

# Technologies of Sexuality: The HPV Vaccine and an Investigation into Parental Responsibility, Progressive Sex-Education, and Adolescent Girls' Subjectivities

by

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Department of Sociology  
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## Abstract

This dissertation problematizes responsibility and the persistent tensions accompanying vaccines, sexual health, and sex-education in contemporary society. I connect the everyday micro-level of parents, teachers, and adolescent girls, with macro-politics of biomedicine, “good parenting,” and progressive sex-ed to understand how vaccine politics and sex-education relate to girls’ development of their own subjectivities. I argue that while parents and teachers work to be responsible to girls’ health and sexual health, their actions may not support adolescents in ways they imagined. Chapter two, using data from 28 qualitative semi-structured interviews with Canadian mothers tasked with consenting to the HPV vaccine, challenges the overly narrow binary where parents are labeled as “responsible” if they vaccinate, “irresponsible” if they do not. I find that HPV vaccine-consenting mothers follow normative conceptualizations of responsibility, aligned with HPV vaccination. Some non-HPV vaccine-consenting mothers exercised alternate responsibilities, aligned with broad efforts to manage their teens’ sexual

health and sexuality. They extend responsibility beyond cancer protection vis-à-vis vaccines to a more general responsibility for their daughters' sexual health and self-esteem. Chapter three, based on observations of four public school sex-education classrooms and interviews with Ontario teachers, shows that these sex-ed teachers deliver lessons in ways that align with key dimensions of "progressiveness" – *facts*, *choice*, and *promoting diversity*. This chapter uncovers how systems of gender, sexual, class, religious, racial, and ethnic inequalities are reproduced despite progressiveness. Chapter four, based on 19 qualitative interviews with girls (aged 11-16), outlines the patterns through which girls' subjectivities, sexual health knowledge, and thoughts on the HPV vaccine are intertwined and operate in relation to other people and larger sociocultural structures. This dissertation serves as a call to challenge and reflect on the taken-for-grantedness of biotechnical inventions, like the HPV vaccine, and progressive sex-education in contemporary society.

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# Chapter 1

## Overview

### 1. Introductions

I would like to introduce you to a few people. First, meet Beth, a 42-year-old mother of two girls. As a mother, deciding on the Human Papillomavirus (HPV) vaccine decision for her daughters was straightforward. She briefly spoke with her doctor about it, and was “pretty sure” her daughters would learn about this vaccine and about HPV during public-school health class. In general, she didn’t<sup>1</sup> give this vaccine decision much thought since she knows it is “supported institutionally,” like by schools and doctors. She believes that her daughter should have bodily autonomy, and yet her daughter had no say in this vaccine decision.

Now, Tessa, a 33-year-old mother of two daughters and a son, who have all other childhood vaccinations, but worries about the long-term impact that the HPV vaccine might have on her daughter’s fertility and reproductive abilities. Tessa feels a need to protect her daughter from HPV-vaccine-related risks, but also from cervical cancer, so has frank conversations with her daughter about the responsibilities that come with becoming sexually active, emphasizing the Pap test as one important health service.

Then, there is Mr. Onuma, a grade seven and eight homeroom health teacher who is responsible for teaching his students about health, sex-ed, sexually transmitted infections (STIs), including HPV. Mr. Onuma is a progressive and charismatic teacher. He is frank with his students about these topics because he believes that parents (especially religious parents) do not teach their kids what they need to know. His sex-ed lessons are built on facts and expert knowledge to legitimize his lessons. On the one hand, he told me that he would not answer to religious parents, but on the other hand, he makes an effort to be sensitive to the differences and inequalities among the students in his classroom.

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<sup>1</sup> While unconventional in academic writing, I use contractions throughout this dissertation to capture the spirit of how my informants spoke to me, particularly when paraphrasing them.

Lastly, meet Charlotte, an energetic 15-year-old girl who felt that the HPV vaccine decision should be hers and that she is mature enough to know that she should get this vaccine. She spoke to me about the importance of being informed and about girls' having a say in these types of decisions. However, due to her age, inadequate school-based health education, and a lack of information, she felt that her mother best made this decision.

The four people introduced above offer individual, yet, interrelated points-of-view, on the HPV vaccine, sex-education, and adolescent health, sexual health, and sexuality. With them in mind, I explore the following questions in this dissertation: *how do mothers and teachers (situated in the context of vaccine politics and controversial sex education) work to manage adolescent health, sexual health, and sexuality? How does adolescent girls' sense of self and subjectivity emerge as they think about the HPV vaccine, their health, sexual health, and sexuality?* To answer these questions, I examine the relationship between schools, families, parents, teachers, and girls as they interact with and make decisions around the HPV vaccine, health, and sexual health. I begin, in chapter two, by investigating the overly narrow binary where parents are labeled as "responsible" if they vaccinate, "irresponsible" if they do not. In this chapter, I ask, *how do mothers conceptualize their responsibility? What does that responsibility include?* I find that HPV vaccine-consenting mothers follow normative public health conceptualizations of responsibility, aligned HPV vaccination. Some non-HPV vaccine-consenting mothers exercised alternate responsibilities, aligned with broad efforts to manage their teens' sexual health and sexuality. They extend responsibility beyond cancer protection vis-à-vis vaccines to a more general responsibility for their daughters' sexual health and self-esteem. Their efforts to manage their daughters' health, sexual health, and sexuality are tied up with what they feel they are responsible for protecting, and their perceptions of how best to be responsible.

Then, in chapter three, where based on observations of four public school sex-education classrooms and interviews with Ontario teachers, I ask, *what guides their teachings and sex-ed lessons? How are they teaching students the HPV vaccine and sexual health more broadly?* I show that these sex-ed teachers deliver lessons in ways that align with key dimensions of "progressiveness" – *facts, choice, and promoting diversity*. This chapter uncovers how inequalities of gender, sexuality, class, religion, race, and ethnicity can be reproduced despite progressiveness. I argue that this progressive teaching is a form of management of health, sexual health, and sexuality, and may not support students in ways that these teachers imagine, since

their efforts may reproduce some inequalities. Lastly, chapter four is based on 19 qualitative interviews with girls (aged 11-16). In this chapter I ask, *how do girls discuss themselves, their families, mothers, schools, and teachers as they relate to conversations on the HPV vaccine, their health, sexual health, and sexuality*. In this chapter, I outline the patterns through which girls' subjectivities, sexual health knowledge, and thoughts on the HPV vaccine are intertwined and operate in relation to other people and larger sociocultural structures.

