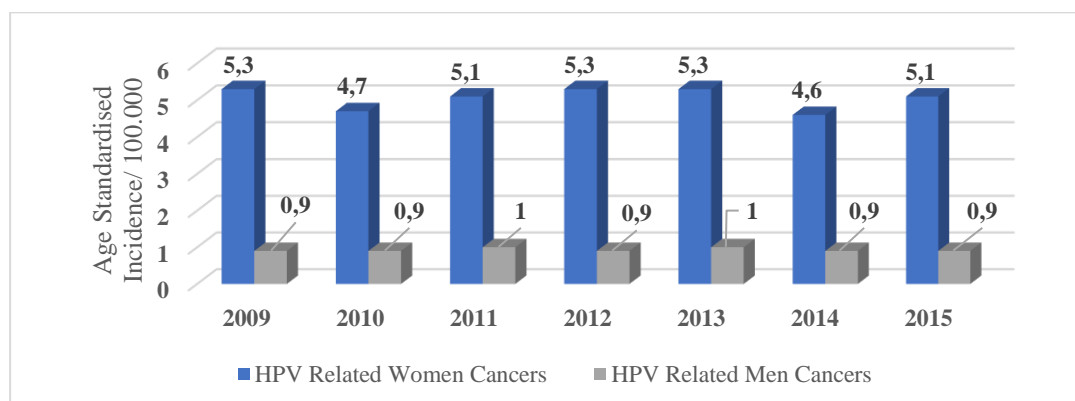


Figure 5: HPV Related Cancers Per 100.000 in Turkey (2009-2015)

Source: Sağlık Bakanlığı Halk Sağlığı Kurumu Türkiye Kanser İstatistikleri, 2016a; Sağlık Bakanlığı Halk Sağlığı Kurumu Türkiye Kanser Kontrol Programı, 2016b.

Cervical cancer is the 13th in all women cancers and 4th in cancer in women aged 15 to 44 years in Turkey (Bruni et al., 2019). Though cervical cancer has a relatively low prevalence in Turkey, HPV related women cancers are 5- fold higher

compared to HPV related men cancers (Figure 5). This number is parallel to the International Cancer Research Centre figures, considering HPV is responsible for 5%-10% of all women cancers and 1% of all men cancers (Bruni et al., 2018; Sağlık Bakanlığı, 2016a; Ohannessian et al., 2019).

3.6. Cervical Cancer Screening Programme

Cervical cancer screenings are performed through Centre for Early Diagnosis Screening and Education for Cancer (KETEM), employing physicians, nurses, midwives, x-ray technicians and medical technologists, who are trained for cancer prevention and screening methods. There are 197 KETEM throughout the country with at least one KETEM in each province (Sağlık Bakanlığı, 2016b).

Women, aged 30 to 65, are invited to screening programmes via different methods including email, telephone, letter or face to face. In case of a negative response or no response within 5 subsequent years, the invitee is recorded as “rejected screening” (Gültekin et al., 2018).

In Turkey, smear test has been performed since 1992 in line with the recommendations of the WHO. Population based cervical screening has started in 2004. Department of Cancer has organised screening programme for women aged between 30 and 65 with 5-year intervals. Cervical screening coverage rate for the test is around 20%, far from 70% coverage target. The reasons behind the low uptake of smear test can be attributed to lack of knowledge in society about the screening programme and indifference of experts about the issue. Besides, the sensitivity and reliability problems with smear test has resulted in that the test to lose its popularity. In consequence, the decision of introduction of HPV test has been taken following series of scientific consultations and meeting in 2012 and HPV testing has begun in mid-2014. Within this context, standards for the cervical cancer screening programme have been updated. Accordingly, it has been planned that women aged 30 and 65 will be screened with HPV testing, which is provided in Family Health Centres, and positive results will be re-analysed with smear testing. (Sağlık Bakanlığı, 2016b; Gültekin et al., 2018).

According to the study revealing initial results of HPV screening of 1 million women in Turkey, the rate of HPV positive (abnormal cytology or HPV 16 or 18

positive) has been detected as 3,5%. In total, 16.962 of 37.515 HPV positive cases contain oncogenic genes and these cases have been directed to colposcopy screening, a detailed examination of the genital area. However, colposcopy is performed only in 25% (3499) of all positive cases. The loss of 75% colposcopy screening data mostly originated from the lack of communication between cancer and screening registries, which was a problem until 2016 (Gültekin et al., 2018). Further data of cervical screening results of 4 million women are expected to be published soon (Gültekin et al., 2019).

3.7. HPV Vaccines in Turkey

Two of three the HPV vaccines (Cervarix and Gardasil 4) are licenced and marketed in Turkey, while Gardasil 9 is still waiting to be licensed. Meanwhile, Gardasil 9 is added to the Foreign Drugs List of Turkish Medicines and Medical Devices Agency as of 18th of November 2019 (TITCK, 2019). This regulation gives individuals the chance to obtain the vaccine by means of Turkish Pharmacists Association, paying out of pocket.

HPV vaccines contain virus-like particles, which are not alive and administered intramuscularly. Age criteria for Cervarix is 9 years and older, and for Gardasil is from 9 to 26 years. Vaccination intervals and doses are updated for adolescents who are younger than 14, so that two doses vaccination in six months offers the same protection as three doses do for those older than 14. Individuals who are completely or partially vaccinated with bivalent or quadrivalent vaccines may also be vaccinated with Gardasil 9 as two doses (Brotherton et al., 2016; 1. Ulusal Aşı Çalıştayı, 2014).

Since all vaccines are neither included into the EIP nor reimbursed by the SSI, individuals obtain the vaccine from pharmacies or TPA, paying out of pocket and administration of the vaccine is provided in health care institutions. Therefore, the vaccine implementation rate in Turkey has remained less than 1% (1. Ulusal Aşı Çalıştayı, 2014; Selçuk & Engin Üstün, 2019).

3.8. The Role of International Actors in HPV Vaccine Introduction

International organisations play a significant role in guiding immunisation policies of countries and/or procuring vaccines worldwide (Piso & Wild, 2009). Global actors and organisations such as the WHO, the Gavi, the Bill & Melinda Gates Foundation and vaccine providers, including, UNICEF and Pan American Health Organisation (PAHO) have made efforts to enlarge the scope of vaccination programmes with the help of vaccine producers (WHO, 2014c). Among those, the WHO has been the most influential organisation in respect to establishing immunisation policies and formulating recommendations worldwide (UN, 2019; WHO, 2007).

WHO recommendations on vaccine introduction navigate countries in case they face competing health priorities, affordability problems and other difficulties. For this purpose, WHO announced Global Vaccine Action Plan (GVAP) for the years 2015 and 2030, aiming to support good quality new vaccine development and setting up rules to organise vaccine delivery technologies (WHO, 2017). On the other hand, the WHO's prequalification process, the initiator of procurement process undertaken by other UN agencies, gives the WHO a regulatory agency identity beyond providing recommendations (Markowitz, 2012; WHO, 2007).

3.8.1. Pathways for WHO Policy Recommendations on Vaccine Use

The global norms and standards noted by WHO assist countries for product development, licensing, safety, efficacy and quality conditions, ensuring countries to check whether their products and legislation are compatible with the international standards of WHO (WHO, 2017; Duclos et al., 2011).

WHO publishes position papers, reflecting its official position on vaccines and vaccine-related diseases, and recommendations on vaccine use. Strategic Advisory Group of Experts (SAGE) Committee provides independent evidence-based recommendations, which are required and form the basis for WHO position papers (WHO, 2007; WHO, 2017).

Policy recommendations are disclosed provided that a vaccine has been authorised by an authority or a positive regulatory assessment is issued by EMA. WHO position papers are intended for use by health policy makers, especially. Vaccine

manufacturers, international funding agencies, advisory groups, medical community and public may benefit from these position papers (WHO, 2017; Duclos et al., 2011).

Epidemiology of disease, characteristics of the vaccine, control and prevention strategies, economic considerations including cost-effectiveness and affordability, health planning considerations including vaccine schedule, logistic and monitoring, social considerations including target population proximity and acceptability of vaccine, legal and ethical considerations are included in the recommendations. WHO recommendations are produced in general sense which may apply all products which have the same characteristics. However, the update of position papers is needed when a new data or vaccine becomes available on the grounds that it affects recommendations (WHO, 2017).

3.8.2. New Vaccine Introduction Criteria

Vaccine introduction implies including a new vaccine into an immunisation programme as well as adding a new formulation or combination of an already existing vaccine in an immunisation programme (WHO, 2014c).

The pathway of introduction of a new vaccine follows those stages in most countries. Accordingly; (1) the new vaccine is authorised by regulatory agency, (2) vaccination recommendations are guided by professional organisations and (3) set by national immunisation programme, (4) vaccine delivery is maintained through logistic distribution, (5) the cost of vaccination is ensured by insurance authorities and (6) people who might be affected by the disease access the vaccine (Shefer et al., 2008).

WHO has differentiated six principles in two different categories for countries to take into account when introducing a new vaccine, which also help to fortify health care system and national immunisation programme (Figure 6). These principles may be related with vaccines or the diseases targeted by the vaccines. They consist of public health and political priority of the disease, burden of disease, other prevention and control measures of disease, performance of available vaccines, availability of vaccine supply and economic and financial issues (WHO, 2014c; WHO, 2005).

Public health priorities are determined by disease burden, presence of WHO recommendation for vaccine, compatibility of vaccine inclusion with national health plans, perception of the disease by public and medical community and considerations

for enabling socio-economic equity among different population groups (WHO, 2014c; WHO, 2005).

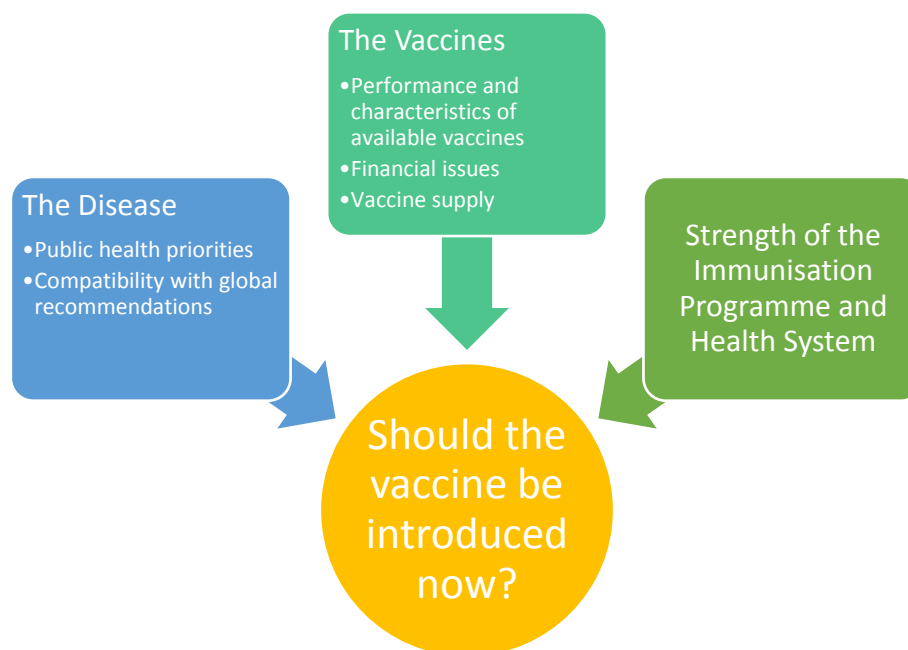


Figure 6: Vaccine Introduction Considerations by WHO

Source: WHO Principles and considerations for adding a vaccine to a national immunization programme 2014

Disease burden is measured by rates of incidence, mortality, prevalence, disability and hospitalisation. Besides, surveillance data of the targeted disease is recommended to monitor to measure the performance of the new vaccine. In cases where disease is controllable and preventable with measures other than vaccination, policy makers need to compare these measures with vaccination and decide which intervention to choose. The criteria for the comparison should be on the basis of relative effectiveness, costs, feasibility, adverse effects and potential for epidemiological change of each interventions (WHO, 2014c; WHO, 2005).

Factors related to the vaccine profile include the characteristic and performance of vaccine which can be measured counting on efficacy, safety and effectiveness features. Furthermore, herd immunity and protection from other diseases provide clues about the performance of the vaccine for countries. Availability of vaccine supply may be another aspect of the decision regarding new vaccine introduction. Supply shortages are crucial for countries in the sense that a miscalculation of needed quantity of vaccine may result in wastage or scarcity. At this point, WHO recommends delaying

introduction of a new vaccine until a healthy market, a market with several suppliers and demand and supply meets reducing prices, develops for countries with large population. Financing mechanism of national immunisation programme and cost of new vaccine are regarded as essential determinants of new vaccine introduction. Budget impact of new vaccine, cost-effectiveness analysis and financial sustainability need to be taken account (WHO, 2014c; WHO, 2005).

Disease burden is seen as the most crucial concern when deciding on vaccination policies. WHO recognises that this policy making framework may not be feasible to implement completely for all countries (Piso & Wild, 2009).

3.8.3. HPV Vaccination Recommendations

The HPV vaccine has been recommended by the WHO in April 2009 for girls provided that the vaccine is cost-effective in the setting under consideration. WHO recommendations have also suggested the inclusion of the vaccine in national immunisation programme in cases where HPV related diseases are regarded as public health priority. The WHO guided a cervical cancer prevention and control scheme composing of three levels; (1) primary level covers girls (and boys) aged between 9 and 13 years; (2) secondary level aims to screen and treat women aged 30 or older, specifically in low income countries; (3) tertiary level gives medical treatment to all women with cancer (WHO, 2014a; Nguyen et al., 2011; Markowitz, 2012).

The WHO advises females between the ages 9 and 14 to get vaccinated with two doses within 6 months to prevent cervical cancer. Screening is not recommended before the vaccination. Females over 15 years and males are regarded as secondary target groups, for which vaccination is recommended if it does not impair the distribution of resources for primary target groups (WHO, 2019).

In 2016, the WHO Strategic Advisory Group of Experts on Immunization updated its recommendation on the vaccine, defining age cohort between 9 and 14 for girls (Drolet et al., 2019).

This chapter addressed the information about the HPV virus, HPV related diseases, cervical cancer screening activities and HPV vaccines, since they are influential in forming the basis of immunisation decisions. The analysis in this chapter reveals, for example, that the prevalence of HPV virus and cervical cancer is highest

in the developing countries. Developed countries on the other hand have much lower levels of HPV prevalence but their use of protection against HPV virus and cervical cancer, including the introduction of HPV vaccine into the national immunization program are more prominent. This fact alone shows that definition of public health priorities may be relative, and that different factors, such as economic costs of protection, as well as political and cultural factors may be determinative in policy decisions.

CHAPTER 4

HPV VACCINATION POLICIES IN DIFFERENT COUNTRIES

This chapter explores the experiences of different polities while including HPV vaccination into their immunization policies. The chapter is organised in two parts. The first part analyses the practices related to the development and implementation of the HPV vaccination policies in developed and developing countries. The second part presents an overview of the contested policy issues that emerged during the national policy debates and processes during the inclusion of the HPV vaccines into the immunisation programmes. The contestations occurred during the policy making process in other countries enable us to locate Turkish experience in global context and compare and the policy concerns raised during the HPV vaccination policy making process in Turkey in the next chapter.

