

Writing Contagion as Cancer: Law, Gender and HPV Vaccination in Australia

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By way of background, HPV is a sexually transmitted infection, mostly affecting women 20 to 24 years of age. Almost all abnormal Pap smear results are caused by HPV. In 98 per cent of cases, HPV clears by itself. In rare cases, if the virus persists and if left undetected, it can lead to cervical cancer.¹

Senator Jan McLucas²

When a girls' focus group was asked if boys could catch HPV, all of the girls answered 'no'.³

Cooper Robbins et al.

1. Introduction

Australia was the first country to implement a national human papillomavirus ('HPV') vaccination program (Leask, Jackson, Trevena, McCaffery & Brotherton 2009, 5510). The program commenced in April 2007 (Garland, Skinner & Brotherton 2011, 531-532). The HPV vaccination program targeted young women and girls from 12 to 26 for government-subsidised HPV vaccination.⁴ The program delivered routine school vaccinations for 12-year-old girls, with older school girls offered school-based vaccinations during the initial program period. Young women up to 26 years old were

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1 Parliamentary debates, Senate, 9 August 2007, 62, Senator Jan McLucas.

2 Australian Senate Debates for introduction of the Australian *National Health Amendment (National HPC Vaccination Program Register) Bill 2007* Cth. The figures quoted are incorrect. Men are infected with HPV at approximately equal rates to women (Giuliano, Anic & Nyitray 2010 S16).

3 Cooper, Bernard, McCaffery, Brotherton, Garland & Skinner 2010, 3400-3401.

4 Similar programs based upon free or subsidized programs are available in a number of countries. Towghi (2013) discusses Indian programs, while others discuss programs in New Zealand (Parker 2010), Canada (Connel & Hunt 2010) and a global overview, including of free and subsidized programs in Europe and the UK, which they compare to the lack of similar programs in many developing countries (Mishra & Graham 2012).

offered free vaccination via their general practitioner from 2007 to 2009 (Ibid., 531-532). From 2013 the HPV vaccine was also offered to school boys.⁵ Uptake in girls was high, with the latest statistics for 12-13-year-old girls showing 77% had received all three required doses of the HPV vaccine.⁶ 67% of 12-13-year-old boys were also vaccinated.⁷

The Australian HPV vaccination program was established using ministerial powers in the *National Health Act 1953* (Cth). The Federal Health Minister may determine a vaccine to be a designated vaccine, if the Pharmaceutical Benefits Advisory Committee has recommended to the Minister that the vaccine should be a designated vaccine.⁸ Once the Minister has made the determination, the Minister may provide for the provision of designated vaccines,⁹ meaning that the vaccine can then be provided free or at reduced costs as part of national vaccination programs. The Gardasil quadrivalent HPV vaccine was determined to be a designated vaccine for females aged 12-27 on 23 January 2007.¹⁰ Boys aged 12-16 were added to the designation on 6 October 2012 for vaccination from 2013.

This paper examines Australia's reification of gendered discourses of health, contagion and consent in those human papilloma virus ('HPV') vaccination programs. HPV vaccination programs and registers in Australia are usually based upon patriarchal gendered concepts of women, and particularly unchaste women, as irresponsible and unclean, potential reservoirs of disease who must be regulated and registered to protect both themselves and wider society from the harms of HPV contagion and cancer. Cervical cancer and HPV prevention schemes use law to write normative gendered expectations which oblige women to internalise a constant pre-illness risk state which casts their bodies as inherently unruly and pathological. These legislative and administrative schemes require women to become complicit with state- and self-surveillance to gain state-mediated health protections. Building on the reasoning of Connel & Hunt 2010 about Canadian HPV vaccination regimes and Mara's work on US HPV vaccination, I examine the discursive gendering effects of HPV governance which mandates medical surveillance and biopolitical measures for health security which posit women as a source of cancer contagion. I also examine how legislation requires or inveigles women's complicity with legislative schemes and normative gendering to reduce HPV transmission while women seek to safeguard

5 Ali, Donovan, Wand, Read, Regan, Grulich, Fairley & Guy 2013, 349.

6 National HPV Vaccination Program Register 2015b. By 2014, the coverage for girls and women was:

- For 14-15 year olds, 84% had one dose, 81% had two doses and 75% had the full three dose course of vaccination.
- 16-17 year olds: 80%—one dose, 77%—two doses and 70%—all three doses.
- 18-19 year olds: 78%—one dose, 75%—two doses and 68% all three doses.
- 20-26 year olds: 66%—one dose, 60%—two doses and 52% all three doses.

7 National HPV Vaccination Program Register 2015c. For boys, who had been eligible for vaccination from 2013, the coverage details were:

- As at 2014, for boys 14-15, 75% had received one dose, 71%—two doses and 63% three doses.
- As at 2014, for boys 16-17, 18% had received one dose, 17%—two doses and 15% three doses.
- As at 2013, for boys 12-13, 78% had received one dose, 74%—two doses and 67% three doses.

8 *National Health Act 1953* (Cth). s9B.

9 Id.

10 *National Health (Immunisation Program—Designated Vaccines) Determination 2007* Cth. Sched 1.

their lives and health.

The paper briefly overviews the prevalence and effects of HPV viruses. Using examples from parliamentary debates and government HPV vaccination program materials, the next sections examine how the organization and messaging of the Australian national HPV vaccination program focuses on cervical cancer such that HPV has become synonymous with cervical cancer in Australian health care. I turn to consider the discursive effects of positioning HPV vaccination as cervical cancer prevention upon women, including how women are configured as disease prone and subject to dangerous sexuality. The next sections considers how discourses of HPV as cervical cancer further medicalise women and force them into a state of cervical cancer proto-illness. I then argue that discourses of HPV that medicalise women legitimise state moral regulation and paternalistic control in purported protection of women that in fact disempowers them. The final part of the paper examines how the paternalistic 'protection' of women becomes imposition of gendered norms justified by social health claims.

2. Risk, science and the HPV vaccine

Human papillomaviruses (HPV) are a family of viruses with over 100 strains (Jones, Coughlan, Reid, Sykes, Watson & Cook 2007, 52). They are colloquially referred to as wart viruses, because many HPV types cause warts. Several strains of HPV are also associated with cancers of the cervix, vulva, vagina, penis, anus, neck and oral areas (Parker 2010, 27; Mishra & Graham 2012, 57). Genetic testing of tumours show that HPV types 16 and 18 are associated with the majority of cervical cancers (70%)¹¹ as well as a significant proportion of anogenital (Parker 2010, 27) and oropharyngeal cancers (Mishra & Graham 2012, 57). Testing of tumours shows that the remaining cervical cancers are caused by other types of HPV infection.¹² Infection with cancer-associated strains of HPV does not automatically result in cancer. Approximately 90% of HPV infections clear spontaneously, through action of the affected person's immune system (Parker 2010, 27; World Health Organization 2014, 469). Only persistent infections are linked with cancers (Parker 2010, 27). Approximately 75% of all people who have been sexually active will be infected with one of the strains of sexually transmitted HPV (Id.). Both men and women are infected at approximately equal rates.¹³

Many HPV related cancers can be avoided via HPV vaccination.¹⁴ Two HPV

11 Parker 2010, 27; Kulasingam, Connelly, Conway, Hocking, Myers, Regan, Roder, Ross & Wain 2007, 165.

12 Kulasingam Connelly, Conway, Hocking, Myers, Regan, Roder, Ross & Wain 2007, 165; other types include 31, 33, 35, 45, 52 and 58.