This dissertation serves as a call to challenge and reflect on the taken-for-grantedness of biotechnical inventions, like the HPV vaccine, and progressive sex-education in contemporary Canadian society. I connect the everyday micro-level of parents, teachers, and adolescent girls, with macro-politics of biomedicine, good parenting, and progressive sex-ed. I argue that while parents and teachers work to be responsible to girls' health and sexual health, their efforts may not support adolescents in ways they imagined.

## 2. Genesis of this Research

In 2012, I set out to design a research project for a funding proposal that would satisfy my interests in the relationship between medical products/technologies, bodies, sexuality, health, and women but was unsure where to begin. While writing this proposal, I brainstormed with friends, and we told stories about our own backgrounds and experiences, talking about topics like “backing” birth control pills as a way to avoid menstruating, or some of the taken-for-granted products we use in our lives like pads and tampons. We thought back to our own experiences getting our periods, with me remembering that I jumped straight to tampons since I got my period in the summer while at our summer cabin on the water. I remember using my first tampon then dancing a little jig to show my sister that I could still move uninhibited, only to learn that I had incorrectly inserted it. Later, in college, I started dating a new person, and soon after learned that the two of us had HPV. We proceeded to visit the sexual health clinic once a week to have liquid nitrogen treat our genital warts. Eventually, the public health nurse let us take the solution home with us, teaching us how to use it to treat each other. It was not until my doctorate that I even learned about the HPV vaccine.

Talking with my friends and reflecting on my own experiences, past and present, has had profound impressions on me for two reasons. First, reflecting back on my own experiences, I thought about my own (and minimal) sex-education in public school, my own embarrassment

using “feminine products” for the first time, and later the dreadful experience of having a stranger burn off genital warts, only to realize how unprepared and ill-equipped I was, and continue to be, in most stages of my life. Second, as I write this dissertation, I see people continue to have strained and confusing relationships with their own health, sexual health, and sexuality, as well as with the health of other people in their lives. I have friends tell me how frustrated they are with what they know (or don’t know), or angry about the healthcare service they receive. Friends laugh (awkwardly) and roll their eyes, telling me about the terrible sex-education they received when they were LGBTQ youth, many of who were not out at the time. Some of my friends are parents and are uncertain about their children’s health and wellbeing, particularly now that Ontario and Premier Ford has reversed former Premier Wynne’s progressive 2015 health curriculum back to a curriculum reflecting one used in the 1990s.

After studying these areas for several years now, what sticks with me the most is the relentless expectation that we as individuals have to take care of ourselves, and the unforgiving bombardments of options, expectations, and responsibilities we are faced with – whether this is about healthy food, dietary supplements, diva cups, alternate therapies, fad diets and fasting trends, or radiation treatments. Research and experts establish “best practices” and normative public health expectations of how we should all best take care of ourselves, and yet, confusion persists. In short, many of us are unsure what’s best (for ourselves, our children, our friends, students, parents etc.) even if we normatively know what is. We are unsure how to do “x”, or who should do “y”, and yet we all work to manage our own, or other people’s, health and sexual health in diverse ways. The fact that this confusion continues to exist, despite normative ideas of what is best, is grounds for investigation. With that in mind, I turn my focus to the HPV vaccine and sex-education.

### 3. Introducing the HPV Vaccine

The Human papillomavirus (HPV) is one of the most common sexually transmitted infections (STIs) in the world, with some types linked to cancers of the vagina, cervix, vulva, penis, anus, and oropharynx (Chaturvedi 2010). Some types of HPV are considered higher risk than others and can develop into cancers, such as cervical cancer. According to Sexual Health Ontario (2018), “there are more than 100 types of HPV that can spread to the genital areas. At least 13 of them can cause cancer (also known as high-risk type). Non-cancer causing types

of HPV (especially types 6 and 11) can cause anal and genital warts. Genital warts are very common and highly infectious.” The Government of Canada (2017a) estimates “that as many as 75% of sexually active men and women will have at least one anogenital HPV infection in their lifetime, but most people with healthy immune systems will eventually clear the infection from their bodies. Of those infected, only a small proportion will go on to develop cancer.” However, the Government of Canada (2017) also estimates that “1,550 women will develop cervical cancer in 2017 and that 400 will die from it”.

In 2004, an HPV vaccine was announced and recommended to be given to girls before the onset of sexual activity, marking “pre-sexual ‘girlhood’ as a new domain for vaccinating against future sexually transmitted disease” (Adams et al. 2009: 253). In Canada in 2006, a publicly funded HPV vaccine was approved and recommended for girls before the onset of sexual activity. In Ontario, the Ministry of Health and Long-Term Care initially offered the HPV vaccine through school vaccination programs at no charge to all grade eight girls, with boys able to receive the vaccine privately on demand. However, as of September 2017, all students now receive the HPV vaccine in grade seven. Each year, Ontario parents are tasked with the responsibility of consenting to the HPV vaccine for their child and receive a consent form from their local ministry of health, advising parents that the vaccine is strongly recommended and provided at no cost through Public Health.

Despite the state’s strong recommendation, HPV vaccination uptake is low in Ontario (Public Health Ontario 2017). While there are efforts to vaccinate approximately 80% of Ontario girls, uptake rates of the HPV vaccine were low in 2013, when I began this research, with only approximately only half of eligible Ontario girls vaccinated (Remes 2013). Today, we still hover around the half vaccination uptake. In Ontario, the HPV vaccine coverage goal is 90 per cent for adolescents (Government of Canada 2018) and yet, only about 60% of girls and 53% of boys are fully immunized against HPV (Public Health Ontario 2018). These alarmingly low uptake rates encouraged me to think about how protected girls, women, and youth are from HPV. If Ontario and Canada are experiencing such low uptake rates, despite efforts to increase vaccination uptake, how might adolescents be otherwise protected from HPV and cervical cancer? These figures inspired my investigation into parental responsibility in chapter two.

