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"Whatever They Say I Do the Opposite": Vaccine Resistance in Turkey During the Covid-19 Pandemic

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ABSTRACT

Following a 2015 ruling in the Turkish Supreme Court, vaccine resistance has increased significantly in Turkey. Where childhood vaccination was once compulsory, it is now voluntary, enabling the transformation of Turkish lay medical culture. This medical culture rose in political importance during the COVID-19 pandemic. Yet, little is known about vaccine hesitancy and resistance in Turkey, and the interconnections with the wider political atmosphere in the country. We draw upon fieldwork conducted during the COVID-19 pandemic and explore the rationales behind people's vaccination choices. We argue that vaccines encouraged by the state offer citizens opportunities for individuation and resistance to the more generalized coercive practices of the Turkish state.

KEYWORDS

COVID-19; expertise; power; resistance; Turkey; vaccines

Why do so many Turkish people hesitate and reject vaccinations? Vaccine hesitancy is on the rise around the world; a topic that has gained more attention with the mass production and distribution of vaccines during the COVID-19 pandemic (Chaudhuri et al. 2022; Hou et al. 2021). The individual healthcare decision to be vaccinated or not is a concern for both population health and the economy, given how viral infections like SARS-COV-19 put pressure on the healthcare system and the workforce, whilst threatening human lives (Yalçın Balçık and Demir 2021). With the increasing significance of vaccines, it is important to understand the drivers of vaccine hesitancy around the world. The dominating drivers are likely to be different depending on social context, but there is "an emerging inverse relationship between vaccine sentiments and socio-economic status" (Larson et al. 2016, 295). Therefore, there is a need to look beyond education and socioeconomic status and consider which emotions, values and priorities impact individual decisions about vaccination. For instance, a recent cross-sectional longitudinal study from the UK suggests "that trust in public sector officials play a key factor in the low vaccination rates particularly seen in at-risk groups" (Chaudhuri et al. 2022, 1). This article offers an ethnographic contribution from Turkey, where there is limited research about vaccine ambivalence (Çapanoğulu 2018). Turkey also provides a compelling case study of a context where a recent history of authoritarian measures and policies may have indirectly encouraged people to refuse vaccination as a way of exerting agency against state rule.

As medical technologies with individual as well as public benefits, but with side effects mostly at the individual level, vaccines cannot easily be seen as a private or a public good in economic terms. Nikolas Rose has pointed out that in contemporary biopolitics, the state has abdicated some of the responsibilities it sought to take on through the twentieth century (Rose 2001, 6). Whereas public health infrastructure is still a matter for the state, "every citizen must now become an active partner in the drive for health, accepting their responsibility for securing their own well-being" (Rose 2001, 6). This

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Media Teaser: Why do so many Turkish people hesitate and reject vaccinations? We argue that vaccines encouraged by the state offer citizens opportunities for individuation and resistance.

responsibility comes with agency, and that agency is enacted based on whatever knowledge individual citizens trust. The success of a vaccine policy therefore relies on trust (Reich 2016): citizens' trust in medical authority and expertise; their perception of the state's intentions; and whether they believe the resulting benefits will outweigh the individual risks. The authoritarian aspects of the Turkish state are widely covered in scholarly literature (see e.g. Başer and Öztürk 2017; Navaro-Yashin 2002; Tansel 2018), and the state has a tendency to resort to coercive measures to implement policies whenever it is faced with resistance (Çalışkan 2018; Waldman and Çalışkan 2017). Despite Turkey's technocratic aspects[1], Turkish citizens' ambivalence to vaccination may stem from insecurities about the relative benefits and risks of vaccination on an individual versus a societal level ("the individual sacrificed for the collective"), as well as a penchant for assuming that politicians and businesses are motivated by other interests and intentions (some of which are conspiracy theories), or a desire for personal benefit ("they're doing this to get rich").

As we argue in this article, when it comes to vaccination policy, the Turkish state's frequent authoritarian measures have gotten in the way of trust building. This lack of trust means that when citizens are asked to become "partners in the drive for health," they do not necessarily do so in the way that the state wants. Up until a 2015 decision in the Supreme Court, the WHO childhood vaccination programme was compulsory for all Turkish children.[2] The Supreme Court then ruled that compulsion was unconstitutional, based on provisions in the European Charter of Human Rights that had been amended to the Constitution. As evidenced by the ballooning number of parents exempting their children from the vaccination programme in the years between 2015 and the COVID[3] pandemic of 2020, public health authorities struggled to achieve their goals through means other than coercion. When coercive means were taken away, there appeared to be no clear plan for how else to achieve and maintain high levels of immunity.

While the politics surrounding childhood vaccination are not the same as those of the COVID-19 pandemic, the 2021 COVID vaccination campaign needs to be understood in the context of the history of vaccination in Turkey. We use this history together with fieldwork to explore how many Turkish people relate to medical expertise and state authority. The role of trust in state authorities and medical expertise for the successful implementation of vaccination through non-coercive means is fairly similar, and some of the ways that one vaccine is resisted may serve to analyze the more general increase in vaccine hesitancy. People who decide to vaccinate use similar ethical, cultural, and political cues to arrive at a decision, but we do not assume that this decision making process is uniform or that the group is homogeneous.[4]

Here, we attend to those who hesitate, seeking to explore their expressed motivations. We see this partially as a case of resisting state power, and partially as an issue of individuals' trust in the state's benevolence toward its citizens and competency in securing their health. Drawing upon Michel Foucault, we see resistance to power as integral to its exercise, also when it comes to vaccination. We argue that it is also difficult to implement a vaccine programme that relies on citizens' trust in benign state intentions when state-citizen relations more generally are based on coercion and mistrust. If resistance to state power is severely sanctioned in fields such as freedom of expression, but not vaccination, then the latter may become a field for individuation that is otherwise near impossible. We explore the state's efforts to nationalize the vaccine produced in Turkey (Turcovac), the responses and management of vaccine hesitancy, and the navigation of trust and responsibility in vaccination discourses. We show that medical uncertainties and ambiguities impinge upon people's trust relationship with doctors, medical institutions, and the state. Moreover, in climates of reduced trust and biopolitical governance, resistance can sometimes serve the purpose of asserting sovereignty vis-à-vis the state. In other words, the Turkish state may be tripping over its own authoritarian tendencies.