13 Smith, Lew, Walker, Brotherton, Nickson & Canfell 2011 9116. Giuliano, Anic & Nyitray 2010 S16.

14 Studies have found that HPV vaccination reduces HPV infections implicated in various non-cervical cancers, including oropharyngeal cancer (Herrero, Quint, Hildesheim, Gonzalez, Struijk, Katki, Porras, Schiffman, Rodriguez & Solomon 2013) and anal cancer (Palefsky, Giuliano, Goldstone, Moreira, Aranda, Jessen, Hillman, Ferris, Coutlee & Stoler 2011) Other experts have predicted reductions in non-cervical HPV-related cancers, based on vaccine uptake and aetiology of HPV-based cancers linked to HPV strains included in vaccines (Smith, Lew, Walker, Brotherton, Nickson & Canfell 2011; Burger, Nygård, Kristiansen & Kim

vaccines are commonly used in Australia: Gardasil and Cervarix. Merck's Gardasil is a quadrivalent vaccine against HPV types 6 and 11 (which cause genital warts) plus cancer-causing HPV types 16 and 18.¹⁵ Glaxo Smyth Kline's Cervarix is a bivalent HPV vaccine against types 16 and 18 (Towghi 2013, 336).

In testing involving numerous trials and over 20,000 women Gardasil was found to be 98-100% effective against HPV types 16 and 18 and 70-100% effective against types 6 and 11.¹⁶ In some trials, there was also cross protection observed against 10 non-vaccine but genetically related HPV types.¹⁷ Cervarix similarly 'demonstrated 100% efficacy against persistent infection and 93% against cytological abnormalities associated with HPV 16 and 18' for up to 4.5 years.¹⁸ No serious adverse reactions have been reported in studies of either vaccine.¹⁹

Benefits of widespread HPV vaccination have already been demonstrated with a rapid decline in Australia of genital wart presentations at sexual health clinics.²⁰ However, cervical screening remains necessary to detect the approximately 30% of cervical cancers caused by HPV types not targeted by the vaccines.²¹

3. The cure for cancer discourse: writing contagion as cervical cancer

The dominant discourse about the Gardasil and Cervarix HPV vaccines are that they are a cure for cervical cancer. In this section I will examine how HPV vaccines are positioned as cures for cervical cancer—the developers and purveyors of the HPV vaccine, including Ian Frazer, the original developer of the vaccine, position the HPV vaccine as a vaccine for cervical cancer to the exclusion of other HPV-based conditions—and how they originally targeted it to women despite the fact that HPV and HPV cancers affect all genders. I will go on to examine how the discourse of HPV as cervical cancer and a disease of women influenced Australian legislative debate, initial HPV vaccine implementation and HPV vaccine messaging to parents, patients and doctors in Australia. Non-cervical HPV conditions,²² such

2014; Castle & Maza 2016; Shabbir, Barod, Hegarty & Minhas 2013; D'Hauwers, Depuydt, Bogers, Noël, Delvenne, Marbaix, Donders & Tjalma 2012; Schlecht, Burk, Nucci-Sack, Shankar, Peake, Lorde-Rollins, Porter, Linares, Rojas Strickler 2012; Barroso 2013.

15 Ali, Donovan, Wand, Read, Regan, Grulich, Fairley & Guy 2013, 346; Parker 2010, 27; Towghi 2013, 336.

16 Jones, Coughlan, Reid, Sykes, Watson & Cook 2007, 54; Thompson 2010, 124.

17 Jones, Coughlan, Reid, Sykes, Watson & Cook 2007, 54; Globerson 2007, 75.

18 Jones, Coughlan, Reid, Sykes, Watson & Cook 2007, 54.

19 Jones, Coughlan, Reid, Sykes, Watson & Cook 2007, 54; Raffle 2007, 376; Connel & Hunt 2010. 26 girls at a Melbourne school who were reported to develop dizziness, syncope and neurological symptoms after HV vaccination were found to be suffering 'a psychogenic response to mass vaccination in a school setting' (Garland, Skinner & Brotherton 2011, 533).

20 Garland, Skinner & Brotherton 2011, 533; Ali, Donovan, Wand, Read, Regan, Grulich, Fairley & Guy 2013, 347.

21 Raffle 2007, 377; Leask, Jackson, Trevena, McCaffery & Brotherton 2009, 5505.

22 As discussed throughout Schlecht, Burk, Nucci-Sack, Shankar, Peake, Lorde-Rollins, Porter, Linares, Rojas and Strickler 2012.

oropharyngeal cancers²³ and anal²⁴ cancers, or male-associated cancers, such as penile cancers,²⁵ are often obscured by this discourse, to the detriment of thousands of both men and women who suffer from or die from these cancers each year.²⁶

HPV vaccine developer Ian Frazer regularly referred to HPV vaccines as cervical cancer vaccines in articles discussing development of HPV vaccines²⁷ and commentary on the development process (Frazer 2010). His clear and laudable goal was to develop a vaccine for cervical cancer, one of the leading cancers experienced by women worldwide.²⁸ In one article, he stated that ‘The main public health goals of an HPV vaccine should be to reduce the incidence of cervical cancer and its precursor lesions’ (Lowy & Frazer 2002, 111).

The pharmaceutical companies who manufacture HPV vaccines, based upon Dr Frazer’s work, developed and position their HPV vaccines as cervical cancer vaccines. By its name alone, Cervarix implies a connection between HPV and the cervix. Merck’s early Gardasil HPV vaccine efficacy testing was based only on the appearance or prevention of cervical abnormalities, which are often a forerunner of cervical cancer (Mara 2010, 135). Though male and female test subjects were tested for initial immune response, success testing was clearly targeted at cervical cancer (Id.).

While there was no parliamentary discussion for the creation of the Australian HPV immunisation program, there were Australian Parliamentary debates about the related *National Health Amendment (National HPV Vaccination Program Register) Bill 2007* (Cth). Those debates include endorsements of the HPV vaccination program and illustrate legislator’s views on HPV vaccination and the girls who would undergo vaccination. Senators and Parliamentarians in those debates refer to HPV vaccination overwhelmingly in the context of preventing cervical cancer or because HPV strains covered by the vaccine are the cause of approximately 70% of cervical cancers.²⁹ As noted in the introduction to this paper, Senator Jan McLucas described HPV and its role in cervical cancers as follows:

23 As discussed in Schlecht, Burk, Nucci-Sack, Shankar, Peake, Lorde-Rollins, Porter, Linares, Rojas and Strickler 2012; Herrero, Quint, Hildesheim, Gonzalez, Struijk, Katki, Porras, Schiffman, Rodriguez & Solomon 2013.

24 As discussed in Palefsky, Giuliano, Goldstone, Moreira, Aranda, Jessen, Hillman, Ferris, Coutlee & Stoler 2011; Saxton, Petousis-Harris, Thomas & Turner 2014; Parada & Veerman 2016.

25 As discussed in Castellsagué, Bosch, Munoz, Meijer, Shah, de Sanjosé, Eluf-Neto, Ngelangel, Chichareon & Smith 2002; D’Hauwers, Depuydt, Bogers, Noël, Delvenne, Marbaix, Donders & Tjalma 2012; Shabbir, Barod. Hegarty & Minhas 2013.

26 The incidence and mortality rates of various cancers in Australia, including those linked with HPV, are discussed in Australian Government 2014. Particular relevant sections include C00-C06, C18-C21, C53, and Appendix G. For worldwide cancer incidence, also including incidence of HPV-based cancers, see Ferlay, Soerjomataram, Dikshit, Eser, Mathers, Rebelo, Parkin, Forman & Bray 2015.