The introduction of the vaccine has been controversial with parents expressing safety concerns, moral concerns, questions around the necessity of administering the vaccine to such young girls, and concerns around the possibility of their daughter developing cervical cancer. Marlow et al. (2007) point out that some parents feel that choosing to approve the vaccine will give the perception of permission or consent to sexual activity for their daughters, with other groups calling the HPV vaccine a “promiscuity vaccine” (Colgrove 2006b). Ontario’s Ministry of Health and Long Term-Care have worked hard to address these concerns through online question and answer support, information clips available on YouTube, and information brochures stressing the importance of the vaccine for girls; they draw on medical experts to strongly advise parents to approve the vaccine for their grade eight daughters. Other governments have taken more aggressive strategies to promote Gardasil, such as in Texas with Governor Rick Perry, who tried to mandate the vaccine and received intense backlash (Mamo et al. 2010). This situation brought to the fore concerns about the coercive hand of the government and their role in the private sphere and individual decisions.

Marketing for the HPV vaccine varies across national contexts, but consistently shows girls as active, empowered, and ‘down-to-earth,’ ready for vaccination from this cancer-causing sexually transmitted infection (STI) (Lindén 2013). Marketing in the U.S. created the “One Less” advertising where girls state they want to be one less cervical cancer statistic (Aronowitz 2010), positioning girls as victims and as at risk of dangerous STIs, with the HPV vaccine positioned as the health product that could protect them (Wailoo et al. 2010). In Ontario, promotion of the vaccine tells parents that “love alone won’t protect your grade 8 daughter from cervical cancer” (Ontario 2009), positioning mothers as moral agents who are responsible for consenting to use of the HPV vaccine and therefore, for preventing cervical cancer. Regardless of the specific marketing campaign, mothers and girls who make the “right choice” are generally interpellated as good citizens, protecting the health of the community at large. They are positioned as “health ambassadors” linking health, sexual health, and responsible citizenry (Munro Prescott 2010).

The HPV vaccine became a technical solution to cervical cancer but was embedded in political, sociocultural, and scientific processes that erased the biological complexity of cervical cancer, downplayed female sexuality (Braun and Phoun 2010: 41) and made men’s sexuality beyond discussion (Epstein 2010). As the controversy continued, “it became clear - to physicians, public health officials, legislators, families, citizens, and girls – that the vaccine discussion ... was not



just about the vaccine per se but also about long-simmering cultural and political tensions, now inflamed by the arrival of Gardasil... Questions of trust, knowledge, and sexuality undergirded the controversy” (Wailoo et al. 2010: xi-xii).

My personal reflections on my own health, sexual health, and sexuality, and the politicized context of this vaccine inform this dissertation. Starting with the HPV vaccine as a point of entry, I aim to bring together the different actors, people, situations, and contexts that grapple with this health technology. In a way, my dissertation is like a point-of-view novel, in which each chapter is written from a point-of-view – here, mothers, teachers, and girls themselves – in order to draw out the interrelatedness of their experiences and lives.<sup>2</sup>

## 4. Theoretical Framework

In this dissertation, I follow the path of the controversy that surrounds this vaccine and the people who it is tied to. I look at the normalized, taken-for-granted, responsible, irresponsible, and biotechnical ways that mothers differently manage their daughters’ health, sexual health, and sexuality. Through observations, I work with teachers and uncover the ways in which their efforts to teach sex-education are progressive, yet can reproduce systems of oppression. I speak with girls themselves, commonly absent from this conversation, about their own thoughts on the HPV vaccine, their health, sexual health, and sexuality, discovering the contextualized and relational nature of their health knowledge and sense of self. Comprising three distinct papers, the entry point of this dissertation is the pharmaceutical biotechnology, the HPV vaccine, as well as the topic of adolescent health, sexual health, sexuality, and sex-education. I investigate the interconnectedness of multiple actors, in particular, parents, teachers, and adolescent girls. Broadly speaking, this dissertation is a story of a biotechnology, but it is also a story of health and sexual health knowledge and sex-education. This research is broadly informed by the following theoretical perspectives: Regulatory and Productive Technologies; Medicalization and Biomedicalization; Inequalities and Sex-Ed.

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<sup>2</sup> This point-of-view approach to analytically imagining this research and the connections or social organization between the actors was particularly inspired by Anne Tyler’s (1996 [1982]) novel, *Dinner at the Homesick Restaurant*. This novel is based on three siblings who recount their lives with their mother, examining how people may share the same experience or event, but experience them differently.

## 4.1. Regulatory and Productive Technologies

In this research, I see the HPV vaccine as a “technology of the gendered body” which constructs a gendered and disciplined body (Balsamo 1996), as well as a “technology of self” and a “technology of power” (Foucault 1988a). Balsamo’s (1996) work emphasizes “the ways in which gendered identities are technologically produced for material bodies” (154). She stresses the role that discourses and competing ideologies play in the construction and management of the body, and as a result, she views the body is both a product and a process: “As a product, it is the material embodiment of ethnic, racial, and gender identities, as well as a staged performance, of beauty, of health...As a process, it is a way of knowing and marking the world, as well as a way of knowing and marking a ‘self’ (3). Foucault’s (1979) work emphasizes normalizing processes, caught up in power and truth regimes, that promote self-surveillance due to a panoptical gaze. Guided by these theoretical insights, my research is part of a large body of research that investigates the normative and disciplining practices of reproductive and health technologies on bodies, lives, gender, and sexuality (for example see, Throsby 2006; Davis 2015; Oudshoorn 2003; Mamo and Fishman 2001; Rapp 2004). I view the HPV vaccine as a regulatory technology that targets girls for prevention purposes (Casper and Carpenter 2008), but which is also productive in that it plays a role in the construction of girls’ own subjectivity and sexuality. Rooting my work in these theories creates analytic space to explore the management and production of girls’ health, sexual health, and sexuality<sup>3</sup>. In a similar way, sex-education is also regulatory and can manage people. The discourses that are put forward in curricula and by teachers can shape the way adolescents think about their health, sexual health, sexuality and themselves. By starting my research focused on parents and teachers, then moving to girls’ own understandings and perceptions, my work outlines adults’ efforts to manage and be responsible for girls’ health, sexual health, and sexuality, and how this relates to girls’ own sense of self.