Methods

This research was conducted as part of a broader project exploring antibiotic use and the regulation of medication use in Turkey, which was approved by the Norwegian Centre for Research Data (NSD) and

the Koç University Clinical Research Ethics Board. The aim of the broader project was to explore how local, cultural and temporal contexts interfere with public health policies, such as the regulation of antibiotic use. With a particular focus on the local contexts, we are here concerned with understanding the drivers and types of vaccine hesitancy. We draw on ethnographic fieldwork and participant observation in private spheres of healthcare and daily life in people's homes and their communities, and on interviews with members of the public and healthcare workers in Istanbul, Turkey, during the COVID-19 pandemic. This approach allowed us to explore not only why some people refuse vaccines, but also the general sentiments toward vaccines in the broader pandemic context, and the political, economic and moral drivers that shape Turkish society and its healthcare system.

Author 1 conducted ethnographic fieldwork in Istanbul, from October to December 2020 and from September to December 2021. The fieldwork continued online between these field visits via Zoom interviews. The research involved a variety of people from pharmacists, nurses, primary and secondary care doctors to laypeople, including individuals who accepted and refused vaccinations. Initial participants were contacted through the researcher's personal social network, including relatives, friends and colleagues, and subsequent participants were reached through snowball sampling. Participants were from middle and low-income backgrounds living mainly on the Anatolian side of Istanbul. Individuals were selected based on either their profession, such as being a healthcare worker, or for having access to and experience of the Turkish healthcare system. Public figures were generally identified online and contacted formally via e-mail. A total of 21 semi-structured, in-depth interviews were conducted, alongside dozens of unstructured conversations and email exchanges. The majority of the unstructured in-depth conversations unfolded through open-ended participant observation in daily life and social gatherings, generally in people's homes. The formal interviews lasted between 45 and 90 minutes and took place in people's homes, doctors' offices, a hospital or over Zoom. Throughout the research, priority and consideration was given to individual participants' needs as well as life and work situations, and interviews were arranged in-person or over Zoom to suit their circumstances. The interviews and conversations focused on understanding participants' daily lives and concerns; their understanding of health and healthcare; their experience with the Turkish healthcare system; their awareness and reflections on public health policies and regulations around medication use; their experience of the pandemic; and their thoughts about the COVID-19 and other vaccines. Everyone participating in a formal interview gave informed consent. All participants are anonymized unless they specifically consented to be identified by name, either because they are public figures or because they want their personal contribution to the research to be acknowledged. Where participants expressed concerns about sharing information they were reassured that the information they share is anonymised and that the interview can be stopped when they want to. This only happened once with a participant who had previously been penalized by the government for political reasons. After my reassurance, they accepted to proceed with the interview without a sound recording, which I allowed the interviewee to guide with a semi-structured interview format. All questions were answered before and after the interviews and contact details of the first author were shared for future contact should participants have further questions.

Interviews were conducted in Turkish, and digitally recorded in accordance with the NSD guidelines, unless participants did not want to be, in which case extensive notes were taken. This happened twice, once as described above, and another time because the interview took place in an informal setting outside a loud pub and the interviewee suggested a recording was not useful given the noise. The interviews were transcribed, analyzed, and translated into English to include in the research analysis and presentation. While vaccines were not the main focus of all conversations and observations for the broader research, interviews and findings that particularly involved the topic of vaccines were specifically selected for this article. Field notes and interviews were reflected on by both authors in regular intervals alongside the fieldwork, allowing to refine themes and follow-up on certain topics in ongoing observations and interviews. Legal documents, public health policies and news media were also analysed as part of the research and studied in conversation with the interviews and ethnographic observations.

Technocracy and vaccination in Turkey

Histories of vaccines in Turkey and the Ottoman Empire emphasize that variolation was brought to England from Istanbul by Lady Montague in the early eighteenth century. Having experienced smallpox as a child, she had the embassy doctor variolate her own children after having seen this practice performed by locals in Istanbul. When she returned to England, the practice was later picked up by Dr. Edward Jenner and introduced in the UK. Mass vaccination of Ottoman civilians and children more generally appears to have become established in 1846 in response to outbreaks of smallpox (Demirci 2008, 122–23), although the use of vaccination of Egyptian recruits (and boys eligible for military service) began a decade earlier (Fahmy 1997). As Tuba Demirci shows, trust in the safety of the vaccines was an issue already back in 1846. Vaccine hesitancy turns on the extent to which the individual and their family trust the state and the medical expertise that makes and administers the vaccination campaign, as well as the extent to which they consider the epidemic urgent. A complicating matter is the extent to which states engage in biopolitical practices that do not necessarily take the individual into account, but takes the population as a whole as their category of analysis and main concern (Esposito 2008). This is not purely a matter of individual interests versus those of the collective, however: decisions are also based on the meanings ascribed to vaccines in a given society and particular subgroup.

By prolonging the lives of individuals, vaccines allow states to invest more resources in each individual subject. Because their life expectancy increases, states get more "return on investment" in their education (Evered and Evered 2011, 470). This economic or biopolitical perspective not only ties vaccines to increasing the collective's productive capacities and makes possible a shift from quantity to quality as the basis of the state's strength, but it also makes fertile ground for conspiracy theories. The new Republic, established in 1923, paid particular attention to public health and the role of vaccination (Günergün 2009). Christopher Dole explains how the Turkish "state came to envision the care of its population as one of its central responsibilities" in the reforms after Turkey became a republic (2012, 37). The paternalistic approach to medicine and to commanding people is fully in evidence in the Protection of Public Health Act (*Umumî Hıfzıssıhha Kanunu*), which the Turkish Republic passed in April 1930 without debate in the General Assembly (1930). While the first chapter of the Act is mostly about the organization of the public health bureaucracy, the entire second chapter is devoted to "The Struggle with Infectious and Epidemic Diseases" (*Sari ve salgın hastalıklarla mücadele*), providing no less than 98 articles (1930). This law made very specific requirements as to when and how often citizens should be vaccinated.