4.1. HPV Vaccine Implementation in Different Countries

The global access to the HPV vaccine demonstrates imbalances, albeit more than a decade since licensing. It is estimated that around 70 countries have launched the vaccine as a part of their national immunisation programme (Brotherton et al., 2016). Australia, Canada, the United Kingdom and the United States are major countries implementing HPV vaccine programmes and achieving a high rate of vaccination. The number of countries introducing HPV vaccine in Europe has increased more than 7-fold in 5 years (2007-2012), from 3 to 22 (Markowitz, 2012 Zimet et al., 2013). The number of countries who have introduced HPV vaccine correlates with the cervical cancer and anogenital warts morbidity rates (Bloem & Ogbuanu, 2017).

Though having achieved the coverage of HPV vaccine into their national immunisation programmes, most of these countries confronted with prejudices, rejections and challenges during their policy making process.

4.1.1 Australia

Australia, one of the countries with the highest HPV vaccination uptakes, has made quadrivalent HPV vaccine publicly available since April 2007. At the start of the programme, all women aged 12-26 had been provided HPV vaccine, either in school programmes or through GPs or other community health care providers. Besides, a 2-year catch-up programme was initiated for mothers and daughters (aged 13-17). As a result, the registries and monitoring since the launch of vaccines suggest that the rate of genital warts have reduced by 73% in women and 44% in men, who are not vaccinated, demonstrating that herd immunity has been achieved by only offering vaccine to women (Machalek et al., 2012; Markowitz, 2012). Australia has initiated a gender-neutral HPV vaccination programme, starting from 2013 (Drolet et al., 2019). Today, all adolescents aged between 9-18 as well as men having sex with men (MSM) are offered the bivalent and nonavalent vaccines. Two-doses vaccine is offered to adolescents aged 9-14, while three-doses is offered those who are older than 14. Vaccination is recommended people who are older than 18 in exceptional cases such as future risk of HPV exposure (Australian Government Department of Health, 2018).

HPV vaccine is offered with a parent consent form and information sheet. It is possible for adolescents to be vaccinated outside the school programme against the negative consent of parents or not vaccinated despite parental consent for vaccination (Garland et al., 2011).

In Australia, where achieved vaccination coverage rates are the highest, concerns about promiscuity are rarely referred. On the other hand, some parents find it difficult to explain adolescents why they need to get vaccinated, a result of shyness to discuss sex related issues and lack of knowledge (Garland et al., 2011; Marshall et al., 2007).

4.1.2. The United Kingdom

The UK has introduced bivalent HPV vaccine in September 2008 for girls aged 12-13 within a school-based programme and achieved to inoculate almost 93% of girls at the targeted group. Also, a catch-up programme was conducted for girls up to the age of 18, who has left school and are still at school. This catch up programme terminated in August 2011. In September 2012, bivalent vaccine was switched to

quadrivalent vaccine. The vaccine has been introduced for MSM who are younger than 45 years. From September 2019 onwards, the vaccine will be offered to boys, as well as girls, aged 12 and 13 in two doses. Three doses schedule is offered to adolescents who are older than 15 and have not been vaccinated before, since the protection level of the vaccine reduces as age increases. A national surveillance programme has been designed to monitor the effects of HPV vaccine and diseases related to the vaccine in 2009 (Markowitz, 2012; Kavanagh et al., 2017; Johnson et al., 2018; Public Health England, 2019a; Health Protection Scotland, 2019).

Though there are parental concerns about the vaccine's effect on early sexual debut and cultural barriers, two dose vaccination coverage has reached about 83,8% in 2017-18, meeting national target of vaccinating 80% of women (Public Health England, 2018; BBC News, 2019). In England, the prevalence of HPV infections declined 86% among women aged 16 to 21 (Public Health England, 2019b). Scottish data suggests that individuals who are vaccinated at ages 12-13 did not show any high-grade lesions and no serious adverse effects were observed in the following eight years (Palmer, 2019).

4.1.3. Canada

Canada started HPV vaccination programme in 2006 (Bird et al., 2017). In Canada, healthcare is a provincial jurisdiction as mandated by the Canadian constitution, and thus the introduction of a new vaccine into an immunisation programme is the responsibility of provinces and territories. As a result, the implementation of the vaccine varies from one to another due to the socioeconomic and fiscal responsibilities that each province may face as it relates to healthcare expenditure (Erickson et al., 2005). Both bivalent and quadrivalent vaccines are publicly offered to girls aged 9-13 as a part of school-based programme and free of charge. A catch-up programme is also implemented (Markowitz, 2012). British Columbia, Nova Scotia, Alberta and Prince Edward Island have started a public vaccination programme for men in 2013. Also, Ontario and Quebec are expected to initiate a gender-neutral programme soon (Bird et al., 2017).

In British Columbia major concerns regarding the vaccine are safety, lack of information and hesitancy. These concerns are what lead the 35% loss in vaccination

coverage despite public funding and school-based programme (Markowitz, 2012; Ogilvie et al., 2010). Furthermore, the Catholic Church in Ontario has drawn attention to need for further to studies regarding adverse effects, which might be a contributor to low coverage in some provinces (Markowitz, 2012; CCRL, 2007).

4.1.4. The United States

In the US, the Advisory Committee on Immunisation Practices of Centres for Disease Control and Prevention (CDC) publishes recommendations on national level with regard to the vaccines approved by the FDA. However, the vaccine implementation and schedule are under the responsibility of states. 42 states or territories have established HPV vaccine legislation. CDC recommendation suggests to immune girls aged 11-12, alongside a catch-up vaccination for females aged 13-26. The age limit for the nonavalent vaccine has been updated by FDA as 45 in October 2018 (Lowy et al., 2008; Daley et al., 2017; Drolet et al., 2019; FDA, 2018). In 2011, CDC has updated recommendation on the vaccine so as to cover males aged 11-12 to 21 who have not vaccinated previously (Markowitz, 2012, Drolet et al., 2019).

The CDC recommendation also includes the purchase of the vaccine through Vaccine for Children Programme (VFC) by the federal government, ensuring females from poor families to benefit from the programme, highlighting the importance of public health aspect of vaccination (Lowy et al., 2008).

Apart from public finance, private health insurances pay for HPV vaccine for targeted and catch up group. The vaccine is distributed through primary care clinics in most cases. Although there are disparities in terms of vaccine coverage among states, the overall coverage rate for 3-doses vaccine was around 32% in 2010 (Markowitz, 2012).

In the US, the results of a cross sectional study using data from U.S. Cancer Statistics (USCS) and covering the years from 2001 to 2014 has found that vaccine has decreased cervical cancer incidence rate significantly among young women, as well as high grade lesions. The reduction in cervical lesions is 8,3% among women aged 15-19 years and 5.3% among females aged 20-24 years (Guo et al., 2018).

The debates around the vaccine consist of concerns about safety, lack of knowledge and provider recommendation and the thought that vaccine administration

age is too low. Albeit not a major concern, risky sexual behaviour and early sexual intercourse are other points referred in studies. Some parents also take the vaccine implementation as an intervention to their parental autonomy (Markowitz, 2012; Dorell et al., 2011; Gottlieb et al., 2009). Religious objections and philosophical beliefs against vaccination has been allowed not to be included in vaccination programmes in some states (Salmon et al., 2006).

4.1.5. Japan

Japan has commenced a cervical screening programme for women over the age of 20 to avoid increasing cervical cancer incidence in young women, especially after 2000s. However, screening rates remained around 10%. HPV vaccine recommendation and public coverage has started in 2010, targeting girls aged 13-16, with small amount out of pocket fee. Though Japan has not implemented a school-based vaccination programme, high vaccination rates are achieved. In April 2013, the national vaccination programme has become free of charge for girls aged 12-16. Just after 2 months of the launch of the programme Japanese Ministry of Health, Labour and Welfare has suspended it due to media reports regarding adverse effects such as complex regional pain syndrome. Despite strong support of medical community in favour of the vaccine, the suspension of the programme is still in effect (Taniguchi et al., 2019; Ikeda et al., 2019; Wilson et al., 2014).

4.1.6. France

France has introduced quadrivalent vaccine in 2007 and bivalent vaccine in 2008 for girls aged 14, with a catch-up programme covering females between 15 and 23. Though the vaccine is provided by public and delivered through primary care providers and clinics, 35% of the vaccine cost is not covered by the National Health Insurance (Markowitz, 2012).

The coverage rate of vaccine has decreased over the years after the first introduction of the vaccine. The rumours that HPV vaccine might cause multiple sclerosis have changed the feelings about the vaccine (Karafillakis et al., 2019). Safety concerns raised in media and public, partial reimbursement of the cost, confusion about vaccine effectiveness compared to screening and absence of public health promotion

are the potential reasons for low vaccine coverage (Markowitz, 2012; Fagot et al., 2011). In response to the low uptake of the vaccine, in 2014, the French government has set the vaccine as an indicator in pay for performance system which is applied to general practitioners (Ohannessian et al., 2019).

4.1.7. Sub-Saharan Africa

Sub-Saharan Africa (SSA) has one of the highest cervical cancer rates worldwide, with 70.722 new cases every year. Overall age standardised incidence rate is over 31 per 100.000 women (Louie et al., 2009). Notwithstanding regional differences, cervical cancer prevalence is higher than breast cancer in many SSA countries (Black & Richmond, 2018). HPV vaccines are not covered by national immunisation programmes in developing countries with limited resources for healthcare. Hence, the affordability problem affects the distribution of the vaccine negatively (Graham & Mishra, 2011).

Cytology screening programmes have limited coverage in SSA because of lack of financial and human resources and competing priorities in healthcare (Louie et al., 2009). The Gavi support has enabled vaccine funding and assistance for Gavi eligible countries in SSA. Cameroon, Benin, Rwanda, Uganda, Kenya, Burundi and Zimbabwe have school-based national programme, of which Rwanda has the highest uptake rate with 99%. The constant support and commitment of Rwanda's government has played a crucial role in high HPV vaccine coverage (Black & Richmond, 2018).

Lack of knowledge about the vaccine, fear of pain and adverse effects are cited mostly as obstacles for children and families (Black & Richmond, 2018). A study conducted in Zimbabwe revealed that sociocultural barriers discourage HPV vaccine implementation. For instance, the implementation of HPV vaccine is believed to promote sexual activity in early ages which is not allowed until marriage indeed. Sociocultural barriers affect parents and policy makers' position towards the vaccine (Crann et al., 2016).

4.2. Contested Policy Issues Regarding HPV Vaccination

Vaccination may seem as a technical term as it refers to biological protection against diseases, however, vaccination has historical, economical, ethical, cultural,

religious, socio-political dimensions, as well (Graham & Mishra, 2011). The HPV vaccine case in Turkey has been a conspicuous example of the fact that vaccination is not only a protection against prospective diseases. HPV vaccination debate has revealed several contested policy issues with regards to HPV vaccine and vaccination in general.

4.2.1. Safety

Even though side effects and safety of the vaccine are not referred in interviews with policy actors, these issues are immensely discussed in the literature. In many countries, side effects of the HPV vaccine contributed to parental concerns (Zimet et al., 2013). In Japan, the vaccine has been removed from the national immunisation programme, enouncing safety profile of the vaccine (Sayaka et al., 2019). In the initial years of implementation of the vaccine in Australia, a doubt of adverse effects of the vaccine- which was psychogenic reactions indeed- has changed general feelings and media reports the other way around (Buttery et al., 2008). Besides, according to a study analysing Australian newspaper articles between October 2006 and December 2009, the most cited concerns related to vaccine were safety and efficacy (Garland et al., 2011). The safety issues about the HPV vaccine have been also raised by Jørgensen, Gøtzsche, and Jefferson in an article published in BMJ in 2018 (Jørgensen et al., 2018). The article criticises Cochrane Collaboration for missing some eligible clinical trials conducted on the effects of HPV vaccine. The debated trials were failed to show the effect of the vaccine on cervical cancer precursors. The challenge includes the absence of data from Gardasil 9 into the review, biased trial design and reporting bias (Jørgensen et al., 2018; Nass & Noble, 2019). On the other hand, Arbyn et al., (2018) claims that FDA has neglected deaths in vaccinated women aged over 25 (Arbyn et al., 2018). Tomljenovic & Shaw (2011) published an article and raised concerns about safety issues, claiming that post-marketing data of vaccine is misused by medical and regulatory authorities (Markowitz, 2012; Tomljenovic & Shaw, 2013).

On the other hand, safety and side effects of the HPV vaccine are at the heart of parental concerns and cited many times in studies surveying the reasons of hesitancy towards the vaccine. As a result, safety concerns cause parents to regard the vaccine

as “not necessary” (Hanson et al., 2018; Markowitz, 2012; Dorell et al., 2011; Gottlieb et al., 2009; Garland et al., 2011; Marshall et al., 2007; Yıldırım et al., 2009).

4.2.2. Effectiveness

In reference to the effectiveness of the vaccine, in the early years of vaccine introduction, a group of public health specialists in Germany expressed effectiveness concerns about the vaccine, leading a reduction in vaccine recommendations by physicians and low public acceptance of the vaccine (Markowitz, 2012). Over the years, the number of studies showing the effectiveness of the vaccine has outnumbered the studies claiming quite the opposite. A recent metanalysis covering more than 60 million people from 14 developed countries over 8 years has concluded that quadrivalent or bivalent HPV vaccine introduction has led to a significant decrease in HPV types 16, 18, 31, 33 and 45, anogenital warts and CIN2+ type of cancer. Moreover, older women and boys are protected with herd immunity (Drolet et al., 2019). Scottish experience with bivalent vaccine reveals that a considerable reduction in the prevalence of HPV has been achieved and the effectiveness of the vaccine decreases as the age of women vaccinated increases (Kavanagh et al., 2017). Similarly, a study in Denmark has demonstrated that cervical lesions has reduced in women who are vaccinated (Baldur et al., 2014). The results of a study performed in the UK suggest that the cervical cancer cases averted are higher amongst white girls compared to black and Asian groups, since vaccination uptake and catch up vaccination is more common in white women (Johnson et al., 2018).

4.2.3. Perception Management

The fear that pharma companies may have been accused of encouraging promiscuity by promoting HPV vaccine lead them to desexualise the perception of the vaccine (Mamo & Epstein, 2014). The claim of preventing cancer instead of sexually transmitted disease is a strategic choice of pharma companies to market the HPV vaccine (Sağlık Bakanlığı, 2016a; Mamo & Epstein, 2017). Furthermore, the vaccine has been promoted as a right and duty for secure sexual health as well as choice. Inoculation against the HPV is associated with the eradication of cervical cancer instead of a sexually transmitted disease (Graham & Mishra, 2011). Desexualisation

of the HPV infection disburdens all parties involved in the issue such as public policy makers, academics and corporate actors since sexually transmitted infections have strong potential of stigmatizing some parts of the population (Mamo & Epstein, 2017).

Furthermore, media can influence the way people consider health issues, focusing on some aspects and eliminating others (Gollust et al., 2016; Baum, 2011). Saulsberry et al., (2019) suggest that the way that scientific evidence used to promote vaccine in society and media is presented may affect the reactions towards the vaccine. Particularly, the promotion of HPV vaccine as an anti-cancer treatment has attracted much attention of women compared to advertising campaign as a sexually transmitted infection prevention (Gollust et al., 2016). For example, media and marketing campaigns have contributed to the perception about the HPV and related diseases in Australia, reflecting the HPV vaccine as a “cancer vaccine” instead of “sexually transmitted disease vaccine” or “sexually transmitted infection vaccine”. The emphasis was on prevention of cancer rather than genital warts throughout the campaign (Garland et al., 2011).