27 For example in Frazer 2004; Frazer, Cox, Mayeaux, Franco, Moscicki, Palefsky, Ferris, Ferenczy & Villa 2006; Lowy & Frazer 2002.

28 Frazer, Cox, Mayeaux, Franco, Moscicki, Palefsky, Ferris, Ferenczy & Villa 2006, S65; Lowy & Frazer 2002 111, Frazer 2004, 46; and his account of the process and goals throughout Frazer 2010.

29 Parliamentary debates, House of Representatives, 8 August 2007, 153, Nicola Roxon MP, 154.

By way of background, HPV is a sexually transmitted infection, mostly affecting women 20 to 24 years of age. Almost all abnormal Pap smear results are caused by HPV. In 98 per cent of cases, HPV clears by itself. In rare cases, if the virus persists and if left undetected, it can lead to cervical cancer.³⁰

Nicola Roxon MP, in the Australian House of Representatives used the same description of HPV infection rates and effects. Their description of HPV as ‘mostly affecting women 20 to 24 years of age’ was incorrect. Studies have placed male HPV infections rates as ‘broadly similar to that in females’,³¹ or that ‘genital HPV infection prevalence among healthy men appears to be as high, or higher, than prevalence among women’ (Giuliano, A.R., G. Anic & A. G. Nyitray 2010, S16). The legislators’ HPV infection age ranges are also skewed, as immune indicators of HPV infection in 2005 (prior to HPV vaccination implementation) were highest for Australian women in the 30-39 age group and for men in the 40-59 year age groups.³² In addition, both parliamentarians mention only cervical cancers rather than the broader range of HPV-caused cancers. Both situate HPV as primarily a disease of young women, rather than of middle-aged Australians of all genders.

Similarly, other parliamentarians referred to HPV as causing cervical cancer, HPV vaccines as cervical cancer vaccines or HPV as a disease of women, saying:

The Gardasil vaccine is a breakthrough in the treatment of cervical cancer, and the Howard government is very proud to be able to make it widely available to young Australian women. (Parliamentary debates, House of Representatives, Australia, 8 August 2007. Michael Johnson MP.)

The reasons for adding this new [HPV] vaccine to the program were clear. Cervical cancer is the world’s second most common gender-specific cancer amongst women and is currently responsible for the deaths of around 200 women in Australia each year. (Ibid., Dr Mal Washer MP.)

The need for this bill arose from the government’s 2006 announcement to fund free HPV vaccine for females in the 12- to 26-year-old age group through the National Immunisation Program with the aim of reducing the incidence of cervical cancer. (Ibid., Tanya Plibersek MP.)

The National HPV Vaccination Program, announced by the government in November 2006 and introduced in April this year, funds free HPV vaccine for females in the 12- to 26-year-old age group, with the aim of reducing the incidence of cervical cancer. (Ibid., Alex Somlyay MP.)

As the father of a 12-year-old girl, I see this bill as being absolutely vital—vitaly important not only for my daughter but, indeed, for me and for the rest of my family, my son included, because none of us wants to lose a wife, a daughter or an aunty (Ibid., Patrick Famer MP.)

30 Parliamentary debates, Senate, 9 August 2007, 62, Senator Jan McLucas, 62.

31 Smith, Lew, Walker, Brotherton, Nickson & Canfell 2011, 9116.

32 Newall, Brotherton, Quinn, McIntyre, Backhouse, Gilbert, Esser, Erick, Bryan & Formica 2008, 1649-1650.

One parliamentarian, Michael Johnson MP, lionised the creator of HPV vaccines, Ian Frazer as, ‘God’s gift to women’ (Ibid.). Most did not discuss the role of HPV infection in men or HPV-linked cancers other than cervical cancer.³³ Members of Parliament also frequently refer to the HPV Vaccination Program Register allowing for easy cross reference of material to Australian cervical cytology and cervical cancer registers, but not other cancer registers.³⁴

The concentration on HPV in women and its link to cervical cancer, but little or no discussion of health effects on men or of non-cervical HPV cancers, elides the role of HPV in non-cervical conditions and positions women as the only people seriously affected by HPV. The characterisation of HPV as a disease ‘mostly affecting [young] women’ ignores that the majority of HPV positive women will have been infected by male partners and that men carry HPV at approximately the same rates as women.³⁵ This not only misrepresents HPV prevalence and infection routes, but characterises women as the source and repository of HPV infections in Australia.

Early Australian HPV vaccination program materials reinforced this discourse by concentrating strongly on the HPV vaccine as a vaccine for cervical cancer, or HPV as a precursor of cervical cancer.³⁶ Approximately 60% of HPV vaccine newspaper coverage in a 2009 study in Australia referred to the HPV vaccine as the ‘cervical cancer vaccine’, while fewer than 20% referred to it as a HPV vaccine (Cooper, Pang & Leask 2012, 154). This messaging raised the vaccine’s profile, especially amongst those ignorant of HPV or the effects of the virus.³⁷ It created a sense of urgency for vaccination, which may have led to greater voluntary uptake of the vaccine (Parker 2010, 32).

More recent Australian HPV vaccination brochures and posters discuss HPV disease more generally, for example saying that the vaccination is for ‘(HPV), which can cause cancers and disease in males and females’ or ‘range of HPV-related cancers and disease’ (Australian Government 2013c). Most specifically mention cervical cancer, while many, especially those aimed at high school students, do not identify other HPV-caused cancers.³⁸ Materials for or specifically about boys generally mention cervical cancer and the need to protect girls from it, in terms like, ‘Vaccinating males will also help to protect females from cervical cancer and HPV-related disease by reducing the spread of the virus’ (Australian Government 2013c).

Medical professionals use similar discourses of HPV and cervical cancer. An

33 Parliamentary debates, House of Representatives, Australia, 20 June 2007. Parliamentary debates, House of Representatives, Australia, 8 August 2007. Parliamentary debates, Senate, Australia, 9 August 2007. Parliamentary debates, House of Representatives, Australia 30 October 1996.

34 Parliamentary debates, House of Representatives, 20 June 2007, 10, Bruce Billson MP. 10 Parliamentary debates, House of Representatives, 8 August 2007, 153 Dr Mal Washer MP, 171 Alex Somlyay, 172.

35 Giuliano, Anic & Nyitray 2010, S16; Smith, Lew, Walker, Brotherton, Nickson & Canfell 2011, 9116.

36 Cooper, Bernard, McCaffery, Brotherton, Garland & Skinner 2010, 3401.

37 Gunasekaran, Jayasinghe, Brotherton, Fenner, Moore, Wark, Fletcher, Tabrizi, & Garland 2015, 829.

38 Australian Government 2013c; Australian Government 2014a; Australian Government 2013b; Australian Government 2013c; Australian Government 2013d; Australian Government 2014e; Australian Government 2014c; Australian Government 2014d; Australian Government 2014e; Australian Government 2014f.

Australian survey showed Australian GP's relied on resources which discussed the HPV vaccine primarily as a vaccine for cervical cancer, for example, the Australian Department of Health and Aging's *Immunisation provider guidelines: cervical cancer vaccination* (Brotherton, Leask, Jackson, McCaffery & Trevena 2010, 294). In the same survey, while most knew the vaccine was protective for cervical cancer, there was substantial GP confusion about cervical cancer aetiology (Id.) and what cervical abnormalities HPV vaccination affected (Id.). The vaccination program materials encouraged even GP's to link a gender neutral virus with cervixes and women's bodies.