Smallpox vaccines, for example, were compulsory from very early on in the republic. The law does not specify how failure to take or provide vaccines would be punished, but mentions generally that the Turkish Criminal Code stipulates particular fines and prison sentences (1930). This implementation of this law has unfortunately not been studied by historians, so we do not know to what extent people complied and what actually happened to those who did not.

Biopolitical power and resistance

The scientific authority of medicine is well suited to the frequently authoritarian paternalism of the Turkish Republic. Smallpox vaccines had been a requirement for primary school attendance in the Ottoman Empire from 1885 (Yenen 2014, 161). Starting with the *Protection of Public Health Act* (1930), Turkey made vaccination compulsory for all individuals within its borders. Turkey introduced the WHO's *Expanded Programme on Immunization* in 1980 and is among the relatively few countries to have made it compulsory. By 2013, Turkish children were subject to 13 compulsory vaccines (Haber 7 2013). The consequence is a very high degree of coverage of the population against the diseases in that programme (NTV 2018). Turkey represents a curious outlier in the OECD, as it is among the countries with the highest vaccination coverage against diseases included in the child vaccination programme such as measles and hepatitis, but among the lowest when it comes to influenza

vaccination coverage of the elderly (OECD 2015). Where the state institutes a programme and makes it mandatory, it seems to do so very efficiently, but where individual citizens are left to choose for themselves, coverage is relatively low. We see this as a good illustration of the relative success of the Turkish state when it resorts to coercion over softer means of governance.

The trend toward making citizens "partners in the drive for health" can be traced back to the neoliberal political transformations in Turkey after the 1980s. The Constitutional principles that identified equal access to healthcare and social security as a responsibility of the state since the 1960s, changed with the 1982 Constitution, which recognizes the protection of healthcare as a mutual responsibility between citizens and the state, where the responsibility of the state is reduced to overseeing public and private health organizations (Elbek and Adas 2009). Some of the goals of this reform, and of the following healthcare development plans and reforms, were to improve the healthcare profile of the population, reduce costs, and to establish a system where people have access to healthcare services based on their needs and contribute to the healthcare economy in proportion with their spending power (Elbek and Adas 2009). Furthermore, in 2003, the newly elected conservative and neoliberal Justice and Development Party (AKP) rolled out the health transformation programme (HTP), which "created a new market, a quasi-market, in healthcare provision by including private healthcare providers in the public health insurance plan and by providing incentives for the establishment of private hospitals" (Yılmaz 2017, 196). In line with this trend, the motivations of vaccine production and vaccine policy have also been shifting further away from being based on public health needs since the 1980s (Blume 2017). These changes to healthcare infrastructure and provision have helped create a healthcare landscape where the difference between citizens and customers have become increasingly blurred. With responsibility comes authority and power, and maybe what policymakers did not foresee was that as patients were given more responsibility over their health, they also acquired more authority and power in their healthcare decisions.

What Trnka and Trundle call "neoliberal modes of responsibilisation" are now widely employed in Turkey (2014, 150). These become "increasingly pervasive and powerful technologies of governance" by positioning patients as "self-governing subjects" that gain authority and power through the value of their choice, but anthropologists have shown how responsibility in healthcare is multifaceted, and more complex than a mere transactional relationship (Mol 2008; Trnka and Trundle 2014, 150). This is, however, a very different kind of responsibility than what became law in 1930, where Article 89 "charged [the father and mother of every newborn child] with fulfilling the vaccination requirement." "Modes of responsibilisation" leave much more autonomy in the provision of care, and the state does not set the same kinds of requirements. In this context, Agartan and Kuhlmann show how healthcare reforms in Turkey have gone beyond responsibilisation and have redefined relationships between patients, doctors and the state (Agartan 2019; Agartan and Kuhlmann 2019). Mol has also demonstrated how care often involves messy processes of negotiating responsibility between patients, patient relatives and doctors (2008). While neoliberal tendencies can sometimes reinforce responsibilisation and give patients more power and authority, Trnka and Trundle draw attention to how patients exist within a larger context of "competing responsibilities," especially when it comes to kinship ties (2014). However "responsible" people may be, they "exist within a matrix of dependencies, reciprocities, and obligations" (Trnka and Trundle 2014, 150). While choice can sometimes reinforce "the values of neoliberal forms of responsibility," it can also have its limits or be undercut by other responsibilities (Mol 2008; Trnka and Trundle 2014, 144). Building upon these theoretical underpinnings, we explore responsibility and authority in Turkey in the context of vaccinations "through the lenses of care relations" alongside neoliberal discourses of responsibilisation (Trnka and Trundle 2014, 137).

Vaccination is a tool of biopolitical governance, and biopolitics is among the more intensive modes of governance (Foucault 2008). We see vaccination campaigns in light of the opportunity that a government-sanctioned, but not coercively enforced, vaccination campaign offers to resist state power: "Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power" (Foucault 1978, 95). We see this in how Turks relate to vaccinating against SARS-CoV-2.