Also, there is no doubt that public policy choices are affected by the government system and political ideology which can be defined as “the set of beliefs about the proper of society” (Baumgaertner et al., 2018; Anyebe, 2018). Political ideology, confidence in government or health authorities are regarded as the most important factors determining attitudes towards vaccination policies indirectly (Mesch & Schwirian 2014; Hobson-West, 2007; Baumgaertner et al., 2018). The perception about HPV vaccination in society is closely related with the political party involvement according to studies (Kahan et al., 2010). Similarly, Malka & Lokes (2010) have found that there is a consistency between political party affiliation and reaction to new political issues (Malka & Lokes, 2010).

4.2.4. Equity

The special focus on females during the development and marketing of the vaccine has contributed to gender biases and feminisation of the HPV related diseases. Another aspect of feminisation of HPV vaccination is degradation of cancer types such as oropharyngeal cancer affecting both males and females (Daley et al., 2017). While advertising campaigns focus on “cervical cancer prevention effect” of the vaccine,

genital warts and men cancers, other results of HPV infection, are underestimated (Siu et al., 2019). Since HPV screening is not suitable for men, women are held responsible for the infection and related diseases, which places a huge burden on women in terms of both prevention and treatment of the infection (Daley et al., 2017). HPV infection has resulted in financial, physical and emotional problems on women such as depression, anxiety, fear of cancer, loss of workforce, pain, sexual problems, isolation from society and treatment expenses (Tatti, 2017).

Vulnerable groups such as sex workers, Lesbian, Gay, Bisexual, and Transgender (LGBT) people or abused children are considered as risk groups for vaccination. Occasionally, these people do not ask for sexual health advice or skip testing in fear of its social consequences (Graham & Mishra, 2011; Mayer et al., 2008). Moreover, poor and vulnerable groups are mostly affected by the accessibility and affordability problems, which also leads to widening health disparities (Graham & Mishra, 2011).

After the proof of administration of the HPV vaccine in men enables protection against HPV related diseases, gender-neutral administration of the vaccine is started to be implemented in many countries such as Australia, Canada, the US, Italy, Switzerland and Brazil (Altobelli et al., 2019). United Kingdom has announced that the national immunisation programme has started to be implemented for adolescent men as of 1st September 2019 (BBC News, 2019; Public Health England, 2019b). In these countries, concerns about equity has contributed to initiation of vaccination programme covering males (Altobelli et al., 2019).

4.2.5. Cost

Vaccine cost is one of the most important barriers in accessing HPV vaccine especially in low-income countries with restricted health budgets. Developing countries require external funding resources such as the Gavi to afford the vaccine (Graham & Mishra 2011; Castro et al., 2017; Louie et al., 2009). However, in middle income countries, which are not Gavi eligible, the cost of the vaccine forms an obstacle to early access to the vaccine (Sağlık Bakanlığı, 2016a; Markowitz, 2012). The rarity of vaccine manufacturers, ongoing intellectual property rights and lack of compulsory licensing contribute to monopoly power of manufacturers and thus high prices

(Graham & Mishra, 2011). To enable cost-effectiveness of the vaccine, dosing schedule and intervals has been re-evaluated. Two doses vaccination for adolescent younger than 14 and a 5-year interval between second and third doses is adopted in some countries. Studies for one dose vaccination are continuing (Markowitz, 2012; Drolet et al., 2019; Kreimer et al., 2011).

4.2.6. Promiscuity

Fear of promiscuity among adolescents has been an important source of parental hesitation. Another leading concern with regards to the vaccine was administration age, voiced by the parents on the grounds that it may encourage early sexual intercourse (Hanson et al., 2018; Garland et al., 2011; Marshall et al., 2007). The level of fear of early sexual behaviour has been observed in various ways between the parents of females and males. Parents of females have more tendency to report that their daughters are “not sexually active” compared to parents of males. Moreover, parents of female teens need provider information and recommendation since they are aware of the HPV infection (Hanson et al., 2018).

This chapter has provided information regarding the HPV vaccine implementation in some developed and developing countries and concerns towards the vaccine during the country implementations. It seems that developed countries have adopted the vaccine and incorporated it into their immunisation programmes, though there have been discussions and arguments against the vaccine, especially about the safety profile. Japan has responded safety concerns by suspending the vaccine implementation contrary to other countries. This chapter has also discussed the contested policy issues related to the HPV vaccine which will be referred in the next chapter as a part of the policy context analysis.

CHAPTER 5

HPV VACCINATION AS A POLICY ISSUE IN TURKEY

This chapter first locates the implementation of immunization policies in Turkey within an overview of the dynamics of health care policy making in Turkey. The chapter then introduces policy actors involved in policy making process and national immunisation policies. Finally, it explores the reasons underpinning the non-inclusion of the HPV vaccine into the immunization program by analysing the contestations in different stages of the policy development. Problem definition and issue framing used by different policy actors as well as the non-decision making strategies adopted by the government are analysed benefiting from the data received from interviews and document based analysis. The chapter contends that there has been a lack of active policy engagement by the government in relation to the inclusion of the HPV vaccine into the immunization program. In the absence of such engagement, social conservative values that associate HPV vaccine with promiscuity have been influential in the mobilization of bias against the issue. Finally, the high costs associated with the HPV vaccine has also been a factor impeding the vaccine to be included into the EIP.

5.1. Health Care Policy Making in Turkey

To understand the particularities of health care policy making in Turkey, we need to refer the functioning of the Turkish state and the bureaucracy. Turkish state has developed as a centralised, strong and non-colonial emperorship (Heper, 1985; Çevik, 2004). Though the collapse of Ottoman Empire gave rise to the birth of new and young republic, the political and social legacy of the Empire has been taken over (Heper, 1991). Turkish state administration and bureaucracy has its own characteristics. In this sense, Turkish bureaucracy is seen as an entrenched institution hosting patrimonialistic values of Ottoman Empire (Heper, 1985; Robins, 2009; Çevik, 2004). Fişek (1982) describes the characteristics of Turkish administration as

“generality, bureaucratism, elitism, over-centralization, formalism, legalism, commandism and traditionalism” (Robins, 2009). In this respect, Turkish state has grown stronger and the civil society remained relatively weaker. Thus, the public opinion and social effects of policies were not taken into account during the policy formulation and implementation processes to a great extent, featuring top-down reform making and policy implementation side of Turkish bureaucracy (Çevik, 2004).

1961 Constitution introduced “the right to health”, paving the way for state responsibility of healthcare provision and populist social redistributive policies (Boratav, 2010). Populism has become a dominant political tool after the 1980’s onwards (Keyder, 2007; Yılmaz, 2017). The approval of 1982 Constitution has strengthened the centralised policy-making processes in Turkey, increasing the influence of technocrats in policy making (Sayari, 1992). Besides, the struggle between the elected elites and the appointed elites has led to the implementation of public policies and programmes from the point of ruling elites. Despite the efforts of forming a rational-legal Weberian bureaucracy, patrimonial features of the state has become prominent. As a result, the bureaucratic elite has tendency to protect the interests and benefits of the state (Çevik, 2004).

The broad features of the public policy making process in Turkey mentioned above can also be observed in the health policy making. Throughout the 1980’s and 1990’s, policy drift dominated healthcare domain due to the lack of formal reforms except the incremental changes aiming to privatise healthcare delivery (Hacker, 2004; Yılmaz, 2017). The top-down characteristic of policy making process is explicitly observed with the implementation of Health Transformation Programme (HTP) in 2003 (Ağartan, 2016; Yılmaz, 2017). The introduction of HTP has increased the involvement of private sector in healthcare provision and delivery, familiarizing new policy actors such as private healthcare providers and their associations which are influential in policy making processes (Yılmaz, 2017).

The history of reforms in Turkey’s health care system dates back to the 1980’s when neo-liberal policies began to widen its scope to cover health policies. At this time, the World Bank (WB) provided grants and credits to trigger the transformation of healthcare system worldwide and in Turkey (Bulut, 2015). The collaboration between the WB and Turkish government on health care policy issues has gradually

increased the involvement of the WB in Turkey's health care policy (Yılmaz, 2017). Other international organisations such as the International Monetary Fund (IMF) and the WHO have also assisted health care system transformation by providing technical and financial support. The main objectives of reforms were reducing health care costs and improving efficiency in health care services without blocking access (Elbek & Adaş, 2009). During 1990's, several efforts have been spent to conduct health care reforms, including strengthening primary health care services, reforms in financing of health care system and restructuring of MoH (Bulut, 2015). The expectation of European Union membership has also contributed to the reform attempts in health care (Vural, 2013). However, the expected large-scale health reforms were not initiated throughout this process which is termed as 'policy drift', referring policy absence in the field of welfare policies (Yılmaz, 2017).

The need for health care policy reform was acknowledged by all competing political actors in 1990's even though their problem definitions and reform proposals differ. The political instability and divergent policy ideas were the main reasons for health policy reform failure (Yılmaz, 2017). In 2003, Justice and Development Party has carried out substantial changes in health care within the scope of HTP, a part of "Urgent Action Plan" which was announced in November 2002 (Bulut, 2015; Akdağ, 2009). HTP has devised transformation in eight headings:

1. Ministry of Health as the planner and supervisor,
2. Universal health insurance gathering everyone under single umbrella,
3. Widespread, easily accessible and friendly health service system:
 - a. Strengthened primary healthcare services and family medicine,
 - b. Effective and staged referral chain,
 - c. Health facilities having administrative and financial autonomy,
4. Health manpower equipped with knowledge and skills, and working with high motivation,
5. Education and science institutions to support the system,
6. Quality and accreditation for qualified and effective health services,
7. Institutional structuring in the rational management of medicine and supplies,
8. Access to effective information at decision making process: Health information system (Akdağ, 2009).

HTP was put into effect in two phases. Practices under the HTP between 2003 and 2009 composed the first part of the Programme. The second part was consisting of Health Transformation Project and Social Security Reform Project between 2009 and 2014 (Kerman & Eke, 2014).

Among those, restructuring social security system was of the top priority. Therefore, three different social security organisations (SSK, Bağ-Kur, Emekli Sandığı) have been unified under the Social Security Institution (SSI) in 2006 and Universal Health Insurance System (UHI) has been introduced for all people settled in Turkey as of 1th October 2008.

The organisation of MoH has been restructured and the MoH was equipped with regulatory functions (Yaşar, 2011; Erol & Özdemir, 2014). Financing and provision of healthcare services have been separated. The SSI has become the single purchaser of health care services. The provision of health care services is designed to provide from both public and private health care providers through contractual base agreements (Yıldırım & Yıldırım, 2011).

A family practice system has been established in 2004 and implemented all country in 2010. Family Health Centres and the Community Health Centres have been introduced into the primary health care system and replaced health care centres, tuberculosis control dispensary, mother and child care and family planning centre. Family physicians have been given the role of primary diagnosis and prevention of diseases, as well as improving health status of individuals (Akdağ, 2009; Yaşar, 2011; Erol & Özdemir, 2014; Sarıkaya, 2018).

Considering Wendt et al., (2009)'s typology of health care systems, the Turkish health care system before the introduction of the HTP was a state health care system, though the universal coverage could not be achieved. Yet, out of pocket payments were also quite high in this period, constituting a significant problem with regards to accessibility of health care services. The adoption of HTP and restructuring of health care system have eased the access to healthcare services (Yılmaz, 2017).

5.2. Actors in Public Policy Making Process

Birkland (2016) has differentiated policy actors taking part in policy making process as official and unofficial actors. The responsibilities of official actors which are enacted by law necessitate them to involve in public policy process, while unofficial actors participate in policy process since they follow their special interests and desires and think that the policy process would be partial. Furthermore, media is seen an important influencer of public policies even though it has no formal role.

Legislative organs are considered as the major policy making actor, establishing the foundations of major policy areas by passing laws which are funded by the government (Birkland, 2016). In Turkey, the effect of legislature in policy making process has changed after the transition to presidential system in 2017 which allows the president to pass presidential decrees in major policy areas. The executive branch includes the president, the ministers and their appointed staff (Birkland, 2016). As the head of government, the power of president is reflected on the agenda setting process and beyond (Kingdon, 1995). In Turkey, the president also can take action to indicate and solve policy problems through presidential decrees. Administrative agencies and bureaucracy carry out the tasks ordered by the government. Civil servants in bureaucracy also engage in decision making process. In some cases, they exercise discretionary power without an explicit order from government. Ideally, civil servants are not expected to have political connections and they are protected against political pressures through job security (Birkland, 2016; Allinson, 2007). The judiciary demarks the boundaries of policy making without involving in decision making process. The role of jurisdiction in policy making process is limited to assure acceptable policy implementation in accordance with law (Birkland 2016).

With regards to unofficial actors, the policy making literature generally focuses on interest groups rather than individuals. Individual participation in policy making process is observed in voting preferences at elections (Chesney & Feinstein, 1993; Birkland, 2016). However, in Turkish case, this type of engagement is indirect and limited with the characteristics of electoral system which does not allow all political parties to enter the legislature and represent the interests of electorate. Considering the fact that individuals can be mobilised, they can act for or against some issues and be organised easily when they get no response from the government in return for their demands. Interest groups are significant actors of policy making process, especially in developed countries. The power of interest groups are not equal in view of the fact that some of those represent the privileged interests of powerful groups, while some claim to represent the interests of “public”. Interest groups can be categorised as institutional interest groups whose members are associated with a specific institution, economic interest groups whose members are gathered to promote the interests of an economic

group such as industry, public interests groups whose members defend broader public interests such as environment protection (Birkland, 2016).

The involvement of interest groups in policy making processes in Turkey have occurred in two ways: private associations and semi-formal (corporatist) associations. The first is organised by independent societal groups in line with the pluralistic view, while the latter is set up or encouraged by the state in order to support special occupational or social groups (Çevik, 2004). As for the healthcare policies, medical doctors and professional organisations are the actors at the centre of healthcare politics and policy making process (Walt et al., 2008). The influence of medical doctors on healthcare policy making and politics stems from the fact that they are seen as an authority in medical issues and thus have higher social status in society. Besides, their unique expertise on medical issues give them a significant power to influence health polices and healthcare reforms (Hyde, 1954; Yılmaz, 2017) Nevertheless, the power within medical associations has not been distributed evenly (Hyde, 1954). Medical professional associations and the governments conflict with each other over healthcare politics in accordance with their class interests. On the other hand, they aim to control healthcare market dynamics and their own affairs by exercising public power (Yılmaz, 2017; Moran, 2000). In Turkish context, Turkish Medical Association (TMA) has been a dominant actor in healthcare until the meddling of the WB in healthcare politics. Also, the social security reform, providing the opportunity of provision of healthcare service from private health care providers, has given chance to advancement of those and their business associations, which are associated with and ordered by the state (Yılmaz, 2017). In some cases, members of those business associations may by-pass their associations in favour of themselves, establishing clientele relations with the state (Heper, 1991).