Advertising HPV vaccines as cervical cancer vaccines has led to public confusion about effect and effectiveness of the vaccines. A 2006 South Australian study found only 54% of women knew of the link between HPV and Cancer (Pitts, Dyson, Rosenthal & Garland 2007, 179). A 2009 study of vaccinated Australian school girls and their parents showed they had little knowledge of HPV or the effects of the vaccine. In the same 2009 study, girls assumed that the HPV vaccine was only relevant to the female reproductive system, showing confusion when asked what the vaccine was called, calling it 'The Cervix Needle' and 'The Vagina Cancer' (Cooper, Bernard, McCaffery, Brotherton, Garland & Skinner 2010, 3401). Many girls and parents responded 'no' when asked if they understood what HPV was (Id.).

For surveyed girls and parents who knew that HPV was linked to cervical cancer, many used the terms HPV and cervical cancer interchangeably and 'more often than not, participants offered that they were not sure what the difference was between the two' (Id.). The majority of study participants thought that vaccinated girls were completely protected against cervical cancer (Id.). One parent cited the then-running Australian HPV vaccination program television advertisements saying '[. . .] just the adverts on TV. It just brought across the idea to most people that this is the thing that is going to stop you getting cervical cancer' (Id.).

Even more recently in 2014, Gunasekaran et al found that many HPV vaccinated women thought that they had been vaccinated for cervical cancer (89% of the study cohort) while fewer had heard of HPV vaccines (76%).³⁹ When asked why they would get a HPV vaccine, overwhelmingly, the response was to protect against cervical cancer (96%) or to 'join the fight against cervical cancer'.⁴⁰ When the vaccine was described as a HPV vaccine rather than a cervical cancer vaccine, 19% of the 2014 respondents were unsure whether they had been vaccinated, which the authors considered due at least in part to the 18% gap in participant knowledge between the existences of so-called cervical cancer vaccines versus HPV vaccines.⁴¹

There are serious implications arising from conception of the HPV vaccines as cervical cancer vaccines. It creates an impression that HPV *is* cervical cancer and that the HPV vaccine prevents all cervical cancers. Women may neglect ongoing cervical testing for abnormalities caused by HPV strains not included in the vaccines.

39 Gunasekaran, Jayasinghe, Brotherton, Fenner, Moore, Wark, Fletcher, Tabrizi, & Garland 2015, 828.

40 Id.

41 Ibid., 829.

The idea of HPV as only cervical cancer also ignores its role in other anogenital cancers,⁴² oral cancers and oesophageal cancers (Globerson 2007, 71). This may explain significantly lower male vaccination rates⁴³ which leave boys vulnerable to a range of preventable HPV-related cancers.

The strong public discourse of HPV created the impression that it was a uniquely female STD. This was so strong in 2009 that the girls in Cooper Robbins' focus group study thought unanimously that boys could not get HPV (Cooper, Bernard, McCaffery, Brotherton, Garland & Skinner 2010, 3400-3401). One participant stated that boys could not catch HPV because, 'Boys don't have cervix' (Ibid., 3401). Another thought 'It's an STI, and it only happens to girls' (Id.). One girl reasoned that HPV could be related to sex because 'I think if you're sexually active, then that's when, it like makes your body trigger that you can have you can contract the virus' (Ibid., 3400). Such misconceptions reinforces gendered tropes of women as having inefficient, disease prone bodies and men as healthier and physically superior to women, unable to catch or harbour HPV. It also reinforces ideas around women's sexuality as dangerous, vulnerable to disease and corruption, requiring social supervision for the safety of women and society as a whole.

4. Medicalisation of women

The idea that HPV viruses, vaccines and HPV-linked cancers relate only to cervical cancer replicates a long-term discourse that medicalises⁴⁴ women's bodies (as canvassed in Mara 2010, 125). Healthy female-sexed bodily functions, such as menstruation, pregnancy and breast feeding, are subject to medical oversight, supervision and intervention in ways that male-specific⁴⁵ bodily processes rarely are (Id.). The explicit focus on cervical cancer in Australian HPV vaccination program literature⁴⁶ reiterates that only cervixes, usually identified with cis women,⁴⁷ are at danger from HPV.

The medicalisation of women's bodies arises from and reinforces the tropes

42 Ibid., 829-830.

43 The male immunisation rates as at 2014 (latest data) were approximately 10% of the population lower for boys aged 12-15 compared to similarly aged girls and much lower in the 16-17 year old age group (15% of boys vaccinated versus 70% of girls for full vaccination) National HPV Vaccination Program Register 2015a. National HPV Vaccination Program Register 2015b, National HPV Vaccination Program Register 2015c. National HPV Vaccination Program Register 2015d.

44 'Medicalisation describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders' (Conrad 1992, 209).

45 In this section, I am using the terms 'male' and 'female' in the same way that West and Zimmerman (1987) use 'sex' descriptors. It is not intended to denote the gender identity of possessors of vulvas and cervixes or penis and testes.

46 Australian Government 2013c; Australian Government 2014a; Australian Government 2013b; Australian Government 2013c; Australian Government 2013d; Australian Government 2014e; Australian Government 2014c; Australian Government 2014d; Australian Government 2014e.

47 The term 'cis' denotes identifying as the gender which the person was assigned at birth or not trans gendered. A cis woman is a person who identifies as a woman and who was identified female at birth because she possesses a vulva.

that men's bodies are normalised and healthy while women's bodies are, as Aristotle argued, a 'mutilated male' (Ibid., 134), inherently faulty and unhealthy, frail and dangerous in a way that men's bodies are not (Ibid., 129). Cis women's bodies are still constructed as more primitive and closer to nature than men's (Ibid., 134) via discourses around menstruation and lactation. Marketing HPV as cervical cancer and HPV vaccination as a women's issue remind us that women's bodies are constructed as more primitive, more reproductively oriented and inferior, since the common construction of HPV is that from the same sexual act, it infects women then causes cancer in women's sexual organs but neither infects men nor causes cancers of the male anogenital area (ignoring HPV's role in penile, anal and other anogenital cancers of men). In gendering tropes, men must, therefore, be immunologically and structurally superior to the primitive female and her inferior, interior organs. Such a discourse can only flourish when information about male anogenital HPV-caused cancers is largely elided from public discourse.

The administration of a 'girl vaccine' becomes a gendering performance for medicalised female bodies (Mishra & Graham 2012, 64). For girls, it is a liminal experience, a symbolic penetration forecasting future female (hetero)sexuality as involving dangerous reproductive anatomy which may turn against women at any time. It reinforces that 'femaleness is a 'nonnegotiable' consequence of 'natural' anatomy' (Id.). For boys, when they were not being vaccinated,⁴⁸ the message was that their anatomy is impenetrable and independent of medical supervision (Mara 2010, 127) and their sexuality is healthy and immune from disease while girls who have sex are inherently prone to disease and disaster.

For boys in Australia now, vaccination program materials targeted to them rarely discuss specific HPV-linked cancers suffered only by men, but invariably mention the link between HPV and cervical cancer and often talk about protecting future female partners, talking about how 'Vaccinating males will also help to protect females from cervical cancer and HPV-related disease.'⁴⁹ For them, the message is multifold, that they will be heterosexual and that as heterosexual cis-males, their role is to protect female partners from uniquely disease-prone female anatomy.