For example, Ercan, a pharmacist with training in homeopathy, refuses the vaccine because he finds it untrustworthy. During an interview in his ground floor office located at the end of his pharmacy, the first author asks him to expand on what the distrust entails:

> Ercan: *The company doesn't stand behind it (the vaccine), the authorities don't stand behind it, all the responsibility is on the patient. The form you sign before the vaccine even includes the possibility of death. They are forcing PCR tests twice a week for teachers and healthcare workers that are not vaccinated, obliging them to be vaccinated. This is against the Protection of Public Health Act in the Constitution. [. . .] They are spreading fear and testing how people respond. There are also a lot of people who die of seasonal flu, but we don't hear about those numbers. For example, the minister of health Fahrettin Koca was not political, I was following what he was saying then, but he became political.*
>
> 1st Author: *How did he become political?*
>
> Ercan: *His lies were exposed. It turns out that he knew there were COVID cases in Turkey in January, but he only revealed the first case in March. So now, whatever they say I do the opposite. They tell you to wear a mask, I don't wear a mask. . . I will not get the vaccine.*

In this example, we see that Ercan is explicitly using his autonomy to resist the Turkish state's practices, because he does not trust the state. His sentiment goes beyond vaccine opposition. Ercan is opposing "whatever they (the state) say" by choosing to not comply with the state's suggestions as a form of resistance.

Apart from the pandemic itself, the immediate context of Turkey's vaccination campaign is that in December 2015, the Turkish Supreme Court ruled that the practice of compulsory childhood vaccination was unconstitutional. According to the Court's decision, the practice violated the human right to integrity over one's own body (2015). In the wake of this ruling, the number of families exempting their children from the vaccination programme has skyrocketed. According to numbers presented at the *National Vaccine Workshop* in Ankara, Turkey's capital, in March 2018, the number of families who exempt their children was then around 13,000 (Ünveren 2018). To combat this trend, various groups mobilized in defense of compulsory vaccination, but to little effect so far. Unsurprisingly, when exemptions increased, compulsion came back on the table, as exemplified by the deputy chairman[5] of the Nationalist Movement Party's (MHP) proposition for a bill to make exempting children from vaccination punishable by two years in prison (Daily Sabah 2018). The proposal failed to get through parliament, and even if it had, it is difficult to see how it would be approved by the Supreme Court given the latter's previous ruling.

Prior to the 2015 court decision, Turkish public health authorities had little incentive to build trust with its patient-citizens, and it appears ill prepared for having to shift quickly from coercive measures to seeking voluntary compliance from citizens. In other words, it was forced into responsibilisation without preparing the grounds for it. The one source of authority, though, was not the state as such, but came in the form of the family doctor, who, as elsewhere, plays a crucial role in the provision of health. What this does is to outsource the implementation of state policy to family doctors, who are imbricated in complex networks of kinship and neighborly relations in a context of high competition over authority in matters of health, care, and medicine. As Önder (2007) has argued, there is a hierarchy in the provision of healthcare, from the mother, via the local bonesetter, through the municipal and provincial clinics, to the state hospitals in the bigger cities of Ankara and Istanbul. This picture became further complicated in Turkey after the reforms that came with the HTP, which challenged the authority of doctors, increased tensions between doctors and the state, and allowed patients more freedom of choice in how they seek clinical care (Agartan 2019). As fieldwork indicates, Americans are not alone in taking an *à la carte* approach to healthcare, with patients trying to individualize, pick and mix to "suit their needs" (for the American case, see Reich 2016). Returning to Foucault, we argue that what the Turkish state does here, perhaps unwittingly, is to shift from a coercion-intensive approach to biopolitical power in the case of public health to a partially implemented kind of governmentality, where doctors serve as the agents of the state and help citizen-patients align their interests with those of the state. *Governmentality*, as a concept introduced and

defined by Foucault, is the governance of self-governance, rule at arm's length, rather than direct coercive measures directed at the individual through discipline and compulsion (Foucault 2000 [1982], 341). This is tied to Rose's point about individual citizens being asked to become "partners in the drive for health," and Trnka and Trundle's modes of responsibilisation. Moving quickly from a coercive-intensive mode of governance to one that seeks to have citizens do as the state wants them to do *because the state has their best interests in mind*, is not a simple matter, least of all when that same state is still coercion-intensive in other political fields.

The COVID-19 pandemic and vaccine hesitancy

Turkey imported their first CoronaVac vaccines produced by the Chinese Sinovac company in late December 2020. The vaccination programme started on January 14, 2021, and starting with the 65-plus age group, in common with other countries. Increasing numbers of people were vaccinated in Turkey, and appointments began being offered to younger population from April 2021, when the state started importing Pfizer-BioNTech vaccines. People typically checked their electronic health system to see whether they are allocated a vaccine, or they received a text message or call from their family doctor. Meanwhile, local campaigns were ongoing across the country, some more organized than others. News reports showed vaccination calls on streets, announcements made from mosque speakers, public service broadcasts featuring famous public figures, and reinterpreted popular songs with "we are rolling up our sleeves" (*#kollarısıvıyoruz*) hashtags, encouraging people to take the responsibility and do their part for resuming social life. Burak, one of our informants, reports that he saw people being invited off the street into his family health clinic (ASM) in the Anatolian side of Istanbul when he went to get his vaccine. Given the scenario reminiscent of merchants in bazaars seeking to attract people's attention to their products, Burak explains how some staff members were amusingly imitating these merchants and shouting: "The German vaccine is here, come brother!" Yet, not everyone is equally comfortable with rolling up their sleeves.

Up until the COVID-19 pandemic, vaccine hesitancy was typoically no a topic that differentiated between vaccine types. The vaccine discourse changed course when it came to COVID-19 inoculations, as they soon appeared to stand apart from the rest of our repertoire of vaccines. First, when they arrived, people did not talk about "a" or "the" COVID-19 vaccine as we do with the polio, tetanus or flu vaccines. Unlike the vaccines that we have lifelong familiarity with, COVID-19 vaccine conversations soon evolved into a branding debate with displays of "vaccine snobbery," with people asking each other which brand of the vaccine they got (Larrain 2021). Many developed a taste for which COVID-19 vaccines we would *like*, whether it be the Oxford AstraZeneca, Pfizer-BioNTech, Moderna, or other. Moreover, just like the attempts to racialize the virus,[6] people also talked about, to name just a few, the Chinese, German, British, Turkish vaccines.