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<sup>3</sup> Many feminist scholars have investigated the production and management of the gendered body, self, and life across a wide range of cases and topics. Their work highlights issues such as normalization, agency, power, risk, medicalization and biomedicalization. Many scholars investigate the management and regulation of “fat” bodies and weight control. For example, see Heyes (2006), Bordo (1993), Gard (2005) and Spitzack (1990). Bartky (1988) investigates the disciplining of bodies through diets. Looking at sports, working out, and body management, see Chapman (1997), (Balsamo 1996, chapter 2).

## 4.2. Medicalization and Biomedicalization

Women's bodies have long been subjects of medicalization (Illich 1975; Oudshoorn 2003) where bodies and human life come under a “medical gaze” (Foucault 1973 in Riessman 1983). Aspects of human life, such as childbirth and sexuality, the menstrual cycle, and menopause, are treated as gender-based medical conditions and women’s bodies become subject to medical study and intervention. Medicalization, a concept studied by sociologists since the late 1960s (Conrad 2007: 4), describes a process wherein “nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (Conrad 1992: 209). It is a process advanced by social and cultural assumptions, attitudes, and beliefs. It is also driven by economic and political forces, as well as by new medications and technologies. The medicalization of bodies during the women’s reproductive health movement of the 1970s “othered” women’s health by attributing to them medical needs and attention distinct from the male body. By “othering” women’s bodies, scientists and pharmaceutical firms can develop tools and drugs for specific gendered disease and illness categories (Oudshoorn 2003). Importantly, Riessman (1983) points out the co-construction of medicalization, between physicians and women – “As women visit doctors and get symptom relief, the social causes of their problems are ignored. As doctors acknowledge women’s experience and treat their problems medically, problems are stripped of their political content...” (59). In other words, the medicalization of women’s bodies produces a paradox for women, wherein women attempt to “free themselves from the control that biological processes have had over their lives, they simultaneously have strengthened the control of a biomedical view of their experience” (Riessman 1983: 59). These insights are important in the context of my research for on the one hand, they emphasize the need to be skeptical of medical interventions into women’s health (or in my case into girls’ sexuality and adolescence), but on the other hand, to also continue health care and acknowledge women’s, girls’ and adolescents’ experiences. Riessman’s (1983) insights emphasize that women have played a role in medicalization, and are not “passive victims of medical ascendancy” (47). Moreover, while medicalization was originally aligned with the influence of medical professionals, Conrad (2007) argues that medicalization has evolved to now be promoted more by pharmaceutical, biotechnical, and insurance companies, with patients as consumers, as a major player in medicalization.

Moving past medicalization (with its analytic focus on controlling bodies), technoscientific

advances in biomedicine have resulted in the present era of biomedicalization (Clarke et al. 2003). Biomedicalization focuses on the *transformation* of bodies through technoscientific means, not just the control of bodies that occurred with medicalization. A biomedical approach focuses on the sociocultural, political, and economic contexts in which new technologies are configured. The biomedicalization of women's lives means technologies are constructive, where new individual and collective identities are constructed, such as "high-risk," through the use and acceptance of health technologies (Clarke et al. 2003). For instance, the HPV vaccine is a biomedical innovation that positions girls' bodies as potential sites of cervical cancer, where girls' bodies and sexualities are collectively situated as "at risk" (Mamo et al. 2010), with the HPV vaccine positioned as the right solution. As Wolfe (2009) points out, "Merck [-- HPV vaccine manufacturer--] facilitated the social construction of the human papillomavirus as a problem needing treatment and successfully positioned [the HPV vaccine] to be the solution to that problem" (86). By doing this, the HPV vaccine became the 'right tool' to protect girls from cervical cancer. Drawing on both medicalization and biomedicalization allows me to investigate the ways in which both the *management* and *transformation* of girls' health, sexual health, and sexuality occur. I do this by working with mothers and teachers – allowing me to focus on the dynamics of management -- and by working with adolescent girls – allowing me to understand their contextualized and relational sense of self.

### 4.3. Inequalities and Sex-Ed

In terms of health, sexual health knowledge, and sex-education, this research is deeply informed by insights and findings from critical feminist sexuality and education scholars. Sex education is a rich site where sensitive and controversial topics are discussed by teachers to young students. It can be stressful and difficult for teachers and they must familiarize themselves with the subject matter, must rethink how they relate to students, and must "continually examine their personal attitudes toward the topics covered, as well as how the students, their parents, and administration, and peers are reacting" (Levenson Gingiss and Hamilton 1989: 427). Sex education has an important place in understanding sexuality and young women's sexual experiences and identities (Fields 2008; Fine 1988; Risman and Schwartz 2002; Tolman 1994). Feminist scholars find that sex-education is structured by race and ethnicity (Ericksen and Steffan 1999; Fields 2008; Patton 1996). For example, "while middle and upper-class white youth are seen as needing intervention to help them navigate their 'normally abnormal' hormone-ridden adolescence, youth of colour

are commonly positioned as ‘at risk’ as well as a source of danger” (Patton 1996: 43). Sex education often excludes discourses on erotics (Elliot 2003) and desire, and constructs women as sexually passive by promoting discourses of victimization and danger (Fine 1988; Fine and McClelland 2006). Furthermore, sex education is also built upon heterosexism and heteronormativity, which reproduces gender and sexual inequalities (Fields 2008; Fine 1988; Fine and McClelland 2006; Tolman 1994; Hughes 1996). Garcia (2009) finds that despite efforts to protect students, sex-education puts some youth who already face multiple inequalities, such as Latina youth, at risk due to the gendered, racialized, and heterosexualizing lessons that are taught. Problematically, many sex education curricula and discourses deny “the different historical meaning [of sex and sexuality] for girls from diverse backgrounds” (Lamb 2010).