Medicalisation of girls also legitimises differing levels of biopolitical control of women and differing legal approaches to health based on reproductive anatomy, formulating women's bodies as sites of 'contestation and conquest' (Thompson 2010, 122). As Mishra and Graham argue:

The 'naturalisation' of femaleness enables the programmatic control of 'female' bodies (Martin 2001). Thus, selves, others, organisations, institutions and pathogens are brought together in the clinical risk discourse around the uterine cervix. (Mishra & Graham 2012., 64.)

48 As in Australia until 2013 and in a range of other countries, including India (Towghi 2013) New Zealand (Parker 2010), Canada (Connel & Hunt 2010) and Texas (Mara 2010).

49 Australian Government 2014a; Australian Government 2013c; Australian Government 2013c; Australian Government 2014e.

If women's bodies are unpredictable and dangerous, then women can be coerced into giving up autonomy and agency for their own protection. The responsibility for not only their health, but partners' and children's health become attached to the greater expectation that women should take responsibility for reproductive health (Mara 2010, 125). Simultaneously, if women's bodies are unpredictable, unstable and prone to fail, this is generalised so that women's minds, emotions and physical abilities must also be Other (Ibid., 129), erratic, frail and less than the stereotyped male norms of strength, greater physical efficiency, bodily integrity and health (Thompson 2010, 124). This then leads to the enacting and subsequent active maintenance of tropes of the masculine as norm and the institutionalisation of sexism based on alleged bodily weakness and irrationality of women (Thompson 2010, 124; Mara 2010, 129). The need to control women's reproductive health justifies legal, social and governmental intervention that furthers the backlash against women's greater participation in public spaces since the 1970's (Globerson 2007, 102).

Control of the body is a fundamental and crucial form of social control (Mara 2010, 135; Shaw 2008, 55). The medicalisation of women's bodies through HPV interventions starts the chain of control which schools women to perceive their reproductive processes, immune systems and bodies as inherently faulty (Mara 2010, 135). The interventions and discussions around them 'can become cultural issues that jeopardise women's bodily autonomy' (Id.).

5. Risk and proto-illness

Australian vaccination program messaging which positions girls as potential carriers of cervical cancer, and boys as protectors of girls from cervical cancer creates a risk status and identity for women as inherently prone to serious disease encourages them to create new identities based on their liminal state of risk (Gillespie 2015, 983) and a state of pre- or proto-illness. Boys are exempted from considering themselves HPV cancer prone, by a lack of penile, anogenital and oropharyngeal disease messaging.

Those who undergo regular medical surveillance for risk 'hover for extended periods of time under medical attention between sickness and health, or more precisely, between pathology and an undistinguished state of "normalcy"' (Timmermans and Buchbinder 2010, 409). Being at risk becomes a 'prototypical experience' produced by 'a society that has come to rely on statistical distributions in the management of population health instead of symptomatology in the treatment of individual pathology' (Gillespie 2015, 975). Those who are at risk may begin to 'interpret preventive measures as treatment' (Ibid., 977) and display behaviours consistent with illness, such as seeking and following medical advice (Ibid., 974). The at-risk person begins to 'reside in a space between healthy and ill, with the likelihood of progressing toward illness' (Ibid., 983).

Targeting of cervical cancer in HPV vaccination programs creates a perceived risk category, which is added to lifelong medicalisation of women's bodies around cervical screening, menstruation, childbirth, lactation, menopause and other reproductive health (Mara 2010, 125). Girls are initiated during HPV vaccination

into a proto-illness state which strongly accords with a dichotomous social view of women as ill and men as inherently healthy (Courtenay 2000, 1388-1389). As a sex women are encouraged to seek and follow medical advice for the risk of being female throughout their lifespan, and conceptualise themselves in a state of proto-illness in ways that only at-risk men experience (Gillespie 2015, 980) while other men do not. Added to social discourses of men's bodies as inviolable, healthy and strong (see Courtenay 2000), the discourses of HPV risk as cervical cancer risk with deliberate vagueness about other HPV conditions, may moderate the risk creation effect of the vaccine for boys while simultaneously creating an at-risk experience for girls. Australian girls may come to experience their own bodies as a source of extraordinary risk, perceiving like the participants in Cooper Robbins study, that only possession of a cervix makes HPV dangerous. This is reinforced in a culture which recommends ongoing cervical testing and surveillance⁵⁰ for HPV-based cervical cancer for girls, but where no equivalent testing for men is recommended.⁵¹

6. Moral regulation

The risk status of women as in danger from HPV and as a dangerous source of HPV leads to state interventions to regulate HPV risks to and from women. The need to undergo HPV vaccination is coded as a moral act to protect girls from the dangers of cervical cancer and thence their own dangerous anatomy. Individual prophylactic health care itself becomes coded as first a public good which protects the population at large and then as a moral imperative to protect others from the dangerous infectious self (Connel & Hunt 2010, 67). Self-governance and submission to governmental programs themselves then become moral virtues required by the moral imperative of public health (Ibid.).

For HPV, the moral wrongness resides in the idea of women's bodies as faulty and the coding of women's sexual behaviours as the cause of HPV infections in themselves and their partners via messaging which concentrates on the effect of infection on women. Any rejection of vaccination in the proffered program format becomes an act endangering the public and demonstrating wilful selfishness. The moralisation of girls takes place via the vaccination and cervical screening discourses which place them as a public health danger which must be curbed via the regulation of their bodies, the direct injection of preventative (moralising) agents into their bodies and their lifelong surveillance by HPV vaccination and cervical screening registers.

Girls are also expected to demonstrate autonomy—in the sense of 'self-governance' (Mara 2010, 125-126)—and moral maturity by paradoxical submission

50 Surveillance of cervical cytology and cervical HPV testing in Australia is by way of state registers of testing and results. There is no similar testing regime for male-only health testing or for the majority of non-female specific regular health testing in Australia (Stagg-Taylor 2013, 572).

51 Anal Pap smear testing can detect HPV-based anal cancers in the same way that cervical Pap smears detect cervical cancer (Globerson 2007, 72), while penile scraping can detect HPV infection of the penis, but has been rejected in at least one study because male participants disliked it (Mara 2010, 135).

to external surveillance, medical control and law. The moralisation of girls requires self-regulatory compliance with social directives which place them as inherently diseased, irrational and subject to dangerous sexuality. To reach female sexual autonomy, they are disciplined to give up their sexuality and sexual health to social control. They are then encouraged to comply with long standing tropes of women as inherently sexual and a danger to sexual morality that places them as having either a sexuality of renunciation and refusal (Connel & Hunt 2010, 71) or dangerous and disordered lasciviousness (Globerson 2007, 97).

Setting cervical cancer as the endpoint of HPV vaccine interventions in legislative debates and vaccination program materials reinforces a trope that links HPV to women's sexual behaviour and raises discourses that justify control of women and their sexuality (Thompson 2010, 127). As Mara theorised in relation to HPV vaccination in Texas, 'Reminding girls and women of the dangers of cervical cancer encourages them to be fearful of a disease that is specific to their reproductive organs, while allowing males to remain free of such fears' (Mara 2010, 133). Women's bodies are 'necessarily sexualised' (Ibid., 129) for their departures from male physical genital norms configured as the neutral human form. Women are 'often addressed or interpellated in issues of health and sex' (Connel & Hunt 2010, 67-68) which means that any health intervention for women may be interpreted as gendered or sexual, especially if it is a matter related to women's genitals or secondary sexual characteristics.