With the 2020 pandemic interrupting human lives worldwide, many people hoped for a herd immunity strategy that would ease social life. However, a looming atmosphere of hesitancy was already present even before the vaccine debates started. The hesitancy started with the obscurity of a virus unknown to our human bodies and experience, and it increased over the course of the pandemic with the growing amount of changing information and conflicting opinions about the virus, tests, masks, quarantine, medication, and finally the vaccine. Except in a few cases, the pandemic responses and management worldwide did not put experts and governments in a place of reliability and trust in the eyes of their citizens. The obscurity of an unknown virus caught most off-guard, including the "experts" and "leaders." It does not therefore come as a surprise that vaccine hesitancy prevails, and not only amongst people who are generally against vaccinations. Many individuals express that they want to wait longer before they get their injection to be assured of any side effects, especially after the news about sudden deaths caused by blood clots in young people associated with the Oxford AstraZeneca vaccine and numerous countries suspending and sending their stocks to other countries (Pottegård et al. 2021). As much as vaccination is about planning for the future of public health in the eyes of the state, many hesitations about being vaccinated are also about foreseeing the

future, yet on a more individual scale. Whilst governments expect their citizens to "roll up their sleeves" for the communal good, the dynamics change as soon as health enters the equation. Choosing to be vaccinated is different from voting for instance. The "logic of choice" – to use Annemarie Mol's term – does not function on its own in the consulting room, where people are more than citizens:

> If patients in the consulting room are "allowed" to become citizens insofar as this is practically possible, citizenship is established as the standard. At first, this may seem fine. [. . .] Their contract stipulates that they are masters of their own lives. However, on closer examination something seems to be missing. By definition, citizens are not troubled by their bodies. But patients are. (Mol 2008, 30)

Troubled human bodies often seek reassurance embedded in trust and care. Moreover, care in this context should not come as an addition to or prep for the vaccine, but vaccines should be delivered as care and with care: without concealing their relative unpredictability for the future (Mol 2008).

Vaccine nationalism

During mid-2020 and mid-2021, the "vaccine race" became a matter of prestige for nation-states around the world. With the media having created tables quantifying how different states were handling the pandemic in terms of cases and fatalities, there was a certain prestige attached to keeping infection rates low.[7] The crucial method of *ending* the pandemic has by and large been claimed to be vaccination, and the timelines for developing these vaccines have been compressed by accelerating the processes of development and regulatory approval. This created, if not something equivalent to a "space race," then a smaller version of it.[8] One of the first and very widely celebrated vaccines against SARS-Cov-2 was developed by a Turkish couple in Germany. While this was celebrated by Turkey, there was surprisingly little effort to appropriate the Pfizer BioNTec vaccine *as the Turkish vaccine*.[9] The mistrust toward Turkish state authorities when it comes to vaccination and biopolitical intervention sits paradoxically with some of the knee-jerk nationalism that is often on display in Turkish politics.

With "all the other" major states having at least one vaccine on the market, it is unsurprising that Turkey would also try to develop its own. The need to be in league with the greatest powers is acted out in exactly this kind of prestige project. President Recep Tayyip Erdoğan declared in June 2021 that the third development phase of the local COVID-19 vaccine had begun and that the name of the vaccine would be *Turkovac*. Turkovac, which will be inactive like Sinovac, was developed through a cooperation between Erciyes University and the Ministry of Health's Directorate for Turkish Health Institutes. In his talks, the Ministry of Health refers to the Turkovac as "our local vaccine" and characterizes inactive vaccines in the following manner:

(1) Produced using traditionalized methods.
(2) Stimulates our immune system without harming the body by dividing up the virus and rendering it inactive (BBC Türkçe).

In the first field trip in autumn 2020, there were only mentions of developing a Turkish vaccine. The second field trip a year later coincided with the third phase of the Turkovac trials being given to volunteers. When no COVID vaccines were yet available globally, some informants mentioned that they would rather get the Turkish vaccine instead of an imported one. A year later, when Turkovac was still in its trial phase, and the Pfizer vaccines were already widely administered across the world, those same individuals had already received both doses of the Pfizer vaccine. Metin had still not had his vaccine when the first author met him at the end of August 2021: "I should probably go and get the Pfizer before they only start providing the Turkish vaccine," he laughed.

While people's decisions about which vaccine to receive are influenced by a variety of factors, the authorities' use of language stressing the production of a "local" vaccine produced through

"traditional" methods are easily melding into the cultural nationalist narrative. People are highly aware of the commodification of vaccines like other medicines (Çapanoğulu 2018), and although they may not pay for these medicines themselves, their sudden distribution on a global scale magnifies how they operate within "global political, economic and medical processes" (Bell and Figert 2012, 2129–30). As Çapanoğlu's shows, the import of "foreign" childhood vaccines to be distributed in Turkey is something that attracts skepticism in and of itself (2018). She cites numerous parents who express that foreign countries have sinister plans over Turkey and other countries, stating: "Why would they otherwise line up to donate vaccines to countries where people are hungry?" (Çapanoğulu 2018). For these individuals, curing a "foreign" virus with "foreign" and novel MRNA vaccinations, rather than "traditional inactive vaccines," are easily used as reasons to support their arguments. Despite that, the local and traditional option will be more appealing to some, although it is certainly possible that there will be more like Metin who will opt for the "foreign" vaccination that is taken up in high numbers both in and outside of Turkey, which statistically provides more certainty and reliability.