My research begins from the insights put forward by these scholars, particularly focusing on how sex-education reproduces systems of oppression and inequality. Tied to my theoretical framework on medicalization and gendered technologies, my research speaks to broader issues of the adult management of, and responsibility to, girls’ health, sexual health, and sexuality. Bringing adolescents into the conversation, and contextualizing them within their families and schools, I investigate how girls grapple with and make sense of these topics and themselves.

## 5. Overview of Dissertation

This dissertation comprises five chapters. This introductory chapter provides an overview of this project, of what is to come, and provides a brief introduction into the theoretical position of this dissertation in the wider field of sociology. Following this, chapters two through four are three distinct papers, each with their own literature review and methodological details. Chapter two has been submitted for scholarly publication and review prior to the submission of this dissertation<sup>4</sup>. This dissertation closes with a brief conclusion, outlining the key contributions of this research, some of the limitations of this research, and points to directions for future research. In what follows, I provide brief summaries of the substantive chapters that make up this dissertation.

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<sup>4</sup> At the time of submission of this dissertation, a similar but amended version of chapter two is accepted with minor revisions in *Sociology of Health and Illness*. I acknowledge this journal and their permission to use this article for this dissertation.

## 5.1. Mothers

The first paper (chapter 2) of this dissertation uses data from 28 qualitative semi-structured interviews with Canadian mothers tasked with consenting to the HPV vaccine. In this paper, I challenge the overly narrow binary where parents are labeled as “responsible” if they vaccinate, “irresponsible” if they do not. I find that HPV vaccine-consenting mothers have a normative conceptualization of responsibility aligned with this vaccine. Some non-HPV vaccine-consenting mothers exercised alternate responsibilities, aligned with broad efforts to manage their teens’ sexual health and sexuality. They extend responsibility beyond cancer protection vis-à-vis vaccines to a more general responsibility for their daughters’ sexual health and self-esteem. While medical research clearly establishes that vaccination is beneficial, I argue that non-HPV vaccine-consenting mothers may nonetheless engage in practices that could have a positive contribution to their daughters’ sexual health and well being, even if their decision to not vaccinate does not do so. By taking seriously these multiple accounts of responsibility -- that which is normative, as well as alternative — my research re-ignites conversations about the taken-for-grantedness of biotechnical interventions into the management of adolescent health, sexual health, and sexuality.

## 5.2. Teachers

The second paper (chapter 3) of this dissertation is based on ethnographic observations of public school sex-education classrooms and interviews with Ontario teachers and uncovers the complexity of teaching sex-education in Ontario, Canada. Situated in a context of controversial sex-education curriculum, multiculturalism, and student diversity, I show that these sex-ed teachers deliver lessons in ways that align with key dimensions of “progressiveness” — *facts*, *choice*, and *promoting diversity*. This chapter not only outlines how teachers *use facts*, *teach choice*, and *promote diversity*, but also uncovers the outcomes of their efforts, explicating how systems of gender, sexual, class, racial, and ethnic inequalities are reproduced, despite their efforts for progressive education. I highlight consequences of secularizing sex-ed, of employing neoliberal and rational-actor approaches to choice, and of teaching “bias-free” sex-ed. This research offers a point of reflection into progressive varieties of sex-education, reminding scholars and educators of the taken-for-granted inequalities that persist, despite best intentions.

### 5.3. Adolescent Girls

The final paper (chapter 4) of this dissertation is based on 19 qualitative interviews with girls (aged 11-17). This paper reveals the patterns through which girls' subjectivities, sexual health knowledge, and their understandings of HPV and the vaccine operate in relation to other people and larger sociocultural structures. When looking at girls' narration of the HPV vaccine, health, and sexual health, I find that other people, negotiations of independence and autonomy, and trust (as in, who girls look to) are main themes in all the interviews (see Table 1). Reading girls' narratives with these themes in mind, I find that particular types of selfhood emerged. Some girls 1) prioritize their mothers' narratives, presenting a type of "tethered self"; 2) explore enactments of agency, autonomy, and independence (although, with varied success), presenting an "autonomous self"; 3) have confidence in the accountability that is diffused between their parents, schools, and doctors -- instilling trust in these institutions gives them a sense of assurance in their stance on these topics. This is the "trusting self." This chapter is in one part a story of knowledge, health, sexual health, and sexuality, but it is also a story of subjectivity formation, testing out agency, trust, or independence. Putting these two stories together reveals the relationship between health and sexual health knowledge and girls' own narratives of self.

## 6. Methodology

This dissertation utilizes several qualitative methodological and analytic approaches in order to gain insight into the controversy around this vaccine, and to conduct research on how these actors i) manage adolescent health, sexual health, and sexuality, and ii) relate to girls' development of their own subjectivities. This dissertation draws on several data sets and engages various analytic techniques, including qualitative interviewing, ethnographic observations, grounded theory analysis (Glaser and Strauss 2006 [1967]; Charmaz 2006) and narrative analysis (Carless and Douglas 2017). These methods are only briefly introduced here since each chapter provides its methodological and analytic details.

To begin this research, I set out to interview parents on the topic of the HPV vaccine, to understand their thoughts, beliefs, and attitudes surrounding this decision. I sought to interview all parents, mothers and fathers, but it was mostly mothers who were interested in interviews or participating in this research. When I approached fathers during recruitment, they quickly referred me to their wives to set up an interview. One exclaimed, "you need to talk to my wife

about this sort of thing. I don't know about this stuff.” After interviews with mothers, I asked if their husbands might be interested in an interview as well. Most women told me that their husbands wouldn't be, or that their husband doesn't even know what the HPV vaccine is. This is likely due in part to the marketing of this vaccine, which framed it as a girl vaccine. Although, my unintentional recruitment of mothers aligns with research arguing that health decisions are usually “shouldered” by women (Salganicoff, Ranji, and Wyn 2005: 40). I did speak to four fathers, but they are not included in the analysis in this dissertation. One of the fathers I interviewed was a doctor. I interviewed him in his role as a physician as part of my larger research agenda on the HPV vaccine. However, he did speak in that interview about his thoughts on this vaccine in his role as a parent. Two other fathers were home during my interviews with mothers -- I had a chance to talk with one for 10 minutes, and the other sat in on some of the interview. The fourth father I unofficially spoke to is a divorced father who I met through snowball sampling. He did not have primary custody of his daughter, and disagreed with his wife's decision to give their daughter the HPV vaccine, yet felt he could not change the decision.