This interpellation of sexuality into vaccination has led to fears that vaccinating girls for HPV would lead to promiscuity among young girls. The promiscuity discourses urging rejection of HPV vaccination common in the USA⁵² and present in Australia (Biggs 2007, 10) are based in fears of women's sexuality as rampant and irresistible if not carefully controlled by fears of cancer. Fears of promiscuity in Australia mirror those of the religious right in the USA (Id.) and come in part from similarly religiously conservative groups. Right to Life WA 'raised concerns that the vaccine might create "not only moral dilemmas but physical dilemmas" for young girls regarding the appropriate age for the onset of sexual activity' (Id.). Some Western Australian parents refused consent to vaccination as a result of Right to Life's assertions (Id.). Some private religious schools refused to allow vaccination programs at the school due to school beliefs (Id.). The Australian Family Association's spokeswoman Gabrielle Walsh was concerned that 'Some parents feel it [HPV vaccination] gives children a sense they are going to be sexually active'.⁵³ She had also publically stated that

A lot of people are opposed to the prescriptive approach; it's not like this is a disease everyone is going to get. It's a culture leading them in that direction and it is probably not relevant for those girls [who abstain while not married].
(Quigley 2007.)

52 USA promiscuity see discussions in Globerson 2007; Biggs 2007, 10; Brotherton, Leask, Jackson, McCaffery & Trevena 2010, 296.

53 Parliamentary debates, House of Representatives, 8 August 2007. Tanya Plibersek MP.

Conservative Senator Barnaby Joyce (now Deputy Prime Minister of Australia) echoed those concerns in statements to a major national daily newspaper *The Australian*, warning about ‘the psychological implications or the social implications’ of the vaccine and that ‘There might be an overwhelming (public) backlash from people saying “don’t you dare put something out there that gives my 12-year-old daughter a license to be promiscuous”’ (Caldwell 2016). He later clarified: ‘It has been said by some that this could be taken as an entree to sexual activity [...] Of course my reply to that, “If the kid is under the age of consent that is a concern and you certainly need the parent’s involvement” and I stand by that’ (ABC News 2006). Other members of Parliament, such as Tanya Plibersek (now deputy leader of the Australian Opposition), acknowledged such fears of teenage sexuality but urged support for HPV vaccination despite them. Plibersek said that early sexuality was a reason to vaccinate because, ‘The uncomfortable truth for many people is that a high proportion of teenagers are actually sexually active... and that is another good reason to say it is very important to vaccinate against human papilloma virus from a young age.’⁵⁴ The *National Health Amendment (National HPV Vaccination Program Register) Bill 2007 Digest* also acknowledged the concerns of Right to Life WA and refusal of consent to vaccination for fear of early sexual activity, though it ultimately argues the minority concerns should be disregarded (Biggs 2007, 10-11).

To avoid sexuality related social anxieties, Australian HPV vaccination materials avoid discussion of HPV as an STI and of safer sex messaging, deflecting controversy through deliberate elision of important disease transmission information (Mishra & Graham 2012, 65). By this omission, the Australian government signals awareness of social fears of teen sexuality and fears related to perceptions around female sexuality, promiscuity and chastity. They acknowledge that parents and patients may not wish young women to be seen as unchaste and reinforce the legitimacy and primacy of such views over accurate health messaging, creating social endorsement of sexual, moral panic related to HPV and other STI’s. To manage anxieties about women’s sexuality, female sexuality is recast as passive in vaccination program materials that ignore or downplay sexual transmission of HPV.⁵⁵

Programs that focus on women’s bodies as at risk and that minimise HPV risks to boys position women as the gatekeepers of public health through explicit messaging or the implicit assertion that women must bear the burden of HPV intervention and surveillance for the benefit of the whole community. HPV vaccination programs are structured around promoting the public good by protecting female fertility from cervical cancer. In vaccine information brochures, women’s health, sexuality and social identity are deliberately constructed around desexualised motherhood and social responsibility (Hall, Howard & McCaffery 2008, 84-85; Australian Government 2013b). Some Australian government brochures have been aimed at

54 Id.

55 Australian Government 2013a, Australian Government 2013b, Australian Government 2013c, Australian Government 2013d, Australian Government 2014a, Australian Government 2014b, Australian Government 2014c.

mothers, strongly emphasising mothers' social responsibility for children's health, even for adult women's sexual health in catch up programs aimed at adult women (Garland, Skinner & Brotherton 2011, 531). Australian Parliamentary debates about the National HPV Vaccination Program Register included references to the responsibilities of mothers to manage children's vaccinations and vaccination records and communicated that men could not be responsible for remembering or keeping vaccination information for children.⁵⁶ Conversely, in HPV vaccination program materials and policy documents, men's sexuality and health is rarely linked strongly to their role as fathers (Thompson 2010, 121). In Australian government HPV vaccination documents for children, fathers are depicted as ignorant of HPV and one brochure features a cartoon father asking a responsible mother about the recommended extent of vaccine programs (Australian Government 2014a).

Messaging and HPV vaccination practices also 'focus [...] on how women will protect the public health through allowing (or preventing) border crossings of their bodies' (Mara 2010, 139). In addition to demonstrating girls' future responsibility as mothers, messaging in Australian girls' brochures more strongly encourages community care compared to boys' brochures (Australian Government 2014a; Australian Government 2013b). For example, a girls' brochure, aimed at indigenous girls, has 5 comic panels explicitly talking about receiving vaccination to keep the girl's community healthy and several more with the girl considering becoming a health worker (to help the community) (Australian Government 2013b), where the similar boys' brochure has 2 mentions of community protection and a focus on the boy being personally healthy so that he can better play football (Australian Government 2014a).

7. Protecting women

In addition to tasking women with protecting the community, paternalistic protection of women is a theme throughout both implementation of HPV vaccination and objections to HPV vaccination in Australia. The very name of the Gardasil vaccine invokes protection from dangers (Thompson 2010, 124). Women must be protected from themselves, either through vaccination or being denied vaccination. As Globerson says in examining US HPV vaccination processes:

Gardasil is therefore without precedent in that it forces the American public to evaluate what it means to protect women, what women need protection from, and what price our society is willing to pay to provide that protection. (Globerson 2007, 69.)

The prices paid are the creation of HPV health messaging and systems which position women as inherently physically inferior and disease-prone. Members of Parliament arguing for the adoption of the *National Health Amendment (National*

⁵⁶ Parliamentary debates, House of Representatives, 20 June 2007, 10, Bruce Billson MP. Parliamentary debates, House of Representatives, 30 October 1996.

HPV Vaccination Program Register) Bill 2007 (Cth), argued that the bill was required to protect women from cancer, with one saying that the new HPV Vaccination Program Register would ‘provide assurance to young women that the Australian Government is doing everything possible to help protect them against HPV’ (Parliamentary debates, Senate, 9 August 2007, 62, Senator Jan McLucas, 63). Others highlight the fact that ‘Having a register such as this will mean that professionals and those people [vaccine recipients] will be comforted that they can access this kind of information and that it is not lost to them forever’ (Parliamentary debates, House of Representatives, 8 August 2007, 169, Kay Hull MP) unlike other health information which the patient is trusted to remember. Some parliamentarians positioned themselves as the imagined familial protector, like Patrick Farmer who said,

As the father of a 12-year-old girl, I see this bill as being absolutely vital—vitaly important not only for my daughter but, indeed, for me and for the rest of my family, my son included, because none of us wants to lose a wife, a daughter or an aunty and none of us wants to lose a close relative when it can be prevented. (Ibid., 173 Patrick Farmer MP.)

In each instance, the parliamentary discourse is one of benevolent protection of an endangered group, girls and women endangered by their female biology. Vaccinated girls and doctors were to be protected from uncertainty, not by the recipients’ memory of vaccination, not by parental record keeping, but by the government’s benevolent recording of medical information.