On the other hand, international organisation intervene in policy making practices in various ways in Turkey. Throughout the 1990's, the WB supported the projects on healthcare mostly by providing funding. The expected outcomes were about improving access to healthcare services and maintaining the financial sustainability of healthcare system (WB, 2004). In 2003, the government and the WB signed an agreement reinforcing the partnership between two parties, particularly in healthcare policies. In the following years, a couple of strategy documents were

prepared to facilitate the implementation of major health reforms (WB, 2003; WB, 2008). Loan agreements are a common practice of the WB to support, initiate or influence healthcare reforms in developing countries (Yılmaz, 2017). The WHO provides global guidelines and policy recommendations with respect to healthcare issues (Mamo & Epstein, 2017; Geissler, 2015). WHO recommendations play a fundamental role in directing country decisions on immunisation for 90% of the countries. Other information sources are international and regional reports, epidemiological studies conducted domestically and globally (Bryson et al., 2010). Besides, a great number of global actors and initiatives other than WHO such as the Gavi have engaged in global health issues in recent years, striving for funding (Mackey & Liang, 2013).

5.3. National Immunisation Policies

The reformation of health care system has induced the involvement of new actors to health policy making environment in Turkey. MoH has the leading role in planning and organisation of health care services. Several government bodies such as Ministry of Family, Labour and Social Services, Ministry of Treasury and Finance, Presidency of Strategy and Budget, Social Security Institution, the Council of Higher Education and other relevant institutions and agencies also play a crucial role in decision making process through inter-ministerial commissions. Moreover, professional and medical associations, advocacy groups and other non-governmental organisations appear in policy making process. International organisations such as the WHO operating in the field of health also engage in decision making processes in various ways (Yıldırım & Yıldırım, 2011). Within this context, commitment to WHO policies is declared with Cooperation Agreements, encompassing a broad range of health issues, signed between the WHO and the Turkish Ministry of Health various times (Resmi Gazete, 2007; TBMM, 2013).

As the principal actor adopting health care policies, MoH has embraced some basic but major indicators to identify and diagnose health problems, such as infant mortality rate, average life expectancy, out of pocket expenses, prevalence of infectious diseases and prevalence of vaccine preventable diseases. At policy development stage, principles mentioned in HTP -accessibility, quality and efficiency-

guide to prioritise issues which are defined by means of aforementioned indicators. At this juncture, MoH suggests that the following considerations need to be taken into account when initiating a policy action. Accordingly, interests of all should be prioritised. MoH advises policy makers to be cautious about ideological approaches and the interests of individuals or groups. The “political, economic and cultural realities” of the country need to be considered on every occasion and when adopting international examples. Moreover, the chance of a problem to become a political decision is closely associated with “willingness, interest and capability of the parties and the political strategy used”. Also, government support for the political decision is of high significance (Akdağ, 2009).

According to General Health Act dated 1930, MoH is the sole authority responsible for organising health system, improving health status of society, preventing diseases and providing health services. Under family practice system, emphasis has been given to preventative measures and immunisation practices. As a part of restructuring of MoH, Directorate General of Basic Health Services has been transformed to Turkish Public Health Institution in 2011 and Directorate General of Public Health in 2017, respectively.

Department of Vaccine Preventable Diseases is the main component of Directorate General of Public Health with regards to immunisation policies. Immunisation services are defined as primary health care services aiming to inoculate infants, adolescents and adults before the period when the risk of catching a disease is high. Immunisation services are organised within the provincial health authorities and provided by Family Health Centres and Community Health Centres (Sağlık Bakanlığı, 2008; Sarıkaya, 2018; Avcı, 2017).

EIP has been implemented since 1981 throughout the country (Sarıkaya, 2018). Today, 13 vaccines (Hepatitis B, BCG, aBDT-IPA-Hib, OPA, Td, Pneumococcus, Measles- Rubella- Mumps, Varicella, Hepatitis A) are covered by the EIP with a coverage rate no less than 96% (Cullu & Vural, 2016). Two vaccines (conjugated meningococcal, rotavirus) in addition to the HPV vaccine are not included into the EIP, yet (Arisoy et al., 2014; Sarıkaya, 2018; Topaç, 2017).

The decision of introduction of a new vaccine into the EIP and vaccine implementation schedule is determined by the MoH. In parallel to the advisory

committees trend in other countries, a National Immunisation Advisory Committee (NIAC), consisting of representatives of relevant units within MoH and academicians, has been established to assist the MoH in defining immunisation policies and strategies by generating opinions and suggestions with regards to immunisation services (Sarikaya, 2018; Cullu & Vural, 2016; Bryson et al., 2010a). Decision making process is based on scientific considerations such as epidemiology of disease, safety, efficacy and cost-effectiveness. In case of paucity of scientific data, political motivations may be taken into account. For some vaccines in the EIP including hepatitis B, influenza and pneumococci, public reimbursement is provided when they are prescribed to high risk groups defined by the SSI (Cullu & Vural, 2016).

The criteria employed in making immunisation decisions in Turkey show similarity to those used in other countries. According to a systematic review investigating immunisation policy making processes in 33 countries, burden of disease and economic considerations are taken into account mostly in many countries (Bryson et al., 2010b).

5.4. Policy Process on HPV Vaccination in Turkey

As noted earlier, the HPV vaccines were authorised in Turkey in 2007 by the MoH. Despite its availability in the Turkish market HPV vaccination has not been included in the scope of the EIP. The issue has been raised to the policy agenda and considered several times, but no progress was achieved. The inclusion of the HPV vaccine into the immunization program therefore remained as a failed policy initiative. Given the widespread coverage of this vaccine in national immunisation programmes across the developed countries, its continued exclusion in the Turkish context is interesting from a comparative policy perspective. This section will analyse the policy process to explore the reasons for this failed policy initiative.

To grasp the health policy making process and reveal the reasons behind the non-inclusion of HPV vaccine into the EIP, semi-structured interviews were conducted with identified policy actors, from public, private and non-governmental parties, contributing in health policy making process in Turkey. For this purpose, seven respondents who are affiliated with Society of Gynaecological Oncology (SGO), Society of Paediatric Infectious Diseases and Immunization (SPIDI), Society of

Adolescent Health (SAH), Turkish Medical Association, Ankara Chamber of Medical Association (ACMA), Directorate General of Public Health (DGPH) and HPV vaccine producer pharma company Merck Sharp Dohme (MSD) were interviewed and asked 10 to 12 questions with some differences, adopted to their positions and specialisations in HPV vaccine case. In interviews, respondents described their role and position in policymaking process and interaction with other actors involved in the process and also shared their views on the process. This chapter, therefore, explores the interviewees' explanations of why there was policy inaction in relation to the issue in the Turkish case.

5.4.1. Problem Definition

After the authorisation and marketing of the HPV vaccines in 2007, proponents of the vaccine started to raise their voice for the inclusion of the vaccine into the EIP. However, right from the start there has been disarray between policy actors about the significance of HPV vaccination as a public health priority. Some voluntary professional associations and the pharma firm marketing the vaccine have been unequivocal in their support in favour of the inclusion of the vaccine into the EIP and the significance of the issue as a public health priority. The respondent of the TMA supported the inclusion of the vaccine into the national immunization program but was more cautious about the extent to which the inclusion of the HPV vaccine can be treated as a public health priority. Meanwhile the government adopted an ambiguous stance about the issue right from the start. While the government did not show active policy engagement in favour of the inclusion of the vaccine into the immunization program, it also did not convey any outright opposition against the vaccine. As discussed below, it did not resist the discussion of the issue in NIAC meetings. In fact, after the vaccine was not included into the EIP following its discussion in the NIAC, the government continued to discuss the inclusion of the vaccine with policy actors from the academic circles.

As noted above, the inclusion of vaccine into the national immunisation program was supported mostly by the pharma firm marketing the drug along with voluntary professional associations, such as the Society of Adolescent Health (SAH), Society of Gynaecological Oncology (SGO), Society of Pediatric Infectious Diseases

and Immunization (SPIDI). The policy actors indicated the urgency of problem by referring to the relevant statistics about the disease related to the HPV infection. This served the purpose of introducing the HPV vaccination issue as a public health problem in Turkey.

When interviewed for this research, the respondents of these associations again referred to statistics about the prevalence, incidence and mortality rates of cervical cancer to emphasise significance of HPV vaccination issue as a public health problem. Both SGO and DGPH respondents confirmed the prevalence of cervical cancer as 4.5 per 100.000 and the ranking of cervical cancer in all women cancers at 9th place in Turkey. MSD's prevalence data, 4.7 per 100.000, is slightly higher than this data. MSD respondent pointed out the increasing diagnoses and mortality rate of cervical cancer, as well as increasing prevalence of head and neck cancers. Similarly, the SAH respondent stressed the high mortality rate of HPV related cancers. According to the SGO respondent, HPV related diseases should be attributed importance as much as any public health issue. SPIDI respondent expressed that surveillance data is important for all countries. In HPV case, however, there is no need to look for extensive surveillance data considering the characteristics of the virus. Still, policy makers may consider surveillance data to make a decision about the vaccine.

Although prevention strategies other than HPV vaccination against cervical cancer are widespread in Turkey, the respondents of the professional associations who were in favour of inclusion of the vaccine were not convinced about their sufficiency. The respondents from SGO, MSD, SPIDI, ACMA and TMA, for example, claimed that the protection against cervical cancer cannot be achieved only through screening programmes carried out by the government. Though they thought that Turkey's implementation of the HPV testing was successful, and Turkey has been taken as a good example by other countries, they contended that cervical cancer programme is complex and difficult to implement. The participation rates to the programme were reported to be low. Therefore, the screening programme should be supported with the vaccination. The respondent from the TMA remarked that though technical teams conducting smear test are trained, this staff is not distributed evenly across Turkey, which may constitute a problem with regards to functioning of the screening

programme. The continuity of the personnel is critical to avert malfunction and sampling errors.

When asked about why they supported the inclusion of the vaccine into the EIP, the respondents of voluntary professional associations emphasised the effectiveness of vaccination as a prevention mechanism against cervical cancer. SAH respondent indicated the lowness of utilisation of the vaccine on individual basis unless it is not included into the EIP. Therefore, he stressed the necessity of inclusion of the vaccine into the EIP. According to the respondent from SGO, recent scientific data and publications confirm the cancer prevention effect of the vaccine. SPIDI respondent attracted attention to burden of disease and mortality rates of HPV related diseases, especially cervical cancer. He stated that cervical cancer screening programme has some problems and participation of women is lower than expected. The vaccine proved itself in the sense that it is successful in preventing precancerous and cancerous lesions as well as genital warts in settings where it is administered. Moreover, the vaccine can easily be incorporated into the EIP since it does not overlap with any of the vaccines which are already in the EIP. Besides, the vaccine is recommended by the WHO and implemented in numerous countries. Respondent of the ACMA thinks that the vaccine needs to be administered to men and transgender people as well as women.

Policy actors who are in favour of the inclusion of the HPV vaccine into the EIP emphasised the significance of the policy problem by referring to the scale and extent to which the problem affects the society. In our interviews, both the SGO and MSD respondents expressed that HPV may affect any women. The frequency of sexual activity and polygamy are risk factors for HPV related diseases for both men and women. SGO respondent emphasised that evolving society structure and transformation in relationships escalate the risk of HPV infection. Moreover, HPV infection is also seen in conservative part of society. ACMA respondent highlighted that HPV is not an infection unique to sex workers. It can be observed in lesbian or bisexual women, as well. In cases of rape or forced marriages women may be infected with HPV. Women who have the first sexual debut with their husband may also be affected, as men are not sensitive enough about the protection from sexually transmitted diseases.

5.4.2. Emergence of the HPV vaccine in the Policy Agenda

Table 3 shows the timeline of policymaking process about the HPV vaccine in Turkey. A respondent from ACMA whom we interviewed for this research stated they discussed the HPV vaccine issue upon the demand of LGBT organisations. SPIDI, SAH and TMA respondents stated that they recommended the inclusion of HPV vaccine in conferences, meetings and lectures. The advocacy carried out by the policy actors resulted in the included into the policy agenda of the NIAC in March 2008 for the first time.

Table 3: The Policy Process Timeline of HPV Vaccination in Turkey

January 2007	Gardasil 4 is authorised in Turkey
December 2007	Cervarix is authorised in Turkey
March 2008	The vaccine is considered in the NIAC meeting
May 2008	The MoH declared that the HPV vaccine is not seen as priority for the EIP
September 2010	The Minister announces that the vaccine can be included into the EIP as soon as an affordable price is guaranteed
May 2011	A MoH official declared that the inclusion of the vaccine into the EIP is seen impossible due to the ethical and economical reasons

NIAC meets twice a year and advises to DGPH regarding the agenda notified by the DGPH. The policy making process regarding HPV vaccination have been described as a top-down process by the respondents in our interviews. Accordingly, DGPH, the main bureaucratic agency organizing the process, invites pharma company/companies to negotiate and may ask for budget estimations and cost-effectiveness analysis. International examples and implementation models may be investigated by the DGPH.

When asked about the dynamics of NIAC meetings, the TMA respondent underlined that the prevalence and transmission of the disease are important indicators for the inclusion of a vaccine into the national immunization agenda. However, she also emphasised that in the HPV case there has not been adequate information. If there

is no public health threat, the vaccine may not be taken to the agenda. ACMA stresses the importance of opinions and suggestions of professional medical organisations in policy making process. SGO respondent mentioned the meetings and consultations conducted at the NIAC, consisted of mostly paediatricians. He adds that since HPV and HPV related diseases are not observed during childhood and adolescence, so paediatricians do not encounter the diseases and complications of HPV and this might result in an underestimation of the seriousness of the issue. Gynaecologists and gynaecological oncologists are only invited to NIAC meetings for consultations. They have no say in decision making process.

Following the discussion of its inclusion in the NIAC in March 2008, the Minister of Health declared that NIAC decided that the vaccine is not of top priority. The Minister of Health stated that the cost of the HPV vaccine was not the only basis for this decision (Son Dakika Web, 24.05.2008).

MSD respondent in our interviews responded that after this initial discussion in the NIAC, the inclusion of the HPV vaccine into the EIP fell off the agenda unexpectedly. She stated that new data and costs need to be submitted to the DGPH when a new agenda occurs. MSD respondent was also asked about the correspondence (TEB, 2014) concerning reimbursement application of the vaccine at the SSI, which was suggested by Turkish Association of Pharmacists (TAP) upon a court decision obliging the SSI to reimburse the cost of the vaccine. In the response letter, MSD enounced that they strive for the inclusion of the vaccine into the EIP, raising public health necessities. Consistently, MSD respondent stated that the nature of vaccination and public reimbursement are not related to each other since vaccination is independent from prescribing.

5.4.3. Reoccurrence of the Issue in the Agenda

Even though the government did not show active engagement to include the vaccine into the EIP over the years, it also did not adopt a consistent policy for its exclusion. The inclusion of HPV vaccination into the EIP thus continued to pop up in different policy debates although to no avail. Two years after his statement in 2008 in which he concluded HPV vaccination was not a public health priority and the cost of the vaccine was not the only reason for this evaluation, the Health Minister announced

in 2010 that they were ready for HPV vaccination as soon as an affordable price was ensured (Haber 7 Web, 18.09.2010).

Apart from the declarations of the Minister, the comments of other policy actors involving in the process inform us about the process of agenda setting and policy formulation stages. In 2012, a member of the Society of Cervical Pathologies and Colposcopy stated that they convinced the Minister about the inclusion of the vaccine into the EIP and the policy implementation is budgeted, but again no decision could have been reached in favour of the inclusion of the vaccine into the EIP. Some members of the NIAC were reported to have been against the policy implementation (Medikal Akademi Web, 19.06.2012).