I used several recruitment strategies, including snowball sampling methods, recruitment posters, individual handbills distributed at grocery stores and shopping centers, and online recruitment through facebook, twitter and pediatrician, health, and parenting blogs. Despite extensive efforts at recruitment, finding participants was difficult. When I asked people I knew to forward information to family members who fit the inclusion criteria, many stated that they felt uncomfortable doing so because of the subject matter.

Data for the first paper (chapter 2) come from in-depth semi-structured interviews with 28 Ontario mothers with at least one daughter between sixth and twelfth grade (ages 11 through 17). Each interview lasted about one hour, was conversational, and we discussed their upcoming or recently made HPV vaccine decision. Semi-structured interviews allow for flexibility in the interview, giving the informant the opportunity to guide discussion (Lofland and Lofland 1995).

The dissertation's second paper (chapter 3) is composed of data derived from observations of four public school sex-ed classrooms from the same school district in Ontario, interviews with these teachers, as well as interviews with an additional five public school health teachers. Both female and male students in Ontario schools receive education on HPV and the HPV vaccine in several curricula and grades. When I conducted this research, grade seven and eight students



would likely learn about HPV and the HPV vaccine in health class, in grade nine and ten during physical education class, and in grade ten, during science class.

In the spring of 2015, I observed 24 classes, totaling approximately 22 hours of classroom observations. I set out to observe lessons directly related to HPV and the HPV vaccine, but this was only one small part of a larger lesson on sexually transmitted infections (STIs) and safe sex. Consequently, this chapter evolved to be about sex-education more broadly. With the HPV vaccine as an entry point into the classrooms and health lessons, I observed all of their health classes related to STIs (sexually transmitted infections). Due to the flexibility of lesson plans, I observed a broad range of topics such as naming and identifying types and transmissions of STIs, explaining reproductive anatomy, learning vaccination schedules, to lessons on poor reasons for having sexual intercourse.

Ethnographic observations have been used by some scholars (see Fields 2008) to study inequality in school-based sex-education. Using observations allowed me to closely observe teachers negotiate their lessons alongside political controversy around this vaccine and sex-education, as well as parental concerns. Being in the classrooms, and conducting follow-up interviews with these teachers, allowed me to understand what happens in the classrooms of these four teachers who each in their own way, consider themselves to be good public school sex-ed teachers. This chapter focuses on what guides teachers lessons, and the inequalities that persist in their classrooms despite their best efforts.

The final paper of this dissertation (chapter 4) is based on semi-structured interviews with 19 Ontario adolescent girls (aged 11-17; grades 7-12). During my interviews with mothers for chapter 3, several expressed interest in me speaking with their daughters, especially when I asked them what they think their daughters knew about HPV. Consequently, girls were recruited following interviews with mothers by asking mothers if their daughter would be interested in taking part in an interview. Out of the 28 mothers I had previously interviewed, not all wanted me speaking to their daughters. Some said their daughters were too busy, others had daughters who did not want to be interviewed, and some girls did not want to talk to me either. Sixteen parents were comfortable with having me speak to their children (some of the girls were siblings).

To establish rapport and to get to know the girls, it was important that I began with easy to answer questions about their lives: hobbies (music, art, sports, games), favorite subjects at school, extra-curricular activities, favorite video games/books, things to do with friends, etc. Then, interviews moved to ask girls about relationships with parents and siblings. Interviews then asked conversational questions about what girls know about HPV, then the HPV vaccine, and where they learned this information. We then discussed what they remember learning in school health class in general, then specifically about the virus and the vaccine. Overall, the interviews were relatively open, allowing girls the freedom to discuss things they wanted to. However, due to the topic of the interview itself, girls were sometimes shy when discussing these topics and needed prompts to get the conversation going. Using open-ended questions in the interviews allowed the informants free rein to use their own language and convey meanings in ways that they were comfortable with.

This research was granted ethical approval by the University of Toronto Tri-Council. Ethics approval for school-based observation was also approved by the school board that was involved. Individual written consent forms were signed by mothers for their interviews. For interviews with their daughters, both parental and girl written consent were individually obtained. For school observations, approval from the principal at each school was obtained, and then permission and written consent from teachers to observe their classes. Individual parental consent was not required for my involvement in the classroom since I was engaging observation only and was not engaging directly with or speaking with students in the classrooms. However, I did have teachers (on my behalf) distribute an information sheet to parents regarding my involvement in the classroom and the purpose of my study. Teachers also provided me with written consent for follow up interviews.

By engaging several methodological strategies across several groups of people and sites, this dissertation provides the needed breadth to individually explore these interrelated groups of people across a similar topic. While this dissertation individually explores these different actors at their everyday level across various sites, reading across these three sites “hooks up” the interrelatedness of their experiences and lives beyond the particular. This allows me to achieve the aforementioned analysis of connecting the everyday experiences of parents, teachers, and

adolescent girls, with the broader politics of biomedicine, good parenting, and progressive sex-ed.<sup>5</sup>

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<sup>5</sup> I am ever grateful to the influence that Dorothy Smith has had on my thinking and analytic way of seeing the social world. While not engaging her methods directly, this dissertation is metatheoretically inspired by her way of seeing how things are “hooked up” -- the interrelatedness of the everyday life, social relations, and social organization.