Beyond a secularist/Islamist divide

Analysis of Turkish social and political matters is frequently couched in a dichotomy between secular and religious motivations. Regardless of whether one sees that dichotomy as useful, it is worthwhile pointing out that the motivations for vaccine hesitancy are not easily reducible to such categories. Few people have been as important for present-day alternative medicine in Turkey as the Ukrainian-born Uzbek Aidin Salih (1943–2014). Trained as a medical doctor in her native Ukraine, she claims that her experiences in hospitals there shaped her skeptical view of the principles of modern medicine. She went on to study biology in Uzbekistan, and, as she claims, "became a Muslim" during the years there. In an interview promoting her widely-read book *Gerçek Tip, Yitik Şifa* (*Real Medicine, Broken Cure*, 2007), she claims that:

> vaccines that are given to children hurt their bodies to a horrible degree, [because] even pig and monkey DNA are joined to the children's DNA with these vaccines, and hence the children are becoming monkeys and pigs [lit: "monkeyfying" and "piggyfying"] (Gül 2012).

One does not have to be very literate in Islamic learning to see how this is not only unhealthy, but religiously impure.[10] It is difficult to estimate the impact of this book or the public's acceptance of its claims, but three events or connections could indicate the level of Salih's reception in Turkish society.[11] The first is that the wife of the Turkish President, Emine Erdoğan, turned to one of Salih's students to be treated for a slipped disc back in 2015 (Cumhuriyet 2015). Secondly, this student, Sümerya Kılınç, became Presidential "health consultant" in 2018 (Patronlar Dünyası 2018). Finally, the *Doğal Sağlık Derneği* (Natural Health Association) has an annual conference named *Aidin Salih Ekolü* (the Aidin Salih School), and the event in March 2019 was opened by President Recep Tayyip Erdoğan's youngest daughter (KADEM 2019). Such political affiliation with the President's family should indicate, if not a *wide* readership, then at least some degree of prominence of her teachings. It may also be worth noting that the concept President Erdoğan used to legitimize the Turkovac vaccine against COVID in mid-2021, namely *geleneksel* (traditional),[12] is one that also features prominently in Salih's work, which is promoted as "the source of traditional medicine" (2007). This is not just distinctly contrasted with trends from abroad, but also in content harks back to Prophetic tradition, emphasizing the importance of fasting and prayer, as well as eating nuts, figs, dates, and honey.

In contrast with this high-level and quite clearly *tıbb-ı nebevî* (Prophetic medicine, based on the example of the Prophet Muhammed) connected rationale for resisting vaccines, in one of the very rare court cases on the issue of vaccination, the reasoning for resisting childhood vaccines was recognizable from the wider international, and perhaps "secular" trend that has become eponymous with Andrew Wakefield. In 2015, the Ordu Provincial Directorate for Family and Social Matters took the couple H. A. and V.A. to court for not giving them permission to vaccinate the couple's children. In the written

affidavit provided by the couple in their defense, they gave their reasons for resisting vaccination of their children as (2015):

> [. . .] in the vaccines that are given to children there are many substances that are harmful to the human body. These are causes of various diseases such as autism, heart diseases and hyperactive disorder [. . .]

While there may be further reasons listed in the full affidavit (which we do not have access to), and we do not know anything about the couple's "real motivations," the reasons they emphasized in court were immediately recognizable from the claims made by American and other Western vaccine resisters (Deer 2020). As such, it is worth considering Turkish vaccine hesitancy and resistance as entangled in a more globally mediatized ecology of rationales, and not easily reducible to a single "Turkish medical culture."

Healthcare à la Carte

With increasing scrutiny toward clinical medicines and pharmaceuticals, users of alternative medicine do not necessarily position themselves against clinical medicine as a whole even if they may refuse certain treatments and services such as vaccinations. Dilek is a frequent user of alternative medicine practices. She is a mother of four children (aged between 6 and 22 years old) from a low to middle income family, actively providing for her family by selling food that she cooks at home and freelance retailing cosmetic products, alongside her housework and childcare duties. All her children are fully vaccinated, except her youngest daughter, who has not been vaccinated since experiencing side-effects after receiving a combination vaccine at six months old. Melek was probably amongst the first children to opt out of the vaccination programme following the exemption granted by the Turkish Supreme Court in December 2015. There is more to Melek's vaccination story. However, we first need to look beyond Melek's vaccine experience to understand the shift in her mother Dilek's perception of vaccines and medicine.

Dilek's relationship with modern medicine and perception of healthcare started changing ten years ago, after her encounter with alternative medicine, which coincides with the recovery period after Dilek underwent a major hip replacement surgery. Dilek has hip replacements on both of her legs. After one of her surgeries, the doctors discovered that the particular series of prosthetics that Dilek received, amongst other patients, was faulty. The cobalt and chromium in the prosthetic was shedding into patients' bloodstreams, posing a high risk of possible future health complications. Patients with high levels of cobalt and chromium were told that they would need another hip replacement. Dilek was amongst them. This is when she decided to visit an alternative medicine practitioner for a leech therapy. On her next visit to the doctor, Dilek's blood work showed a reduction in the level of toxicity in her blood, and she no longer needed surgery. Her doctor told Dilek to carry on doing whatever she was doing, since when she has been receiving leech therapy every six months. She says that the enzymes secreted by the leeches did not only save her from a major high-risk surgery, but also reduced the frequency of how often she gets ill.

Fast-forward a few years to after Dilek's surgery, her daughter Melek experienced side effects after the combination vaccine she received at six-months-old. Dilek sent photos of Melek to a medical doctor friend of hers who recommended that she would need to get an MRI scan. Yet Dilek decided to also visit her alternative therapist, who, after telling Dilek off for vaccinating her child, put three baby leeches at the back of Melek's head, down toward her neck. Melek's crying fits stopped and her hand gestures improved soon afterward. She has since not received any other vaccinations and Dilek says that Melek is the least likely to get ill and quickest to recover amongst her children. Dilek still uses clinical medicine practices, but not as much as before.