It appears that from the beginning a powerful alliance in favour of the inclusion of the vaccine could not have been initiated amongst the policy actors. As interview participants noted in this research, one of the most important reasons why the vaccine was not included in the EIP was because the issue was not seen as a political priority by the government. While not showing active engagement the government also did not reject the issue outright. Instead, one can observe the employment of postponement and in some instances issue suppression as non-decision making strategies by the government to keep the issue off the agenda.

The DGPH respondent emphasised the significance of prevention strategies other than the HPV vaccination they employed against cervical cancer. The use of alternative prevention mechanisms, in other words were seen reduce the need for HPV vaccination. DGPH respondent gave information regarding HPV DNA testing and smear testing, which are conducted at primary health care centres (including KETEM, Centres for Healthy Life, Community Health Centres, Family Health Centres) within the cervical cancer screening programme. He emphasised that mobile screening vehicles offer cervical cancer screening services in some provinces. He also referred to opportunistic screening is offered in public hospitals and tertiary care institutions. On another occasion, a MoH coordinator in Istanbul province expressed that the recommendation of the vaccine by the MoH would take long time, let alone the inclusion into the EIP. He implied that the main principle is to prevent deaths from cancer rather than preventing cancer cases. Therefore, pap smear test was helpful in identifying the infection in precancerous stages (Internet Haber Web, 16.05.2011).

This was also seen in the reaction of Minister of Health to a parliamentary question in which he refers clinical and cost-effectiveness of pap smear test as a tool of intervention before the development of cervical cancer. On the other hand, he referred to scientific data and recommendation of the WHO regarding cervical cancer and the HPV vaccine to underpin his position (Son Dakika Web, 24.5.2008). In this sense, the existence of a policy alternative and the recommendation of an international organisation have been utilised to confirm the inaction about the vaccine.

The DGPH respondent interviewed for this research indicated that the discussions and consultations with related departments and universities about the inclusion of the HPV vaccine into the EIP were continuing. When read in the light of power theories discussed in chapter two, it is clear that in response to the attempts by different groups to reintroduce the issue the government employed non-decision making strategies. Postponement, which indicate actions to procrastinate certain issues (Marchbank, 2000), and issue suppression here an important issue is taken out of the political agenda, seem to be common tactics used by the government.

The document based analysis demonstrated that against the background of concerns about the cost of the HPV vaccine, the NIAC planned to inoculate and cover the cost of vaccine for at least the vulnerable groups including sex workers, homosexuals and children suffered from sexual abuse in the first place. This position was also supported by some prominent professional associations such as TMA. The TMA respondent interviewed for this research confirmed that they suggested the vaccine be implemented in a small sample and then generalised throughout the country. Thus, the cervical cancer screening programme and the vaccine implementation need to be placed on a scientific background. However, the concerns about the negative perception of the vaccine and the aim to increase vaccine acceptance in society affected recommendations of starting off immunisation in vulnerable groups. Instead, the need for a comprehensive vaccination programme was emphasised (2. Ulusal Aşı Çalıştayı, 2016). In interviews, respondents indicated the significance of immunisation of both sexes. On the other hand, administration in adolescent men was debated by advocates as a condition of EIP in Turkey in order to increase acceptability of the vaccine in society (1. Ulusal Aşı Çalıştayı, 2014). In other

words, vaccination in men is demanded not only for equity reasons but also for easing adaptation of the vaccine by society.

5.4.4. Interviewees' Interpretations of Policy Inaction About the Inclusion of HPV Vaccination into the EIP

In interviews, the reasons for the lack of policy action have been noted as a combination of multiple factors by most respondents. These refer to many of the contested policy issues related to the HPV vaccine that have been reviewed in the fourth chapter. First, political reasons are of high importance. Political actors interviewed for this research seemed reluctant to initiate the policy process since there is no political determination regarding the inclusion of the vaccine into the EIP. Some interviewees emphasised that the existence of different Health Ministers throughout the years the HPV vaccine is on the market might have hampered the policy continuity. In this sense, the government's viewpoint and priorities may not favour the HPV vaccine. Recent public health issues such as measles outbreak or inoculation of Syrian people who are under temporary protection surpass the HPV vaccine case.

Second, the high cost of the vaccine has been a concern expressed at different points to the debate, especially as a justification for not covering the vaccine. In Turkish case, policy actors expect that the inclusion of the vaccine into the EIP decrease the cost per dose substantially (Brotherton et al., 2016). While the cost has been a factor in the in the exclusion of the vaccine from the EIP, it was not the only one. The relatively lower levels of HPV disease burden in the Turkish case is referred by policy makers as a barrier to access to access the HPV vaccine. The criteria to incorporate a vaccine into the EIP are specified by the Minister of Health as the burden of disease, effectiveness, quality and safety of the vaccine, existence of other protection methods for preventing the disease and the ease of supply of the vaccine, as well as the priority of the vaccine in competing public health issues (Son Dakika Web, 24.05.2008). As noted by some of the interviewees competing public health priorities, vaccines advocated by other pressure groups may have blocked the decision in favour of HPV vaccine. The government also referred to its attempts to prevent cervical cancer through pap smear and HPV DNA tests. These examples indicate that the HPV vaccine is not seen as a priority by policy makers. Considering priority setting and

funding decisions are inherently political that policy makers choose one policy over others among various alternative, a policy decision about the HPV vaccine is suppressed and thwarted (Terwindt et al., 2016; Smith et al., 2014).

Third, respondents emphasised that the fact that the vaccine is administered adolescents in order to protect them against a sexually transmitted disease increases concerns regarding promotion of early sexual intercourse among adolescents. Moreover, the vaccine evoked ideas about sex and thus people have prejudices against the vaccine. Parental concerns, specifically the fear of promiscuity and cultural values of society. This issue was also referred to in the literature as the one of the most common obstacles against the vaccination. In Turkey, it is known that even when some families are not against the vaccine they question the early age determined for the vaccination. A study investigating knowledge and opinions of Turkish mothers who have daughters about HPV vaccine have revealed that they have limited knowledge about the vaccine. The high cost of the vaccine and the fear of early sexual activity have also influenced vaccination decisions of mothers, negatively (Ulus et al., 2017). It is emphasised that cultural structure of the Turkish society has been an important part of the concerns related to promiscuity (1. Ulusal Aşı Çalıştayı, 2014). It is also highly possible that promiscuity stigma attached to the HPV vaccine made its inclusion into the EIP harder. This is especially true if the conservative ideology of the government in power is taken into consideration. Fourth, the HPV vaccine issue concerns medical professionals from different disciplines such as gynaecological oncology, paediatrics, infectious diseases, public health. According to some interviewees, this multi-disciplinary characteristic of the vaccine complicates the management of policy making process. Fifth, the fact that mostly women are affected by the infection and related diseases to a great extent overshadows public health aspect of the issue. As a sixth factor, the low levels of the knowledge and awareness about the vaccine in the society has also been shown as a reason for the failure to create public opinion in favour of the vaccine. Therefore, demand for the vaccine cannot be generated at the grassroots level. Seventh, the Turkish Constitutional Court decision adjudicating that mandatory vaccination is an intervention to physical integrity of individuals may affect the attitude towards the HPV vaccine adversely in the sense that the vaccine is seen as a private responsibility. Eighth, the belief that the real effects of

newer vaccines such as HPV vaccine arise later in life has been a barrier for coverage by the EIP. After all, none of the respondents stated any safety or effectiveness concern regarding the vaccine as a barrier to access through the EIP, contrary to experiences of other countries.

The policy process regarding the inclusion of HPV vaccine into the EIP in Turkey has not completed its cycle. The inclusion of the vaccine into the EIP has been put on the EIP agenda. Even though the issue has been elevated to the policy agenda several times and has been discussed at least twice in the NIAC, no development was recorded about the vaccine's inclusion into the EIP. Policy formulation activities have been undertaken mostly by unofficial policy actors. They notified the government and the NIAC about the potential policy implementation options through consultations. The recommendations of international organisations and clinical guidelines had an important role to cope with HPV infection and cervical cancer screening policies. As stated in interviews, the proponents of the vaccine expect the involvement of the UN and the WHO in policy formulation process by mandating the compulsory implementation of the HPV vaccine.

In the absence of active policy engagement by the government in favour of the inclusion of HPV vaccine into the immunization program, social conservative values that associate HPV vaccine with promiscuity have been influential in the mobilization of bias against the issue. Mobilization of bias is also an important strategy used in non-decision making by the government. In the absence of active policy engagement existing bias against policy change is sustained (Terwindt et al., 2016; Smith et al., 2014). Predominant societal values that associate the HPV virus with promiscuity and sexual behaviour are then reinforced and they preclude policy change. Thus, policy inaction by the government triggered mobilization of bias which then supported non-decision making.

According to the document based analysis, policy formulation process about the vaccine in Turkey needed the assistance of mass media in creating a positive perception about the vaccine. According to proponents, emphasis has to be given to the internet and mass media to attract attention to the positive sides of the vaccination since technology is utilised by adolescents actively (Brotherton et al., 2016). The document-based analysis showed that the majority of articles in Turkish newspapers

favours and promotes the vaccine, while few archconservative media introduced HPV as a deviant LGBT disease (CNN Turk Web, 16.04.2019; Habertürk Web, 21.01.2018; Yenisöz Web, 5.12.2017). The deliberate result of not associating HPV infection with promiscuity or low level of personal hygiene does not attribute to people any kind of misdeed and stimulate them to voice political will favouring the need for HPV vaccine (Sağlık Bakanlığı, 2016a). This approach has also gained support from experts to increase the applicability and acceptability of the vaccine in Turkey, where promiscuity and taboo of sex politicize the debates about the HPV vaccine and suppress the attempts to cover the cost of vaccine by health authority. Recommendations focus on that the duty of providing confidence about the vaccine in society needs to be given to teachers, local authorities and religious leaders (Bruni et al., 2018; Brotherton et al., 2016; 2. Ulusal Aşı Çalıştayı, 2016).

Although the government presented several reasons against the non-inclusion HPV vaccine into the EIP, safety or efficacy has never been proposed or implied as a reason. Also, none of the professional organizations, even the most critically informed ones referred to safety and efficacy dimensions of the HPV vaccine. As noted in the fourth chapter, safety and efficacy concerns created significant controversy in Europe, North America, and Japan. Compared with policy development elsewhere, this has also been a unique characteristics of the process in Turkey.

This chapter analysed the policy process about the inclusion of HPV vaccine into the immunisation programme and explored the reasons for policy inaction in this sphere. It appears that policy the disarray amongst the policy actors about the significance of HPV vaccination as a public health issue was generated a weak start to the inclusion of policy issue in the agenda. The government adopted an ambiguous policy position, where it did neither showed active engagement in favour of inclusion nor, rejected ongoing discussions about the inclusion of the vaccination. Simultaneously, it also employed non decision making strategies of postponement and suppression when policy actors tried to probe further advancement on the issue. The interviews conducted in this research with relevant policy actors in the process showed that these policy actors interpreted the lack of policy actions to be resulting from a combination of factors. The high cost of the vaccine, alongside with issues of promiscuity are shown as the factors where vaccination was not defined as a policy

priority by the government. Several factors, expressed by the interviewees and underpinned by document based analysis, seem to explain and contribute to policy inertia for this specific issue. In this respect, the political, cultural and economic considerations appear to have contributed in policy inaction.

CHAPTER 6

CONCLUSION

In this thesis, I aimed to reveal the reasons behind the non-decision making about the inclusion of HPV vaccine into the EIP in Turkey. Some non-decision making tactics employed by the government such as postponement and issue suppression as well as the related reasons of policy inaction as interpreted by policy actors have been explored through elite interviews and document based analysis. I conducted semi-structured interviews with different public and private policy actors involved in HPV vaccination case in Turkey to understand the dynamics underlying policy making processes.

Throughout my thesis, I tried to demonstrate that the non-inclusion of the HPV vaccine into the EIP have been affected by the policy positions adopted by different actors throughout the stages of the policy process. Interviews with policy actors and document-based analysis indicate that the inclusion of HPV vaccination in the EIP has been considered several times in Turkey. Nevertheless, there has been no active policy engagement on the issue by successive governments over the years.

Chapter five showed that HPV vaccine could not have been established as a priority issue in the policy agenda. In the problem definition stage there has been a disarray amongst the actors about the significance of the HPV vaccination as a public health issue. Interviews also revealed that most of the policy actors believe that they are not engaged and influential enough to affect policy making process regarding HPV vaccine. The government on the other hand adopted an ambiguous position. It did not show active engagement about the inclusion of the vaccine into the agenda. At the same time it continued negotiations with the policy actors for the inclusion of the vaccine into the agenda. When probed into further advancement on the issue, the government used postponement strategies, or issue suppression by referring to low prevalence of HPV virus, and alternative prevention mechanisms. The inclusion of the

HPV vaccine emerged in the agenda several times, and continued to pop up in other policy debates but policy outcomes were recorded.

According to respondents and document-based analysis, political reasons play a crucial role in the current non-decision making process. The concerns regarding HPV vaccine has demonstrated similar characteristics to those discussed in developed countries which already have included the vaccine in their national immunisation programmes, with the exception of safety concerns.

In brief, three reasons figure important as to why the HPV vaccine policy issue has resulted in non-decision in the Turkish case. The first and the foremost explanation is the characteristics and viewpoint of government, not favouring a policy initiation with respect to the HPV vaccine. Despite statements of policy makers, successive delays in decision making provides evidence for eagerness of maintaining status quo. The government also adopted issue postponement and suppression as non-decision making strategies on the issue. The second reason includes cultural characteristics of society and negative perceptions about the vaccine, specifically fear of promiscuity. Third, the cost of the vaccine and affordability problems have dominated the policy agenda and thus the HPV vaccine issue have been disregarded.

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APPENDICES

Appendix A: Human Subjects Ethics Committee Approval

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER



DUMLUPINAR BULVARI 06800
ÇANKAYA ANKARA/TURKEY
T: +90 312 210 22 91
F: +90 312 210 79 59
Sayı: 28620816 / 293
www.ueam.metu.edu.tr

28 Haziran 2019

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (IAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Canan Aslan AKMAN

Danışmanlığını yaptığınız Dilek Sernur EMİNOĞULLARI'nın "Küresel ve Yerel Aktörlerin Türkiye'deki Aşı Politikasının Oluşturulmasına Etkileri: HPV Aşısı Örneği" başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve 274-ODTÜ-2019 protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.