## Chapter 2

# Beyond the Responsibility Binary: Analyzing Maternal Responsibility in the HPV Vaccination Decision

### Abstract

With the HPV vaccine positioned as the “right tool” to protect girls’ health and sexual health, public discourse labels parents as “responsible” if they vaccinate, “irresponsible” if they do not. The problem with this binary, however, is that it cannot account for the full spectrum of responsibilities and social norms that parents enact in vaccine decisions. In this paper, I challenge this binary and encourage a fuller view of adolescent health, sexual health, and sexuality. Using data from qualitative semi-structured interviews with 28 Canadian mothers tasked with consenting to the HPV vaccine, this paper examines the complexity of this responsibility. I find that HPV vaccine-consenting mothers have a normative conceptualization of responsibility aligned with dominant interpretations of health. However, rather than articulating irresponsibility, some non-HPV vaccine-consenting mothers articulated alternate responsibilities, aligned with broad efforts to manage their teens’ sexual health and sexuality. They extend responsibility beyond cancer protection vis-à-vis vaccines to a more general responsibility for their daughters’ sexual health and self-esteem. In conclusion, I recommend the need for a broader public health approach to HPV, which includes, but goes beyond vaccination. Moreover, I suggest that some of these alternate responsibilities be viewed as complementary to vaccination.

# 1. Introduction

The Human papillomavirus (HPV) is one of the most common sexually transmitted infections (STIs) in the world, with some types linked to cancers of the vagina, cervix, vulva, penis, anus, and oropharynx (Chaturvedi 2010). In Canada in 2006, a publicly funded HPV vaccine was approved and recommended for girls before the onset of sexual activity. Each year, Ontario parents are tasked with the responsibility of consenting to the HPV vaccine for their child and receive a consent form from their local ministry of health, advising parents that the vaccine is strongly recommended and provided at no cost through Public Health<sup>6</sup>. Despite the state's strong recommendation, HPV vaccination uptake is low in Ontario (Public Health Ontario 2017).

Across many national contexts, the HPV vaccine has been controversial<sup>7</sup>. Some parents worry the vaccine will encourage premarital sex, calling it a promiscuity vaccine (Colgrove 2006). Other people raise questions around “family values, the role of the government, the reliability of scientific evidence, the oversight of sexuality, global equity, and trust in drug companies” (Wailoo, Livingston, Epstein, and Aronowitz: 2010: xiii). In light of controversy, the HPV vaccine has been framed in personal terms rather than political or public good arguments, as a “solution to ‘women’s health issues’,” as “a family issue,” and as a “cancer vaccine” -- a framing which was thought to help reduce stigma around STIs (Mah et al. 2011: 1853). In fact, throughout its promotion, sexualities were erased and undiscussed (Braun and Phoun 2010;

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<sup>6</sup> Given through school vaccination programs, though also available through other means such as doctor's offices, age of vaccination differs by province with boys only recently offered the vaccine as part of public funding in select provinces (See Ruryk 2015). Girls initially received this vaccine in grade eight (age 13), but as of September 2017, all students in Ontario now receive this vaccine in grade seven (age 12).

<sup>7</sup> There is of course controversy around and opposition to vaccines in general as part of a broader anti-vaccination movement. Vaccine opposition dates back to the 18<sup>th</sup> Century Victorian age, where “fear and controversy accompanied the introduction of every new vaccine” (Stein 2017: 168). Today, anti-vaccination movements are linked to misinformation, disinformation, much of which comes through social-media like Facebook and Twitter, celebrity testimonies, and bloggers (Stein 2017: 168).

There is a well-established counter-discourse of public mistrust surrounding the HPV vaccine and the science behind it. In Canada, in 2007, this became particularly evident when Maclean's (2007) magazine (a popular national magazine in Canada) published an article titled, “Our Children Are Not Guinea Pigs: Is an Upcoming Inoculation of a Generation Unnecessary and Potentially Dangerous?” and then in 2009, one titled, “Quebec's HPV ‘experiment’? One doctor questions how the province administers shots.” This 2009 article states that, “Some readers said the [2007] article helped them consider all sides of the debate over whether to administer the vaccine, at what age, in what context and with what hopes. Others condemned the story, including the federal chief public health officer, who called the suggestion that girls and women were being put at risk ‘irresponsible’” (n.p.).

Epstein 2010), and reproductive and sexual health literacy were ignored (Mamo, Nelson and Clark 2010) despite the HPV vaccine being tied up with meanings of sex, gender, sexuality, cancer, risk, and adolescence (Carpenter and Casper 2009; Casper and Carpenter 2008). In an effort to convince parents about the importance of this vaccine, “risk and protection” needed to be seen outside of the parent-child relationship, with pharmaceutical companies poised as the answer (Reich 2010: 166). For example, in Canada, public health marketing told parents that, “love alone won’t protect your grade 8 daughter from cervical cancer” (Ontario 2009), framing “parental decisions to vaccinate as the right, reasonable, and responsible choice to ‘protect’ their daughters and arm them ‘for life’ in the ongoing war against cancer” (Polzer and Knabe 2009: 869).

This type of normative public health framing and marketing creates a binary where responsible parents vaccinate their children, and irresponsible ones do not. The problem with this binary, however, is that it cannot account for the full spectrum of responsibilities and social norms that parents enact in vaccine decisions. It is therefore important that this narrow promotion of the HPV vaccine -- as the right intervention to protect girls from cervical cancer -- does not discourage a broader approach to adolescent health, sexual health, and sexuality, of which vaccination is only a part.

Based on data derived from in-depth interviews with 28 Ontario mothers, almost evenly split between those who consented to the HPV vaccine for their daughters and those who did not, I investigate the complexities of this responsibility and vaccination decision. I ask, *how do mothers conceptualize their responsibility? What does that responsibility include? What becomes visible when we pay attention to both consenting and non-consenting mothers’ narratives of responsibility?* I find that what comes into view are differential treatments of adolescent sexualities, gendered norms around “good girls” and “dangerous men,” limited conversations between parents and children, a reliance on school based sex-education, negotiated responsibilities between mothers and girls, and a lack of scientific literacy. More specifically, I find that mothers who consent to the vaccine generally conceptualize their responsibility as primarily aligned with vaccination. While enacting individual choice, they tend to place trust in experts and state recommendations. This has the effect of diffusing precisely who is responsible for girls’ health, sexual health, and sexuality between the mother, schools, and the state. In contrast, mothers who do not consent to *this* vaccine tend to have an alternative sense of

responsibility that does not begin and end with this vaccine. These mothers see their responsibility as extending beyond cancer protection vis-à-vis vaccines, to a more general responsibility for their daughters' future well-being, sexual health, and self-esteem. This comes with an intensified and individualized sense of responsibility, rooted in their own actions, yet they often attempt to share some responsibility with their daughters by asking them to be involved in the decision-making. State institutions and health care providers are as much obstacle as a resource in this latter account.