Since governments are acting as benevolent protectors of irrational females, publishing misinformation or incomplete information is justified to compel consent to the HPV vaccine. Messaging around HPV vaccination in Australia is tailored to push parents, children and women in the catch up programs to vaccinate. A leading Australian HPV vaccination researcher (who is not a sociologist or psychologist) recommended that ‘Message should be tailored for uptake, not to create HPV vaccine experts. Parents especially make vaccine decisions from a place of emotions, not a place of random facts’ (Brotherton 2015b). The implied recommendation therefore was to hide the ‘random facts’ from both parents and recipients and create emotional responses, especially fear for their children’s health. The facts usually hidden in HPV vaccination program brochures are neither random nor unimportant for future health care. They include the fact that HPV is an STI (hidden to avoid parents considering children’s burgeoning sexuality), the full range of cancers and conditions triggered by HPV, any information which may impliedly threaten masculinities of male recipients (Courtenay 2000, 1389) (such as HPV’s link to ‘gay’ coded anal cancers) and details of the need for future cervical screening, because HPV vaccinations are not a complete protection against cervical cancer.⁵⁷ They may also leave recipients

⁵⁷ Gunasekaran, Jayasinghe, Brotherton, Fenner, Moore, Wark, Fletcher, Tabrizi, & Garland 2015, 830. Australian Government 2013a, Australian Government 2013b, Australian Government 2013c, Australian Government 2013d, Australian Government 2014a, Australian Government 2014b, Australian Government 2014c.

with potentially dangerous misunderstandings about the vaccine and HPV, which may expose recipients to future disease or encourage them to avoid cervical screening (Hall, Howard & McCaffery 2008, 81). They show a paternalistic disregard for fully informed consent to medical intervention.

Ignoring informed consent is problematic. It is possible that HPV vaccinated children, especially in older cohorts, may be *Gillick* competent⁵⁸ for the purposes of vaccination, especially if appropriately informed (Garland, Skinner & Brotherton 2011, 531). In Australia, a child is competent to give consent to medical treatment if the minor is ‘capable of giving informed consent when he or she “achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed”’.⁵⁹ However, Australian materials and vaccination processes do not give children age appropriate information about the full effects of the vaccine, HPV-based disease or the relative disease risks they may face.⁶⁰ There is no clear indication in children’s vaccination materials that they could choose to refuse or request the vaccine if their parent chooses an opposite course for them.⁶¹ There is no discussion of consent in the HPV program factsheet for Australian health care professionals (Australian Government 2014f).

There is no insurmountable reason to avoid fully informed parental or *Gillick* competent child consent. In fact, the use of ‘opt off’ consent for the Australian HPV Vaccination Program Register, in which patients’ details are entered without consent at vaccination, was recommended because ‘This model of consent, it is argued, can also reduce the administrative burden on the program, because the patient’s consent does not need to be explicitly sought or recorded’ (Biggs 2007, 15). The Australian system of ignoring potential *Gillick* competence exists as it does for the convenience of doctors, school staff, and administrators.⁶² Lack of consent by children to the vaccine itself is not a necessary part of an HPV vaccination system. The UK HPV vaccination program allows for assessment of *Gillick* competence in adolescents under 16, while UK recipients 16 and over generally provide consent to their own vaccination (Garland, Skinner & Brotherton 2011, 531).

In Australia, consent comes from parents, who are assumed to control their child’s medical and sexual state. The girl herself, even if capable, is given no space to seek or refuse the vaccination. She is taught that she has little or no control over who can touch her body or control her sexual health (Mara 2010, 136). While boys are now included in Australian HPV vaccination programs, they are late entries to a system designed to force compliance from girls and their families, rather than

58 From *Gillick v. West Norfolk AHA* [1986] AC 112.

59 *Department of Health and Community Services v JWB and SMB (Marion’s Case)* 1992) 175 CLR 218 at paragraph 19, per Mason CJ, Dawson, Toohey and Gaudron JJ quoting *Gillick v. West Norfolk AHA* [1986] AC 112, 189.

60 Australian Government 2013c; Australian Government 2014a; Australian Government 2013b; Australian Government 2013c; Australian Government 2013d; Australian Government 2014e.

61 Australian Government 2013c; Australian Government 2014e; Australian Government 2014f.

62 For schools, see discussion in Biggs 2007, 13 and Garland, Skinner & Brotherton 2011, 531. For doctors see Leask, Jackson, Trevena, McCaffery & Brotherton 2009, 5510.

founding participants in a more gender neutral system. Their participation is encouraged through exhortations to protect female peers from cervical cancer, rather than explicit messaging about dangers to male health.

The Australian de-emphasis on consent and emphasis on the need for governmental paternalistic HPV protection continues with the creation of the Australian National HPV Vaccination Program Register which contains personal and HPV vaccination details about those who have had HPV vaccinations entered automatically for anyone who undergoes HPV vaccination.⁶³ The Register inducts girls into women's disciplining lifelong medical surveillance as they undergo a health intervention which foreshadows future sexual 'autonomy' based on compliance with social controls. They are enjoined to obedience and reminded of the irrelevance of female consent to actions which touch on female sexuality as their privacy and information are seized by the state. The dangers to them from cervical cancer and from them, in the discourse that they are repositories of a gendered disease, HPV, justify overriding consent to entry on the Australian HPV Vaccination Program Register or use of their health information once registered.

The purposes of the HPV Vaccination Register include 'to ensure the successful implementation of the National Human Papillomavirus (HPV) Vaccination Program.'⁶⁴ To do so, it facilitates 'an electronic database of records for monitoring vaccination of participants in the HPV Program',⁶⁵ monitoring of vaccine effectiveness by 'future cross referencing of data against Pap Smear and other cervical cytology or cervical cancer registers',⁶⁶ and sending reminders to eligible people who had not completed their vaccinations.⁶⁷ The disclosure of personal information for the purposes of the National HPV Vaccination Program Register is exempted from the normal requirements for consent to use of private information in the Australian *Privacy Act 1988* (Cth).⁶⁸ Doctors can access the records of patients without patient consent.⁶⁹ Researchers may access de-identified information for research without patient consent.⁷⁰ It is not an offence or breach of an agreement to misuse or improperly disseminate information from the HPV register (which was originally designed to only contain girls' private information), unlike for other Australian vaccination registers (designed from the start to also include males' information).⁷¹

Those entered on the Register can 'opt out' by requesting that the Commonwealth remove their personal information or the personal information of a child for whom the requestor is a parent or guardian.⁷² While, in theory, patients or parents could

63 *National Health Act 1953* [Cth], s 9BA.

64 *National Health Act 1953* [Cth], s 9BA (3).

65 *National Health Act 1953* [Cth], s 9BA (3)(a).

66 *Id.*

67 *National Health Act 1953* [Cth], s 9BA (3)(f).

68 *Health Insurance Act 1973* (Cth), s 9BA(5) *Privacy Act 1988* (Cth) Shed 1 Australian *Privacy Principle 6*.

69 *National Health Act 1953* (Cth), s 9BA(6) and (7).

70 Information for researchers requesting data from the NHVPR (2013). 1.

71 *Australian Immunisation Register Act 2015* (Cth) s 23 which creates an offence or *Health Insurance Act 1973* (Cth) now repealed s46E(2) which requires agreement to stringent conditions of use.