Prof. Dr. Tülin GENÇÖZ
Başkan

Prof. Dr. Tolga CAN

Üye



Doç.Dr. Pınar KAYGAN

Üye



Dr. Öğr. Üyesi Ali Emre TURGUT

Üye



Dr. Öğr. Üyesi Şerife SEVİNÇ

Üye



Dr. Öğr. Üyesi Müge GÜNDÜZ

Üye



Dr. Öğr. Üyesi Süreyya Özcan KABASAKAL

Üye



Appendix B: List of Organisations and Institutions Contacted to Interview

1. Ankara Chamber of Medical Association (ACMA)
2. Directorate General of Public Health (DGPH)
3. Glaxo Smith Kleine Turkey (GSK)
4. Merck Sharp Dohme Turkey (MSD)
5. Society for Adolescent Health (SAH)
6. Society for Infectious Diseases (SID)
7. Society for National Pediatrics (NPS)
8. Society for Pediatric Infectious Diseases and Immunization (SPIDI)
9. Society for Social Pediatrics (SSP)
10. Society for Gynaecological Oncology (SGO)
11. Turkish Medical Association (TMA)
12. Turkish Medical Devices and Medicines Agency (TMDMA)
13. Turkish Pharmacists Association (TPA)
14. Turkish-German Gynecological Education and Research Foundation (TGGERF)

Appendix C: Mülakat Soruları

1. HPV enfeksiyonundan kaynaklanan hastalıkların Türkiye’de görülme sıklığı nedir?
2. HPV enfeksiyonundan kaynaklanan kanserlerin bir halk sağlığı problemi olduğunu düşünüyor musunuz?
3. Rahim ağzı kanseri Türkiye’de sık görülen kanserler arasında mı?
4. Rahim ağzı kanseri Türkiye’de en çok hangi grupları etkiliyor? Görülme sıklığı ve etkilediği gruplar yurt dışı örneklerden farklılık gösteriyor mu?
5. Biriminizin rahim ağzı kanserini önlemeye yönelik ne gibi çalışmaları var?
6. Rahim ağzı kanseri ile mücadelede geliştirdiğiniz taramalar hangi birimler aracılığıyla yürütülüyor?
7. Rahim ağzı kanserinin taramasında kullanılan Pap smear testi ve HPV DNA testi hakkındaki görüşünüz nedir? Bu testler ile gerekli koruma sağlanıyor mu?
8. Rahim ağzı kanserine karşı koruyucu sağlık hizmetleri ile ilgili mevcut uygulamamız uluslararası kuruluşların tavsiyeleri ve klinik kılavuzlar ile uyumlu mu?
9. Kanser aşılıları hakkındaki görüşünüz nedir? Bunları gerekli buluyor musunuz? Eğer gerekli olmadığını düşünüyorsanız bunlar yerine hangi koruyucu sağlık uygulamalarından faydalanılabilir?
10. HPV aşısı hakkındaki görüşünüz nedir? Bu aşının etkili olduğunu düşünüyor musunuz?
11. Bireysel ve/veya kurumsal bazda HPV aşısının finansmanının kamu tarafından karşılanması/ulusal aşı programına alınması için girişimleriniz oldu mu? Oldu ise hangi düzeyde temaslarda bulundunuz? Sonuçları nelerdir?
12. Herhangi bir aşının bağışıklama programına alınması süreci nasıl işliyor? Hangi birim ve kurumların önerisi üzerine hangi birim ve kurumların değerlendirmesi sonucu bu kararlar veriliyor?
13. Sizce HPV aşısı Ulusal Aşı Programına alınmalı mı? Bu konu daha önce gündeme geldi mi? Biriminiz bu çalışmalarda yer aldı mı?
14. HPV aşısı bugüne kadar bağışıklama programına alınmadı. Bu kararda etkili olan faktörler nelerdir?
15. Son bilimsel yayın ve gelişmeler neticesinde gelinen noktada HPV aşısı konusundaki görüşünüzde değişiklikler oldu mu?
16. Aşının kamu tarafından finansmanının sağlanması durumunda bağışıklanacak tahmini kişi sayısı nedir?

Appendix D: Interview Questions

1. What is the prevalence of diseases related to the HPV infection in Turkey?
2. Do you think that diseases related to the HPV infection are a public health problem?
3. Is cervical cancer one of the most prevalent cancers in Turkey?
4. Which groups are mostly affected by cervical cancer in Turkey? Does prevalence rates and affected groups differ from the cases abroad?
5. What activities does your unit perform to prevent cervical cancer?
6. Through which units do you conduct cervical cancer screening activities?
7. What is your opinion about Pap-smear test and HPV DNA test which are used in cervical cancer screening? Do these tests provide necessary protection?
8. Does the preventive health services against the cervical cancer in our country compatible with the recommendations of international organisations and clinical guidelines?
9. What is your opinion about vaccines against cancer? Do you find them necessary? If not, what kind of preventive health services can be utilised instead?
10. What is your opinion about the HPV vaccine? Do you think that this vaccine is effective?
11. Did you have any individual or corporate attempts to ensure financing of HPV vaccine by the public or the EIP? If yes, at what levels did you make official contacts? What were the results?
12. How the process of coverage of any vaccine by the EIP works? Based on which units' or institutions' recommendations and evaluations these decisions are taken?
13. Do you think that HPV vaccine should be covered by the EIP? Was this item added to the agenda before?
14. The HPV vaccine is not covered by the EIP to date. What are the factors affecting this decision?
15. Considering recent publications and developments, have you changed your opinions about the HPV vaccine?
16. What is the estimated population to be vaccinated in case of the coverage of the vaccine by the public?

Appendix E: Türkçe Özet / Turkish Summary

Giriş

Aşılar hastalıkları önleyen, sakatlıkları engelleyen ve böylece hayat kurtarıcı olan sağlık müdahaleleridir Eski aşılar toplum düzeyinde bağışıklık sağlayarak klinik ve ekonomik etkinliklerini kanıtlamışken yeni aşıların güvenilirlik ve etkililiklerini kanıtlanması beklenmektedir (Schuchat, 2011). Bugüne kadar, en az 31 hastalık aşılar sayesinde önemli ölçüde önlenmiştir (Stern, 2016). Bununla birlikte, enfeksiyonlardan kaynaklanan aşı ile önlenemez hastalıklar nedeniyle, her yıl 3 milyondan fazla insan hayatını kaybetmektedir (CHOP, 2018).

1980'lerin sonlarında, rahim ağzı kanseri (servikal kanser) ile cinsel yolla bulaşan en yaygın enfeksiyonlardan biri olarak bilinen insan papilloma virüsü (HPV) arasındaki ilişkinin bulunması, bu virüsle ilgili hastalıkların tanı ve tedavi yöntemlerinde yeni gelişmelere yol açmış ve HPV aşısı, HPV ile ilişkili hastalıkları, özellikle de rahim ağzı kanserini önlemek için bir tedavi stratejisi olarak ortaya çıkmıştır (Lowy ve ark., 2008).

HPV aşıları Türkiye'de 2007 yılında Sağlık Bakanlığı tarafından da ruhsatlandırılmıştır. (Örenli, 2015). HPV aşılarının Türkiye pazarında 10 yıldan fazla erişilebilir olduğu göz önüne alındığında, HPV ile ilişkili hastalıkların prevalansı ve ölüm oranları bir halk sağlığı problemi oluşturmasına rağmen, ulusal bağışıklama programına dahil edilmemiştir (Bruni ve ark., 2018; Sağlık Bakanlığı 2016a; 3. Ulusal Aşı Çalıştayı, 2018). Bu nedenle, halk sağlığını ilgilendiren önemli bir konu olan HPV aşılarının bağışıklama programına neden dahil edilmediğini anlamak için, Türkiye'de sağlık politikası süreci ve gündeminin analiz edilmesi gerekmektedir.

Politika oluşturmanın ilk ve en önemli koşulu, toplumu ilgilendiren ve devlet müdahalesine ihtiyaç duyan politika probleminin ne olduğunun tanımlanmasıdır (Fischer ve ark., 2007).

Bu tezin amacı Türkiye'de HPV aşısının bağışıklama programına dahil edilmemesinin arkasındaki nedenleri araştırarak ortaya çıkarmak, ilgili aktörleri ve süreçleri tanımlamak, kamu politikası konusunda bu alandaki önemli aktörlerin sürece

etkilerini ortaya koymaktır. Tezin sonunda cevaplanması amaçlanan araştırma soruları şunlardır: HPV aşısı hükümetin gündemine nasıl girmiştir? Toplantılarda hangi politika alternatifleri tartışılmıştır? Önde gelen politika aktörleri kimlerdir? Politika aktörlerinin HPV aşısı tartışmasına etkileri nelerdir? HPV aşısı konusundaki eylemsizliğin altında yatan nedenler nelerdir? Hangi tür karar almama yöntemleri uygulanmıştır?

Bildiğimiz kadarıyla, bu çalışma Türkiye'de HPV aşılara ilişkin politika oluşturma ve gündem belirleme süreçlerini analiz eden ilk çalışmadır. Daha önceki çalışmalarda, araştırmacılar HPV aşı bilgisi düzeyi, toplumda ve tıbbi branşlarda HPV ile ilgili hastalıklar hakkındaki farkındalık ve HPV aşısına yönelik tutumlar üzerinde odaklanmışlardır (Örenli, 2015; Hatem, 2019; Çelik, 2018; Yurtsev, 2011).

Kamu Politikası Oluşturma Süreci ve Politika Yaklaşımları

Politika kavramı pek çok şekilde tanımlanmıştır. Lasswell (1971) politikayı değerler, araçlar, menfaatler ve sonuçlardan oluşan 'önemli' kararlar olarak tanımlamaktadır. Schulman (1988) ise politikayı "bir kamu probleminin analizine yönelik bir dizi kavram, aksiyom ve tümdengelimli çıkarımlar" olarak tanımlamaktadır. Benzer şekilde, kamu politikası hükümetlerin belirli amaçlara ulaşmak için tercihleri olarak tanımlanabilir. Kamu politikası sosyal bir problemin varlığı ve hükümetin bu problemi çözme istekliliğinden kaynaklanmakta ve bu nedenle bu sorunu çözmek için bir uygulama yöntemi ortaya koymaktadır (Anderson, 2003; Osman, 2002).

Politika oluşturma süreci politikaların planlandığı, geliştirildiği, formüle edildiği, müzakere edildiği, uygulandığı ve değerlendirildiği aşamaları ifade etmektedir (Buse ve ark., 2005). Politika süreci ilerleyen bir süreç gibi görünmesine rağmen farklı şekillerde ortaya çıkabilmektedir (Hill, 1997b; Kraft & Furlong, 2018). Politika oluşturma süreci her aşamada yer alan aktörlerin rolleri ile birlikte detaylı olarak sunulmuştur. Modeldeki kavramlar ve tanımlamalar her politik sistem ve politika oluşturma sürecine uyması için tasarlanmıştır (Kraft & Furlong, 2018; Cairney, 2011).

Politika oluşturma sürecinin ilk aşaması problemin tanımlanması ve devletin konuya dahil olması gerekliliğidir (Fischer ve ark., 2007). Basit görünmesine rağmen problemin objektif olarak tanımlanması kolay bir iş değildir. Problemin tanımlanması

ayrıca önerilecek çözüm önerilerini de yönlendirmektedir. Bir politika probleminin karşı olanlar ile bunu destekleyenler farklı perspektiflerden konuya bakacaklardır (Kraft & Furlong, 2018).

Problemin tanımlanması bir politika probleminin politika yapıcılar tarafından tanınması için yeterli değildir. Bu nedenle problemin ön plana çıkarılması ve gündeme girmesi gereklidir (Kraft & Furlong, 2018; Kingdon, 1995; Birkland, 2005). Gündemdeki tüm konular uygulamayı sağlamak için birbirleri ile yarış halindedirler. Bu nedenle, gündem belirleme grupları arasındaki rekabeti artırmaktadır (Fischer ve ark., 2007; Buse ve ark., 2005). Kingdon (1995) kamusal problemlerin aciliyetine dikkat çekmede istatistiklerin önemine vurgu yapmaktadır. Çıkar grupları ve hükümet yetkilileri kamunun dikkatini çekmek ve politika seçeneklerini geliştirmek için bu göstergelere dikkat çekmektedir (Fischer ve ark., 2007; Buse ve ark., 2005; Kraft & Furlong, 2018). Öncelik belirleme farklı politika seçenekleri arasından bir seçim yapmayı amaçlamakta ve özellikle kaynakların kısıtlı olduğu gelişmekte olan ülkelerde politika seçeneklerinin uzlaştırılmasını gerektirmektedir (Terwindt ve ark., 2016; Wikler, 2003).

Bir problem tanımlandığı ve gündeme alındığı zaman problemin olası çözümleri geliştirilmeli ve formüle edilmelidir. Bu aşamada politika aktörleri argümanlarını destekleyecek ve amaçlarına ulaşmak için argümanlara ihtiyaç duymaktadır (Kraft & Furlong, 2018).

Politika uygulaması politika fikirlerinin pratiğe dönüştürülmesidir. Bu diğer süreçlerden ayrı bir süreçtir. Politika yapma sürecinde uygulama aşamasının olmaması politika uygulamasını sınırlayan bir problem işaret etmektedir (Buse ve ark., 2005).

Politika değerlendirmesi 'bir kamu politikasının etkililiğinin niyetler ve sonuçlar açısından değerlendirilmesi' olarak tanımlanmaktadır. Politika süreci döngüsünün son aşaması olan politika değerlendirme aşaması tasarlanan politika amaçlarını başarıyla başarmadığını değerlendirmek için kullanılır. Bu aşamanın sonunda mevcut politikalar devam ettirilebilir, değiştirilebilir, sonlandırılabilir veya yeni politikalar ile değiştirilebilir (Buse ve ark., 2005).

Kamu politikası kapsamında gücün kullanımına ilişkin teorilerden çoğulculuk, bireylerin devlete aracı gruplar ile bağlı olduğunu iddia etmektedir (Hill, 1997a). Çoğulculuk gerek elite gerekse elit olmayanlardan oluşan çıkar grupları üzerine

odaklanmaktadır (Buse ve ark., 2005). Bu çıkar grupları temel olarak meslek gruplarıdır ve çoğulculuğun temelini sosyal kimlikte çoğulculuktan uzlaşmada çoğulculuğa kaydırmışlardır (Schlosberg, 2003).

Ünlü çoğulcu Robert Dahl, gücün batı demokrasilerinde gücün topluma ve gruplara eşit dağıldığını iddia etmektedir. Dahl'a göre 'A'nın B'den daha fazla gücü vardır' ifadesi A ile B'nin tercihleri ve çıkarları çatışmatıkça anlamsızdır. Bunun yerine, 'A'nın B üzerinde B'nin yapmayacağı şeyi yaptırma gücü vardır' ifadesini tercih etmektedir (Cairney, 2011).

Çoğulculuğa göre her grup veya bireyin farklı gücü vardır ve karar verme sürecine etkileri her grup için aynı değildir. Hiçbir grup tamamen güçsüz değildir. Yükselen seslerin fazlalığı ve çeşitlilik çoğulcu bir ortamda başarının belirleyicileridir (Hill, 2005; Buse ve ark., 2005). Böylelikle çoğulculuk farklı geçmişleri ve deneyimleri olan grupların varlığının teşvik edilmesine dayanmaktadır (Schlosberg, 2003).

Çoğulculuk bazı itirazlarla karşılaşmıştır. İlk olarak, bir toplumda birbirine benzemeyen farklı grupların aynı sınıflandırma ile biraraya getirilmesi demokrasi konusunda yanılıya düşülmesine neden olabilmektedir. İkinci itiraz, çoğulculuğun organize devlet gücüne önem vermemesi, bunun yerine demokratik siyasi sisteme odaklandığını iddia etmektedir. (Hill, 2005; Hill, 1997a). Eleştirel çoğulculara göre, güç farklı biçimlerde ortaya çıkabilir ve illa ki bir baskı ve üstünlük içermesi gerekmemektedir (Solar & Irwin, 2010).

Politika aktörleri arasındaki güç asimetrisi, bazı konuların gündemde kalması ile sonuçlanırken bazılarının gündemden çıkarılmasına neden olmaktadır (Sandberg, 2016). 'Önyargının mobilizasyonu' olarak adlandırılan durumda toplumda genel olarak kabul edilen 'değerler, inançlar, ritüeller ve prosedürler' karar verme sürecinde elitler tarafından manipüle edilmektedir (Cairney, 2011). Önyargının mobilizasyonu bazı konuların karar alma sürecine dahil olmasına engel teşkil etmekte ve böylece politika yapmayı sınırlandırmaktadır (Hill, 2005; Bonal, 2012).