Dilek is one amongst many that make use of both clinical medicine and alternative medicine. Amongst these are people who believe in the importance of vaccinations and who are being vaccinated, as well as those like Dilek who are suspicious toward vaccinations. Vaccination programmes are part of today's complex healthcare systems that "allow for many possible choices, changing

explanations, new healing methods, social criticisms of individuals' choices and actions, and ways to reject failed methods" (Önder 2007, 22). Rather than taking a side with a specific treatment method or medical ideology, individuals seek healthcare from practices and people that they trust. For instance, when asked what she seeks to trust about vaccines, Dilek replies, "First of all with vaccines, the state, states, I'm not really sure about whether they care about us or not. . .to trust the doctor, the state, all are together actually, one wants to trust all of them." Thus, her distrust towards the state is among the other things mentioned above that influence Dilek's suspicion towards vaccines.

Facing hesitancies

On June 30, 2021, a Zoom seminar titled "Why should we be vaccinated? And COVID vaccinations in Turkey" was published on one of The Turkish Medical Association (TTB)'s provincial chamber's YouTube channels (2021). The target audience being medical practitioners, the talk described the vaccination programme in Turkey compared to other countries, different vaccine types as well as types of vaccine hesitation in the public. Dr Emrah Kırımlı, a practicing family doctor and the president of The Turkish Medical Association (TTB)'s Family Medicine Branch, was one of the speakers sharing an overview of the vaccination programme on the primary care front. The first author met Dr Kırımlı in his clinic in November 2020 in Turkey, when the vaccines were still in the trial phase. In his talk, Dr Kırımlı underlines that it is *güven* (trust) that brings people to the clinic. He clarifies that around 40 million childhood vaccinations are done in family healthcare clinics (ASM) every year, which continued during the pandemic despite the reduction in healthcare appointments and visits:

> During a period when people were scared to go outside, we showed mothers that we created a safe (*güvenli*) environment in the ASMs. Since our space and staff were limited we allocated times and days (for the vaccinations).

The word *güven* in Turkish means *trust*, but that is not the only definition. As it may be clear in the above translation of the doctor's talk, *güven* is also associated with safety, alongside reliability, having faith and confidence. When talking about creating a safe space in Turkish, the word *trustworthy* (*güvenli*) is used. Thus safety, being safe with a person or in a space, is inherent to how people in Turkey understand and experience *trust* (as described in English). G*üven* is especially critical when it comes to healthcare, as people want to trust the people and space that make up the institutions they consult and visit for their health and safety. Dr Kırımlı suggests that it is this trust – gained over the years and in difficult times like a pandemic – that should be relied on when approaching people about COVID-19 vaccinations and vaccine hesitancies. He reminds us that people come to the ASM's for many different reasons, which is an opportunity to talk to them about their hesitations, which he lists as: fear of injections, abundance of information and vaccines, fear of infertility, and conspiracy theories.

At the outset, Turkey only imported the CoronaVac vaccine from China, which provides a 50% protection against illness from the virus (IHME 2021). As a result, those aged 50 years and above were able to get a third top-up dose of the Pfizer-BioNTech vaccine. Doctors admitted that it was also difficult for them to offer a vaccine whilst knowing the low percentage of efficacy, which they were also among the first to receive it as frontline workers, but they suggest it was still better than offering no protection when they had no alternatives available. This was the first time that people were being vaccinated to protect against COVID-19, and despite the clinical trials, many saw themselves as guinea pigs in a global vaccination programme. In his book *Biocapital*, Kaushik Sunder Rajan argues that biotechnologies should be understood in relation to the economic markets they are embedded within (Rajan 2006). In the situation where the vaccines we have are commercialized as biocapital (Rajan 2006), and earn pharmaceutical companies billions amidst a pandemic, some people questioned the competing priorities when their health is at stake, especially in an environment where the distinctions between patient, customer, and citizen status are blurred.

Marriage is amongst the reasons why people visit ASMs in Turkey. Couples wanting to get married need to get a marriage report issued by their family doctor before they can "qualify" for marriage. Dr Kırımlı reports that about one million weddings were expected in Turkey in 2021, meaning one million wedding reports and visits to doctors' clinic. This gives the doctors an opportunity to ask about the COVID vaccine, says Dr Kırımlı, "just like we ask parents about whether their children's childhood vaccinations are complete (when they come in for a consultation)." One of the vaccine hesitations in this particular group can be infertility, in which case Dr Kırımlı says that he cites some of the research studies suggesting that the vaccine improves sperm quality. In one case the patient not only agreed to be vaccinated but also promised to name one of his children after the doctor should they have four or five children. Dr Kırımlı tells his young visitors that they will not be able to travel abroad, the elderly that they will not be allowed to go on pilgrimage without a vaccine and he advises his vaccinated patients to pass on to their neighbors the message that nothing happened to them after the vaccine. In some cases, he says that it requires responding to conspiracy theories in the same language: where people tap into the widely known conspiracy narrative that Israel is tricking the world to be vaccinated to manipulate people's health, Dr Kırımlı chosoes to point to how Israel has vaccinated the majority of its population. What we take away from Dr Kırımlı's talk is that despite how much patients are presented as customers and/or citizens in the healthcare infrastructure with their right to pick and choose, that is not what always thrives in the consulting room. As Esra Çapanoğlu suggests, the rejection of childhood vaccinations is a complex process influenced by healthcare workers, social media, friends, religious factors, healthcare policies, laws, socioeconomic factors, and understandings of health (2018) Responding to vaccine hesitancy requires tapping into patients' daily lives, worries, priorities, and social networks. Family doctors are clearly becoming key sources of information in this process. Similarly, a study in Italy shows that the responsibility and role of general practice (GP) doctors has increased significantly during the pandemic with one in five patients referring to their GP as their main source of reference (Bucchi and Saracino 2021).

When the first author brought up the topic of people who may refuse the vaccinations with Dr Kırımlı in November 2020, before vaccinations were rolled out, he said:

> I used to feel sorry for them before but it's a liberal world and everyone lives their own freedom so, it's not my problem . . . of course I will work with my patients, some who trust my word would get their vaccine but there are those who will not get it.