72 *National Health (Immunisation Program—Designated Vaccines) Determination 2012 (No.1)* Cth, s 9BA(4).

choose to opt off of the HPV register at vaccination, none of the parent, student or teacher materials for the HPV vaccination program mention the register or the ability to opt off.⁷³ If a parent wants their child to have the benefits of vaccination, there is no easy way to refuse recording of information on the Register. None of the Australian State consent forms for HPV vaccination give full details about the recording or use of information on the National HPV Vaccination Program Register.⁷⁴

Entry onto the Register and potential exposure of medical records and other private information without consent becomes the cost of HPV vaccination in Australia. When debating the *National Health (National HPV Vaccination Program Register) Bill 2007* (Cth), Alex Somlyay MP considered that a safeguard for those concerned about the gathering of private information on the Register was ‘of course choice. All vaccinations are voluntary. Good sense, yes; highly desirable, yes—but still voluntary’ (Parliamentary debates, House of Representatives, 8 August 2007). The MP’s views were echoed in the Explanatory Memorandum to the Bill, which said:

Subsection (3) paragraph (a).

Paragraph (3)(a) establishes and allows for the maintenance of an electronic database which will allow for monitoring of individuals who are vaccinated with HPV vaccine. *There is no compulsion for females to be vaccinated and participation in the HPV Program is voluntary.* Nor is there any compulsion for individuals to have their personal or vaccination details entered onto the HPV Register. [My emphasis.]⁷⁵

It is very clear that Somlyay MP and the writers of the Explanatory Memo, as well as those who design HPV vaccination program materials and consents, consider that entry on the Register is the price women must pay for vaccination. If women don’t want personal information recorded and released to doctors and researchers without the woman’s consent, they can forego the potentially lifesaving vaccine.

The symbolic sexualisation of HPV vaccine recipients through STI prophylaxis, leads to a discounting of normal consent boundaries. Until 2013 and the inclusion of

73 All but one individual Australian state’s HPV vaccination consent forms mention the National HPV Vaccination Program Register. The remaining state, Western Australia, does not mention the National HPV Vaccination Program Register on its form: Government of Western Australia Department of Health Public Health Communicable Disease Control Directorate 2013; ACT Government Health 2012; Government of South Australia, Department for Health and Aging 2012; Government of South Australia, Department for Health and Aging 2013; Northern Territory Government 2012; Queensland Government 2013; Tasmanian Government 2013; Victorian Government 2013; Victorian Government 2012; NSW Government Health 2015.

74 ACT Government Health 2012; Government of South Australia, Department for Health and Aging 2012; Government of South Australia, Department for Health and Aging 2013; Northern Territory Government 2012; Queensland Government 2013; Tasmanian Government 2013; Victorian Government 2013; Victorian Government 2012; NSW Government Health 2015; Government of Western Australia Department of Health Public Health Communicable Disease Control Directorate 2013.

75 *National Health Amendment (National HPV Vaccination Program Register) Bill 2007* Explanatory Memorandum, 5.

boys in HPV vaccination programs in Australia, the vaccine recipients were usually imagined as cervix bearers, and therefore, often, cis girls and women. The discounting of consent for women has a long history in rape culture. In rape culture tropes, a woman's consent to sex may be implied or assumed from one sexualised encounter or a woman's sexual history. Acknowledging a girl's sexuality reduces the validity of her refusals or consent. By acknowledging that a girl may not be chaste in future and may therefore need protection from HPV, she is sexualised. She demonstrates unruly and dangerous female sexuality and, therefore, her desire for privacy and consent may be discounted, either punitively or for protection against the irrationality of her desires. As a woman may be accused of 'leading on' a male partner to justify sexual assault, the HPV vaccination patient by agreeing to one act, vaccination, is taken to agree to a series of subsequent unrelated acts, like entry on the register and release of medical information.

8. Irrationality and responsabilisation

The biopolitical approach to HPV vaccination registers in Australia treats women as inherently unreliable. They are positioned as unreliable medical record keepers.⁷⁶ They are assumed unable to remember their own vaccination status, despite being adolescent or adult when undergoing vaccination, thus needing the National HPV Vaccination Register to record vaccinations. A parent or patient wanting informed consent or access to or control over her health information is constructed as irrational in the scheme of the Australian HPV vaccination and register program.

Girls' irrationality is also combatted by handing control of their bodies to parents and doctors. Parents control girls' bodies by giving or withholding consent to the vaccinations. Doctors and nurses penetrate girls' bodies with needles, initiating the lifelong expectation that women will allow medical professionals access to their bodies throughout their life (Mara 2010, 135). HPV vaccination programs encourage 'preteen girls to believe that they have no control over who (medical authorities included) can touch their bodies, whether against their will or not' (Ibid., 136). The removal of physical autonomy starting with HPV vaccines against female frailty also sends clear messages to girls about their social roles, teaching them that '[w]omen's bodies and their sexualities represent the locus of both their oppression and their liberation, for to deny women the right to make their own decisions at this most intimate level of the self is to deny them selfhood, subjectivity, and agency' (Shaw 2008, 55). The HPV vaccination programs teach recipients that their boundaries and they themselves will not be respected in a world where 'understanding that respect for a person's body is an integral part of respect for the person' (Mackenzie 2001, 420-421).

The drive to control women through external medical control and surveillance and imposition of internal self-governance becomes part of the project which

⁷⁶ Parliamentary debates, House of Representatives, 20 June 2007, 10, Bruce Billson MP; Parliamentary debates, House of Representatives, 30 October 1996.

Sheldon refers to as ‘responsibilisation’ of women (Sheldon 1993, 7). While undergoing medicalisation and social control, women are expected to control themselves, their sexual health and their health states for the good of society, while being simultaneously constructed as irresponsible and unable to understand medical nuance. HPV immunisation ‘burdens women with a commitment to good prophylactic behaviour’ (Mishra & Graham 2012, 59) which is the start of a lifetime of responsible self-monitoring of a socially constructed unruly body and sexuality, enforced via government monitoring for compliance (Id.) while men are placed in the background as protective bystanders and beneficiaries of female health monitoring (Id.).

9. Conclusion

HPV vaccination programs established at the national level in Australia acts not only to control the spread of a cancer-triggering virus, but to encode and enforce fundamentally patriarchal gendered tropes upon the recipients of the vaccine. The girls who were the original target of the vaccine program were configured as a social resource for population increase and as fundamentally irrational.

The Australian government’s HPV messaging positioned HPV as cervical cancer. This reinforces tropes of female physical inferiority and infirmity whilst encoding female sexuality and sexual health within social fears of promiscuity, disease and female abandon. The discourse of HPV as cervical cancer, rather than a cause of multiple cancers exposes men to anogenital and oropharyngeal cancers while simultaneously bolstering social tropes of the superior, strong and impervious male body by implication that only female bodies suffer dangers from HPV.

The imagined weakness of the female body becomes justification for programs of responsibilisation and control of women’s health under lifelong systems of vaccination and cervical cytology surveillance. Girls are initiated into a surveilled sexuality and health status via HPV vaccination programs which function as liminal and defining events that establish their sexuality as risky and disease-prone. Boys are encouraged by the same event to consider themselves protectors and controllers of faulty female bodies.

The HPV vaccination and recording keeping systems were designed and deployed in a culture which dismisses women’s bodily autonomy and women’s right to consent to bodily interventions and sexual acts. HPV vaccination and record keeping disregards consent to privacy violations and physical interventions, in a way that medical interventions for gender-neutral care do not. To reduce Australian gender inequality, vaccination processes and record keeping for all adult and teen vaccinations, including HPV, should be consistent and respectful of consent.

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