Peter Bachrach ve Morton Baratz, Dahl'ın teorisinin yarım ve kısmi olduğunu düşünmektedir. Onlara göre güç, politika sürecinde alınan kararlardan daha fazlasıdır. Karar almama da güç sahiplerinin bazı konuların ilerlemesini engellemek için yaptıkları eylemdir ve karar almanın olumsuz anlamından farklılaşmaktadır (Hill,

2005). Marchbank'a göre (2000) karar vermeme açık bir tartışma veya çatışma olmaksızın statükonun korunmasının bir yoludur. Bachrach ve Baratz gündemde olan konular kadar gündemde olmayan konulara da önem atfetmektedir (Bachrach & Baratz, 1962). Karar vermeme konsensüs olması veya şikayet olmaması durumlarında söz konusu değildir. Çoğulcu yaklaşım gözlemlenebilir eylemlere odaklandığından, karar vermemeyi gözlemlemenin imkansızlığı eleştirel çoğulcu yaklaşımın bir eksiği olarak görülmektedir. Bun karşılık, Bachrach ve Baratz karar vermemenin bazı politikaların diğerlerine tercih edilmesi durumlarında görülebildiğini belirtmektedir (Cairney, 2011).

İnsan Papilloma Virüsü

HPV, dünya çapında hem kadınlar hem de erkekleri etkileyen ve cinsel yolla bulaşan en yaygın enfeksiyondur. HPV türlerinden 13'ü (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59 ve 66) servikal, anogenital veya orofaringeal kanserlere neden olabilen yüksek riskli tipler olarak kabul edilmektedir (Crosbie ve ark., al. 2013, WHO 2011).

Erkeklerde HPV prevalansı kadınlara göre çok daha yüksektir, ancak enfeksiyonun sürekliliği düşüktür. Birçok cinsel partnerin bulunma olasılığı erkeklerde onkojenik HPV tipleri edinme riskini artırmaktadır (Bruni ve ark., 2008).

HPV'nin neden olduğu en önemli hastalık rahim ağzı kanseridir. Rahim ağzı kanseri, kadınları etkileyen kanser türleri arasında dördüncü sırada yer almaktadır (Howard ve ark., 2017; Globocan 2018; Bray ve ark., 2018). Rahim ağzı kanserinin en sık sebebi olan HPV ayrıca genital siğiller gibi cinsel yolla bulaşan hastalıklara da yol açmaktadır (Bloem & Ogbuanu, 2017).

HPV aşılması rahim ağzı kanserine ve HPV ile ilgili diğer hastalıklara karşı önleme mekanizması olarak kabul edilmektedir (Lowy ve ark., 2008). HPV'nin 100'den fazla türü olduğu için, korunmanın tam olarak sağlanabilmesi için servikal tarama mekanizmalarının kullanılması gerekir (WHO, 2014a). Günümüzde ise dünya pazarında 3 tür HPV aşısı (GlaxoSmithKline'in Cervarix ve Merck'in Gardasil 4 ve Gardasil 9) bulunmaktadır.

HPV'nin başlıca sebeplerinden biri olduğu rahim ağzı kanserinin Türkiye'de ki insidansı 5,7 / 100.000, ölüm oranı ise 2 / 100.000'dir (Bruni ve ark., 2008; Brotherton ve ark., 2016). Türkiye'de rahim ağzı kanseri vakaları tüm kadın kanser türleri arasında dokuzuncu, 15-44 yaş arası kadınlarda ise dördüncü sıradadır. Rahim ağzı kanseri

Türkiye'de nispeten düşük bir prevalansa sahip olmasına rağmen, HPV'ye bağlı kadın kanserler, HPV'ye bağlı erkek kanserlerine göre 5 kat daha yüksektir.

Rahim ağzı kanseri taraması, Erken Teşhis Tarama ve Kanser Eğitimi Merkezi (KETEM) aracılığıyla gerçekleştirilmektedir (Sağlık Bakanlığı, 2016b). Türkiye'de Smear Testi 1992'den beri WHO'nun önerileri doğrultusunda yapılmaktadır. Nüfusa dayalı servikal tarama ise 2004 yılında başlamıştır. (Sağlık Bakanlığı, 2016b; Gültekin ve ark., 2018).

Uluslararası kuruluşlar, ülkelerin bağışıklama politikalarını yönlendirmede ve /veya dünya çapında aşı temin etmede önemli bir rol oynamaktadır (Piso & Wild, 2009). HPV aşısı, WHO (Dünya Sağlık Örgütü) tarafından Nisan 2009'da kız çocukları için önerilmiştir. WHO ayrıca, HPV ile ilişkili hastalıkların halk sağlığı önceliği olarak kabul edildiği yerlerde aşının ulusal aşı programına dahil edilmesini önermiştir. WHO, rahim ağzı kanseri önleme ve kontrol şemasını üç seviye olacak şekilde oluşturmuştur; (1) ilk seviye 9-13 yaşları arasındaki kızları (ve erkekleri) kapsar; (2) ikinci seviye, özellikle düşük gelirli ülkelerde, 30 yaş ve üstü kadınlarda tarama ve tedaviyi kapsar; (3) üçüncü seviye, kanserli tüm kadınlara tıbbi tedaviyi kapsamaktadır (WHO, 2014a; Nguyen ve ark., 2011; Markowitz, 2012).

HPV Aşısının Farklı Ülkelerdeki Uygulaması

On yıldan uzun süredir ruhsatlanmış olmasına rağmen HPV aşısına küresel düzeyde erişim farklılıklar göstermektedir. Aşığı 70 kadar ülkenin ulusal bağışıklama programına dahil ettiği tahmin edilmektedir (Brotherton ve ark., 2016).

Avustralya HPV aşısı kullanımının en yüksek düzeyde olduğu ülkelerden biridir (Garland ve ark., 2011). Ebeveynlerin gelişigüzel cinsel ilişki endişesi nadiren gündeme gelmiştir. Ancak, bazı ebeveynler cinsel konuları konuşmaktan çekinme ve bilgi eksikliği nedenleri ile aşının neden yapıldığını anlatmakta güçlük çektiklerini bildirmiştir (Garland ve ark., 2011; Marshall ve ark., 2007). Birleşik Krallıkta HPV aşısı Eylül 2008'den bu yana uygulanmaktadır. Ebeveyn endişeleri ve kültürel engellere rağmen aşının uygulama kapsamı %83,8'e ulaşmıştır (Public Health England, 2018; BBC News, 2019). Kanada'da HPV aşının uygulaması bölgeler ve eyaletlerin sorumluluğunda olduğundan aşı uygulamasında eyaletlerin sağlık harcamaları ile bağlantılı olarak farklılıklar söz konusudur (Erickson ve ark., 2005). British Columbia eyaletinde aşı ile ilgili başlıca endişeler güvenilirlik, bilgi eksikliği ve

tereddüttür. Ayrıca Ontario Katolik Kilisesi de aşı güvenirlğine dikkat çekerek bazı eyaletlerde aşının daha az kullanılmasına neden olmuştur (Markowitz, 2012; CCRL, 2007). Birleşik devletlerde aşının uygulaması ve aşı takvimi eyaletlerin sorumluluğundadır (Lowy ve ark., 2008; Daley ve ark., 2017). Aşı ile ilgili tartışmalar güvenirlilik, bilgi eksikliği, önerilmeme ve uygulama yaşının çok erken olmasına ilişkindir. Çok önemli olmamakla birlikte riskli cinsel davranışlar ve erken cinsellik de belirtilen endişeler arasındadır (Markowitz, 2012; Dorell ve ark., 2011; Gottlieb ve ark., 2009). Dini itirazlar ve felsefi inançlar da bazı eyaletlerde aşının programa alınmamasına neden olmuştur (Salmon ve ark., 2006). Japonya’da HPV aşısı uygulaması 2010 yılında cepten ödemeler ile başlamıştır. 2013 yılının Nisan ayında aşılama programı yürürlüğe girmiş ancak yan etkiler nedeniyle program askıya alınmıştır (Taniguchi ve ark., 2019; Ikeda ve ark., 2019; Wilson ve ark., 2014). Fransa’da HPV aşısı birinci basamak sağlık kurumlarınca temin edilmesine rağmen aşı bedelinin tamamı Ulusal Sağlık Sigortası tarafından karşılanmamaktadır (Markowitz, 2012). Medyada ve kamuda ortaya çıkan güvenirlilik endişeleri, aşı maliyeti, aşının etkililiğine ilişkin endişeler ve kamu sağlığı tanıtım eksikliği aşının az sayıda kullanılmasının nedenleri olarak gösterilmektedir (Markowitz, 2012; Fagot ve ark., 2011). Sahra altı Afrika her yıl 70.722 vaka ile dünya çapında en yüksek rahim ağzı kanseri oranına sahiptir (Louie ve ark., 2009). HPV aşıları sınırlı kaynaklara sahip olan gelişmekte olan ülkelerde ulusal bağışıklama programlarınca kapsamamaktadır (Graham & Mishra, 2011). Aşı hakkında bilgi eksikliği, enjeksiyon korkusu ve yan etkiler çocuklar ve aileler tarafından en sıkça belirtilmektedir (Black & Richmond, 2018). Sosyokültürel engeller ebeveynlerin ve politika yapıcılarının aşıya karşı duruşlarını etkilemektedir (Crann ve ark., 2016).

HPV aşısı Türkiye’de aşılardan sadece hastalıklara karşı koruma sağlamadığına ilişkin olarak öne çıkan bir örnek olmuştur. HPV aşısı tartışmasının pek çok boyutu bulunmaktadır.

Politika aktörleri ile yapılan mülakatlarda hiç dile getirilmemesine rağmen HPV aşısı ile ilgili literatür aşı güvenirlğine ilişkin pek çok tartışma içermektedir. Birçok ülkede HPV aşısının güvenirlğine ilişkin olarak ebeveyn endişeleri gündeme gelmiştir (Zimet ve ark., 2013).

Aşının piyasaya girdiği ilk yıllarda aşını etkililiğine ilişkin endişeler Almanya gibi pek çok ülkede gündeme gelmiştir (Markowitz, 2012). Yıllar içinde HPV aşısının genital siğil oluşumunu engellediği ve kanseri engellediğine ilişkin veriler yayınlamıştır (Drolet ve ark., 2019).

Aşının geliştirilmesi ve pazarlanması sürecinde kadınların hedef alınması aşının feminize olmasına ve cinsiyet önyargılarına neden olmuştur. Bu durumda aşının servikal kanser haricinde yol açtığı diğer hastalıkların daha az önemsenmesini beraberinde getirmiştir. Servikal taramanın erkekler için mümkün olmaması nedeniyle virüs ve hastalıklar ile ilgili bütün yük kadınların üzerinde kalmaktadır. Bu da kadınlara hem enfeksiyondan korunma hem de tedavi aşamasında büyük bir yük yüklemektedir (Daley ve ark., 2017). HPV aşısının cinsel yolla bulaşan bir enfeksiyon yerine kanser aşısı olarak pazara sunulması aşı firmalarının stratejik bir kararıdır (Sağlık Bakanlığı, 2016a; Mamo & Epstein, 2017). HPV enfeksiyonunun kişisek hijyen eksikliği veya gelişigüzel cinsel ilişki ile ilişkilendirilmemesinin aşıya yönelik talepleri daha güçlü biçimde dillendirilmesine katkıda bulunacağı düşünülmektedir (Sağlık Bakanlığı, 2016a). HPV aşısının erkeklerde etkili olduğunun gösterilmesinin ardından pek çok ülkede aşı erkeklere de uygulanmaya başlanmıştır (Altobelli ve ark., 2019). Aşının erkeklere uygulanmasının aşının toplum çapında kabul edilebilirliğine de katkıda bulunacağı düşünülmektedir (1. Ulusal Aşı Çalıştayı, 2014). Seks işçileri, LGBT kişiler veya istismara uğramış çocuklar gibi hassas gruplar, aşı için risk grupları olarak kabul edilmektedir. Bu kişilerin cinsel danışmanlık alma konusunda kararsızlık yaşarlar veya sosyal sonuçlarından korktukları için test yaptırmaktan çekinirler (Graham & Mishra, 2011; Mayer ve ark., 2008). Ayrıca, fakir ve korunmasız gruplar çoğunlukla erişilebilirlik ve ödenebilirlik problemlerinden etkilenmektedir (Graham & Mishra, 2011). Aşı maliyeti düşük gelirli ülkeler başta olmak üzere aşıya ulaşmada pek çok ülke için önemli bir sorun teşkil etmektedir. Bu nedenle düşük gelirli ülkeler uluslararası örgütlerden hibe alarak aşmaktadır (Graham & Mishra, 2011; Castro ve ark., 2017; Louie ve ark., 2009). Ancak orta gelirli ülkelerde aşı maliyeti önemli bir sorundur (Sağlık Bakanlığı, 2016a; Markowitz, 2012). Ebeveyn endişeleri HPV aşısına ilişkin endişeleri inceleyen çalışmalarda en çok bahsedilen hususlar arasında yer almaktadır. Buna göre çalışmalarda 2 temel endişe bildirilmiştir. Birincisi, aşının güvenilirlik ve yan etkilerine ilişkindir. İkincisi, aşının adolesanlar arasında gelişigüzel

cinsel birlikteliği artıracığından korkulmaktadır (Hanson ve ark., 2018; Markowitz, 2012; Dorell ve ark., 2011; Gottlieb ve ark., 2009; Garland ve ark., 2011; Marshall & ark. 2007; Yıldırım ve ark., 2009).

Bir Politika Problemi Olarak Türkiye’de HPV Aşılması

Türkiye’de sağlık sisteminde yapılan reformların tarihi, neoliberal politikaların sağlık politikalarının kapsama alanını genişletmeye başladığı 1980’lere dayanmaktadır. Sağlık sistemindeki bu dönüşüme Dünya Bankası, IMF ve WHO gibi uluslararası kuruluşlar teknik ve finansal destek sağlayarak yardımcı olmuşlardır. Dönüşüm için yapılan reformların temel amacı sağlık hizmet maliyetlerini azaltmak ve sağlık hizmetlerine erişimi engellemeden verimliliği artırmaktır (Bulut, 2015; Elbek & Adaş, 2009).

2003 yılında Adalet ve Kalkınma Partisi, Kasım 2002’de açıklanan “Acil Eylem Planı”nın bir parçası olan “Sağlıkta Dönüşüm Programı (HTP)” kapsamında sağlık hizmetlerinde önemli değişiklikler yapmıştır (Bulut, 2015). Bunların arasında sosyal güvenlik sisteminin yeniden yapılandırılması en büyük önceliğe sahipti. Bu nedenle, 2006 yılında Sosyal Güvenlik Kurumu (SGK) kapsamında üç farklı sosyal güvenlik kuruluşu (SSK, Bağ-Kur, Emekli Sandığı) bir araya getirilmiş ve Ekim 2008’de tüm nüfusu kapsayacak Genel Sağlık Sigortası Sistemi (UHI) uygulamaya alınmıştır.