Yet as Mol puts it, "microbes and liberalism do not go well together. While in liberalism every body counts for one, microbes make far wider calculations;" the longer the period of infection and bodies without antibodies the more opportunities for the virus to mutate (Mol 2008, 68). One thing that is becoming more and more apparent is that whilst governments are pushing vaccinations to predict and plan the future of collectives, individual decisions are often concerned about what the vaccine means for their personal and social lives. Hence why "Individuals and populations need completely different types of care" (Mol 2008, 70). Moreover, drivers of vaccine behavior do not solely depend on state-individual relations. Meltem, who is working at a major Turkish oil company states: "I thought everyone is eventually going to get vaccinated, so I got it. Also, the employees who do not get vaccinated at our company first get a warning, they have to get PCR tests twice a week, they then a cut in their salary, and if they still refuse to get vaccinated they get fired." She added: "I am not against vaccines by the way, I think everyone should get it." Feriha, on the other hand, fired her cleaner at home because she was against getting vaccinated. Thus there are multiple power structures and dependencies within society that enforce vaccine programmes.

Conclusion

The Turkish state has long been known for its reliance on disciplinary power. So also in the case of childhood vaccination. When the Supreme Court ruled the practice unconstitutional, it took away a tried-and-tested method that had secured some of the highest vaccination rates in the world.

Turkey, which has high rates of mandatory vaccines but very low rates of those that are voluntary, was then faced with having to use other means to get compliance and achieve "satisfactory" rates of vaccination. This became particularly pertinent during the COVID pandemic, as the vaccine offered a rare opportunity for individuals to exempt themselves from the coercive apparatus of the Turkish state. What we show in this article is that some individuals who resist vaccines use them as an opportunity to assert their sovereignty as individuals and decide for themselves. As Ercan, the pharmacist quoted earlier, phrases it: "whatever they say I do the opposite." This is by no means a universally shared sentiment, but it is indicative of how the vaccine has been politicized not because of its own characteristics, but because of what it represents – state intentions penetrating and quite literally getting under the skin of individual bodies (Kasstan 2021; Rosen et al. 2021). There have been many other issues in Turkish public that have become politicized, where citizens' preferences on an issue follow from their political position. Things like kissing on the Ankara Metro suddenly became an act of resisting state power in 2013, and during the late 1990s headscarves became symbols of resistance. These are also complicated matters and citizens' preferences cannot be reduced to being simply a negative function of state imposition. However, the state does have a tendency to politicise that which it imposes, with political opponents sometimes embracing a position they previously did not care much about. Asserting the right to draw upon their own "lay medical knowledge" or medical culture, and deciding upon health matters in an "à la carte" manner, are ways to also assert that sovereignty vis-à-vis the state. However, in contrast to Ercan, Dilek's refusal to vaccinate her children is motivated by multiple competing responsibilities, including her experiences as a patient, her responsibility as a mother, and her trust relationship with the authorities. Although we cannot generalize too broadly from these interviews, we would like to highlight this contrast between one informant who seeks to reject and resist state power and one who sees her responsibility for her children's health as autonomous from state recommendations. The lack of trust in the state's intentions, as well as the knee-jerk tendency of some to take the opposite position on almost any matter, is making it difficult for the Turkish state to transition from dominance and coercion to ruling through aligning citizens' preferences with the state's by having them internalize the values of the state. Rather than *trusting* medical advice, as sanctioned by public health authorities dispensed through the state apparatus, segments of the Turkish public use this as an opportunity to resist state dominance.

Notes

1. Technocracy in Turkey has been covered primarily in a critical manner, seeking to highlight its connections with various ideologies. The foremost example of this is Begüm Adalet's Hotels and Higways, who looked at the use of Turkey as a "laboratory" for the formulation of "development theory" in the 1950s, and the use of this theory to develop Turkey (Adalet 2018).
2. 'Zorunlu Aşı Uygulamasına İlişkin Halime Sare Aysal Kararı'. Başvuru Numarası: 2013/1789. Karar Tarihi: 11/11/2015 R.G. Tarih ve Sayı: 24/12/2015-29572. Türkiye Cumhuriyeti Anayasa Mahkemesi. https://kararlarbilgibankasi.anayasa.gov.tr/BB/2013/1789 (accessed 9.11.2022).
3. When dealing with the wider epidemic in its social and political fullness, we use the simpler and more popular label COVID, but use the more proper name "SARS-CoV-2" for the virus itself.
4. To the extent that we write about "medical culture," we see culture as a toolbox along the lines of Ann Swidler's work, and the rationales analyzed in the article as tools individuals use for making sense of vaccines and deciding how to proceed (Swindler 2003).
5. Sefer Aycan, who incidentally is also a medical doctor specializing in public health.
6. Such as the "Chinese virus" and the "Indian variant." Jérôme Viala-Gaudefroy and Dana Lindaman. 2020. "Donald Trump's 'Chinese virus:' the politics of naming" The Conversation 17 April 2020, https://theconversation.com/donald-trumps-chinese-virus-the-politics-of-naming-136,796 (accessed 28.10.2021). For pre-COVID research (see Mason 2015).
7. Compare Cooley and Snyder (2015).
8. For scientific achievement as prestige hierarchy between states, see: Musgraveand Nexon (2018).
9. The Turkish government has appropriated other German Turks qua Turks once they are successful in one field or another, with footballer Mesut Yılmaz being the best-known case.

10. Religiously founded arguments for resisting vaccination is not uniquely Muslim (Kaastan 2021).
11. The book was allegedly in its 36th print run by February 2019, see www.twitter.com/gercektip (accessed 28.10.2021).
12. The other concept he used, yerli (local), is one that is widely used together with millî (national) by the government in prestige projects and import-substitution schemes alike, and widely mocked by the opposition.

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Ethical approval

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