Politika yapma sürecinde yer alan aktörler resmi aktörler ve resmi olmayan aktörler olarak ikiye ayrılabilir. Resmi aktörlerin kanunla belirlenen sorumlulukları onların kamu politikası oluşma sürecine katılmalarını gerektirmektedir. Diğer yandan, resmi olmayan aktörler politika oluşturma sürecine kendi çıkarları ve istekleri doğrultusunda katılmaktadırlar ve onlar olmadan politika sürecinin eksik olacağını düşünmektedirler. Ulusal yasama meclisi başlıca politika aktörüdür ve devlet tarafından finansmanı sağlanan başlıca politika alanlarında kanun oluşturur. Devlet başkanı, bakanlar ve atanan yöneticiler ise yürütmeyi oluşturmaktadır (Birkland 2016). Yürütmenin başı olarak devlet başkanının gücü gündem belirlemeye ve bunun ötesindeki konulara yansımaktadır (Kingdon, 1995). İdari kurumlar ve bürokrasi hükümet tarafından belirlenen işleri yürütmektedirler. Bürokraside yer alan memurlar da politika oluşturma sürecinde yer almaktadır (Birkland, 2016; Allinson, 2007). Yargı, karar alma sürecine katılmaksızın politika oluşturma sınırlarını

belirlemektedir (Birkland, 2016). Resmi olmayan aktörlerle ilgili olarak literatür daha çok çıkar gruplarına odaklanmaktadır. Politika oluşturma sürecine bireysel katılım kişilerin oy verme tercihlerinde görülmektedir (Chesney & Feinstein, 1993; Birkland, 2016). Çıkar grupları özellikle gelişmiş ülkelerde önemli politika aktörleridir. Çıkar gruplarının güçleri de eşit değildir; bazıları güçlü grupların çıkarlarını takip ederken bir kısmı kamunun çıkarlarını gözetmektedir (Birkland, 2016).

Tıp doktorları ve profesyonel birlikler sağlık politikası ve politika oluşturma sürecinin merkezindedir (Walt ve ark., 2008). Tıp doktorlarının sağlık politikası üzerindeki etkisi sağlık konularında otorite olarak görülmeleri ve toplumdaki yüksek sosyal statülerinden kaynaklanmaktadır. Bunun yanında, tıbbi konulardaki uzmanlıkları onlara sağlık politikalarını ve sağlık reformlarını yönlendirme gücü vermektedir (Hyde, 1954; Yılmaz, 2017). Tıbbi birlikler ve hükümet sınıfsal çıkarları çerçevesinde sağlık politikaları konusunda çatışmalar yaşamaktadırlar (Yılmaz, 2017; Moran, 2000).

Bağışıklama politikalarının oluşturulması bakımından, Sağlık Bakanlığı Halk Sağlığı Genel Müdürlüğü'nde Aşı ile Önlenbilir Hastalıklar birimi bulunmaktadır. Bağışıklama hizmetleri, İl Sağlık Müdürlükleri bünyesinde düzenlenmekte ve Aile Sağlığı Merkezleri ile Toplum Sağlığı Merkezleri tarafından hizmet verilmektedir (Sarıkaya, 2018; Avcı, 2017).

Genişletilmiş Bağışıklama Programı (GBP), 1981'den beri ülke çapında uygulanmaktadır (Sarıkaya, 2018). Günümüzde 13 aşı (Hepatit B, BCG, aBDT-IPA-Hib, OPA, td, Pnömonokok, Kızamıkçık - Kabakulak, Varicella, Hepatit A) % 96'dan az olmayan bir kapsama oranı ile GBP kapsamındadır (Cullu & Vural, 2016). HPV aşısının yanısıra iki aşı daha (Konjuge meningokok, Rotavirüs) henüz GBP'ye dahil edilmemiştir (Arısoy ve ark., 2014; Sarıkaya, 2018; Topaç, 2017).

GBP'ye yeni bir aşı dahil edilmesi ve aşı uygulama takvimi kararı Sağlık Bakanlığı tarafından verilmektedir. Sağlık Bakanlığı ve akademisyenler arasındaki ilgili temsilcilerden oluşan Bağışıklama Danışma Komitesi (BDK) bağışıklama hizmetleri ile ilgili görüş ve öneriler üreterek bağışıklama politikaları ve stratejileri belirlemede yardımcı olmaktadır (Sarıkaya, 2018; Cullu & Vural, 2016). Karar verme süreci, hastalığın epidemiyolojisi, güvenliği, etkinliği ve maliyet etkinliği gibi

bilimsel konulara dayanmaktadır. Bilimsel verilerin yetersizliđi durumunda, siyasi motivasyonlar dikkate alınabilmektedir (Cullu & Vural, 2016).

Politika probleminin tanımlanmasına ilişkin olarak, tüm katılımcılar HPV'nin sađlıđa etkilerinin ve virüsle ilgili hastalıkların, özellikle de rahim ađzı kanserinin öneminin ve prevalansının farkında olduklarını enfeksiyona ve sebep olduđu hastalıklara ilişkin istatistiklere vurgu yaparak belirtmişlerdir. Tüm katılımcılara HPV'ye bađlı hastalıklar, özellikle de rahim ađzı kanseri, için potansiyel risk grupları ile bu risk gruplarının yurtdışında görülen örneklerden farklı olup olmadığı sorulmuştur. Bazı katılımcılar 30-65 yaş arası kadınların rahim ađzı kanseri tarama programı tarafından hedef alındığını belirtirken bazıları HPV'nin herhangi bir kadını da etkileyebileceğini ve cinsel aktivite ile çok eşliliđin, hem erkek hem de kadınlar için HPV'ye bađlı hastalıklar açısından risk faktörleri olduğundan bahsetmiştir. Bir katılımcı ise toplum yapısında ve ilişkilerde deđişimin HPV enfeksiyonu riskini artırdığını vurgulamıştır. Hatta HPV enfeksiyonunun toplumun muhafazakar kısmında da görülebilme ihtimalinden bahsetmiştir. Diđer bir katılımcı erkeklerin cinsel yolla bulaşan hastalıklardan korunma konusunda yeterince hassas olmadıkları için, ilk cinsel deneyimini yaşayan kadınların da bu durumdan etkilenebileceğini belirtmişlerdir.

Tüm katılımcılar tarafından aşının GBP'ye dahil edilmeme nedenlerinin başında politik sebeplerin önemli olduğunu düşünölmektedir. Aşının GBP'ye dahil edilmesi ile ilgili politik kararlılık olmaması sebebiyle politik aktörlerin politika oluşturma konusunda isteksizliđi söz konusudur. Aşının ruhsatlandıđı günden itibaren sađlık bakanlarının deđişmesi de politik istikrarsızlıđın nedenlerinden birisi olmuştur. Bu açıdan, hükümetin bakış açısı ve öncelikleri de aşmayı tercih etmeyebilir. Ayrıca son dönemde ortaya çıkan Suriyeli mültecilerin bađışıklanması veya kızamık salgını gibi halk sađlıđı sorunları aşının önüne geçmiş olabilir. İkinci olarak, aşının adolesanlara uygulanması sebebiyle adolesanlarda cinsel aktiviteye izin verme veya cinsel aktiviteyi artırmaya izin verme olarak algılanacağına ilişkin görüş yaygındır. Buna el olarak aşı kişilerde cinselliđe yönelik çağrışımına neden olmakta bu da aşuya karşı önyargı yaratmaktadır. Üçüncü olarak, HPV aşısı farklı disiplinlerden pek çok uzmanın biraraya gelip karar vermesini gerektirmekte, bu interdisiplinerlik aşı hakkında karar vermeyi güçleştirmektedir. Dördüncü olarak, HPV enfeksiyonundan ve enfeksiyonun yol açtığı hastalıklardan kadınların büyük oranda etkilenmesi aşının

halk sađlıđına iliřkin olan ynn glgede bırakmaktadır. Beřinci olarak, toplumda ařı ile ilgili bilgi dzeyi ve farkındalık olduka dřktr. Bu durum ařıya olan talebin az olmasına ve toplum tabanından ařıya iliřkin taleplerin artmasını engellemektedir. Altıncı olarak, ařının maliyeti nemli bir faktrdr. Suıeđi ařısının GBP'ye ge dahil edilmesi hkmetin finansal anlamda bazı kořulları gzettiđi anlamına gelmektedir. Yedinci olarak, Anayasa Mahkemesinin ařının kiřilerin vcut btnlđne bir mdahale olduđuna iliřkin kararı sonrasında ařılara iliřkin olarak verilen mesajları olumsuz ynde etkileyerek ařının bireysel bir sorumluluk olarak grlmesine neden olabileceđi dřnlmektedir. Sekizinci olarak, GBP kapsamında yer almayan iki ařının da programa girme abaları nedeniyle HPV ařısına iliřkin karar verme sreci ertelenmiř olabilir. Dokuzuncu olarak, ařının etkilerinin yařamın ilerleyen yıllarında ortaya ıkması da ařının kapsama alınmasına engel olmuřtur. Sonu olarak, katılımcılardan hibiri diđer lkelerdeki durumun aksine ařının etkililiđi veya gvenirliđine iliřkin bir endiře belirtmemiřlerdir.

HPV ařısının GBP'ye alınmasına iliřkin olarak bulunan giriřimler hakkında bir katılımcı ođunluđu pediyatrist hekimlerden oluřan BDK'nın ařı ile ilgili grř verdiđini bildirmiřtir. Ařının gndeme alınması durumunda ařıya iliřkin yeni veriler ve maliyetlerin ilgili birime sunulması gerekmektedir. Diđer katılımcılar ise gerek derslerde gerekse katıldıkları konferans ve toplantılarda ařının nemine iliřkin bilgilendirme yaptıklarını ifade etmiřlerdir. Katılımcılar HPV ařısı ile ilgili politika oluřturma srecini yukarıdan ařađıya olarak tanımlamıřlardır. Buna gre, ilgili Sađlık Bakanlıđı birimi ila firmalarını davet etmekte, bte etkisi ve maliyet etkililik verilerini talep etmektedir. BDK yılda iki kez toplanmakta ve Sađlık Bakanlıđı'na tavsiyelerde bulunmaktadır.

HPV ařısının GBP kapsamına alınmasına iliřkin politika sreci dngsn tamamlamamıřtır. HPV enfeksiyonu ve iliřkili hastalıklarla ilgili politika probleminin ciddiyeti politika belgelerinde tanımlanmıřtır. HPV ařısını GBP kapsamına alınması konusu gndeme alınmıřtır. Konu pek ok kez gndeme gelmiř olmasına ve BDK'da en az iki kere grřlmř olmasına rađmen ařının GBP'ye girmesine iliřkin geliřme kaydedilmemiřtir. Politika formlasyonu genel olarak resmi olmayan politika aktrleri tarafından stlenilmiřtir. Hkmet ve BDK olası politika uygulamaları konusunda danıřmalar aracılıđıyla bilgilendirilmiřtir. Uluslararası rgtlerin tavsiyeleri ve klinik

kılavuzları da HPV enfeksiyonu ve rahim ağzı kanseri politikaları konusunda önemli rol oynamıştır.

Mülakatlarda belirtildiği üzere, Türkiye'deki uzmanlık derneklerinin ve kuruluşlarının çoğunluğu HPV aşısının GBP'ye girmesini desteklemektedir. Aşı, gelişmiş ülkelerin ulusal aşı programlarında geniş bir biçimde yer almasına karşın Türkiye'deki süregelen politika oluşturmama durumu karşılaştırmalı politika bağlamında ilgi çekicidir.

Mülakatlarda katılımcılar HPV aşısı konusunun hükümet tarafından öncelikli bir konu olarak görülmediği noktasında birleşmişlerdir. Bunlar dördünde bölümde bahsedilen aşı ile ilgili tartışmaya açık konuları da içermektedir. Aşının maliyeti tartışmanın pek çok noktasında dile getirilmiştir, özellikle de aşının kapsama alınmaması için bir neden olarak sunulmuştur. HPV ile ilişkili hastalıkların görece olarak düşük prevalansı politika aktörlerince aşıya erişimde bir engel olarak öne sürülmüştür. Yarışan kamu sağlığı öncelikleri ve diğer çıkar gruplarının baskıları da aşıya ilişkin bir karar alınmasına engel olan nedenler arasında yer almaktadır. Rahim ağzı kanserini önleme noktasında tarama testlerinin varlığı da hükümet tarafından dile getirilen bir nedendir. Aşının cinsel davranışları değiştireceği endişesi de aşının programa alınmasının önündeki bir diğer engeldir. Bu örnekler aşının politika yapımcılar tarafından bir öncelik olarak görülmediğini göstermektedir.

İkinci bölümde bahsi geçen güç kullanımı teorileri çerçevesinde değerlendirildiğinde, farklı gruplarca aşının GBP kapsamına alınmasına ilişkin taleplerine karşılık olarak hükümet tarafından bazı karar vermeme yöntemlerinin kullanıldığı görülmektedir. Bunlar arasında konunun baskılanması ve erteleme en önemlileridir. Konunun baskılanmasına ilişkin örnekler politika aktörleri ve politikacıların açıklamalarından anlaşılabilir.

Konunun baskılanması ve ertelenmesi durumları hassas gruplar örneğinde olduğu gibi aşının toplumdaki algısından etkilenmektedir. Öte yandan, ebeveyn endişeleri de aşı ile ilgili politika yapmanın önündeki kültürel engellerden biridir. Sempatik eksikliği karar vermemeye dolaylı olarak katkıda bulunmaktadır (Marchbank 2000). Kadınların HPV ve ilişkili hastalıklardan fazlaca etkilenmesi kadınların aşıya ilişkin taleplerinin gözardı edilmesini beraberinde getirmektedir.

Sonuç

Kısaca, HPV aşısının karar vermeme ile sonuçlanmasının üç neden bulunmaktadır. Bunlardan ilki hükümetin bakış açısının HPV aşısı ile ilgili politika oluşturmayı desteklememesidir. Dönem dönem yapılan açıklamalara rağmen sürekli olarak konunun ertelenmesi bu durumun bir kanıtıdır. İkinci olarak, toplumun kültürel özellikleri ve aşıya karşı gelişen negatif bakış açısı etkili olmuştur. Üçüncü olarak, aşının maliyeti ve finansal karşılanabilirliği ön plana çıkmış ve bu durum aşıya ilişkin bağışıklama programına dahil edilme konusunun gözardı edilmesine neden olmuştur.

Appendix F: Tez İzin Formu/Thesis Permission Form

TEZ İZİN FORMU / THESIS PERMISSION FORM

ENSTİTÜ / INSTITUTE

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- Enformatik Enstitüsü / Graduate School of Informatics
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YAZARIN / AUTHOR

Soyadı / Surname :EMİNOĞULLARI

Adı / Name :DİLEK SERUR

Bölümü / Department :SİYASET BİLİMİ VE KAMU YÖNETİMİ/ POLITICAL SCIENCE AND PUBLIC ADMINISTRATION

TEZİN ADI / TITLE OF THE THESIS (İngilizce / English) : NON-DECISION MAKING IN POLICY PROCESS: THE CASE OF HPV VACCINES IN TURKEY/ POLİTİKA SÜRECİNDE KARAR VERMEME: TÜRKİYE'DE HPV AŞILARI KONUSU

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1. Tezin tamamı dünya çapında erişime açılacaktır. / Release the entire work immediately for access worldwide.
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A copy of the Decision of the Institute Administrative Committee will be delivered to the library together with the printed thesis.

Yazarın imzası / Signature

Tarih / Date