While medical research clearly establishes that vaccination is beneficial (e.g., Sweden: Herweijer et al 2016; Japan: Konno et al 2018; France: Heard et al 2016), I argue that non-HPV vaccine-consenting mothers may nonetheless engage in practices that do have a positive contribution to their daughters' sexual health and well being, even if their decision to not vaccinate does not do so. By taking seriously these multiple accounts of responsibility -- normative, as well as alternative ones — I expand the scholarly and public health conversation around the HPV vaccine and maternal responsibility beyond a focus on vaccination rates and the efficacy of disease control, to a focus on fostering adolescent health, sexual health, and sexuality more broadly. I conclude by suggesting a need for a more robust public health response to HPV, one that includes, but goes beyond, vaccination.

## 2. Background

### 2.1. “Good” Mothering and Vaccines

Showing that mothers are discursively constructed as responsible for decisions like the HPV vaccine and that this is tied to normative assumptions about good and ideal mothering is not new (see Mamo, Nelson, and Clark 2010). Much research focuses on how mothering is constructed and contested vis-à-vis health decisions, health behaviours, and risk management in a wide range of areas from breastfeeding (Faircloth 2010; Knaak 2010) to childhood vaccines like MMR (Fitzpatrick 2004; Brownlie and Howson 2005). My research does not aim to show that mothers have this gendered responsibility, but instead focuses on how they view their responsibility and what they feel responsible for when tasked with this decision.

My work is informed by Reich's (2014; 2016) insights and findings on intensive and individualist mothering/parenting and non-vaccination decisions. Her work reveals to us the

ways in which mothers' individualized vaccine decisions are at odds with public health interventions, and how they may even contribute to inequality<sup>8</sup>. We know from Reich (2014) that that neoliberal cultural frames influence US mothers who refuse state-mandated vaccines for their children. She argues that maternal vaccine choices are related to intensive mothering practices, where women individually manage their children's risk and health. Reich (2016) critically demonstrates the ways in which personalized and individualized medicine, rooted in middle-class, privileged, and affluent parenting, is part of a trend where bodies are privatized and tied up with the idea of informed choices. These mothers challenge experts and opt out of vaccines, instead choosing other means of protection as a way to demonstrate "their commitment to their children, which overrides a commitment to community responsibility and social justice" (ibid: 19). However, recent research expands our understanding of the individualized management of risk and shows that while this is common for white parents, Black and Hispanic parents and sons might consent to the HPV vaccine for more prosocial, (i.e., "social good") reasons beyond reducing individual risk to their children (Polonijo et al. 2016). This work uncovers a level of nuance in health and vaccine decision-making, revealing variance in what parents and teens feel they are being responsible for. I build from these insights, further investigating these nuances in order to bring into view the ends to which parents are, or are not, using biotechnologies, like the HPV vaccine, to enact responsibility.

## 2.2. Constructing Responsibility: Biopolitics, Technologies of Sexuality, and the HPV Vaccine as the "Right Tool"

The HPV vaccine is discursively constructed within a social and institutional context that produces normative notions of responsibility, with the HPV vaccine positioned as the "right tool" to protect at-risk girls' health and sexual health (see Fosket 2010; Clarke & Fujimura 1992 on the "right tool for the job"). Through vaccination consent, parents can participate in responsible parenting, which Charles (2013: 771) argues constructs a type of "gendered and responsible

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<sup>8</sup> Reich (2016) is right to be critical of individualist parenting, especially with health behaviours since this is usually at odds with public health initiatives. However, my goal is to understand the ways in which their alternate responsibility may also broaden how adolescent health and sexual health is conceptualized, beyond and including biotechnological interventions. I am not just interested in what parents think, but also what can be learned from these different enactments of responsibility.



citizenship” or “biological citizenship” (Rose and Novas 2005; Wehling 2011). In an era of risk calculation, anxiety, and uncertainty, parents rely on “risk assessment” to organize and manage life (Kaufman 2010:12). This occurs alongside marketing that establishes the HPV vaccine as the ideal way to be responsible and protect daughters from cancer (Polzer and Knabe 2009).

These conceptualizations of normative responsibility are entrenched in the discourse of “healthism” where health is moralized and seen as an individual’s (or mother’s) responsibility (Crawford 1980), with negative consequences for inaction (Roy 2008), such as public ridicule and shaming. Responsibilization occurs within a neoliberal context emphasizing entrepreneurial self-governance and self-care where governance operates through “regulated choices” by discrete actors rather than through state responsibility to ensure public health (Petersen and Lupton 1996; Petersen 2003: 192). Through this, individual actors are seemingly obligated to “express their agency in line with official goals” and are subjected to “penalties for error or failure to comply” (Petersen 2003:195). Through “rhetorics of choice” (Rothman 1998), individuals, like parents, are confronted with the decision to participate in medicine and health in particular ways, where citizens have a choice to vaccinate (or not), but external demands (i.e., from the state) almost require that parents accept vaccines (Rose and Blume 2003). This creates a context wherein HPV vaccination is discursively and normatively constructed as the ideal and legitimate way in which parents are expected to be responsible for their daughters’ health and sexual health.<sup>9</sup>

There is much at stake when biotechnologies like vaccination become discursively prioritized as the main intervention into their health and sexual health.<sup>10</sup> Critical researchers have long

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<sup>9</sup> The term discourses is used widely in many senses, and in this article, I draw on a loose understanding of discourse. I am not strictly Foucauldian in my use, but do view discourses as objects of knowledge and networks of speech, that produce normative frameworks of knowledge through the way in which they are structured and the way in which they are supported by institutions. Such normative frameworks identify certain “knowledge” or “truths” about something as being valid or invalid (Foucault 1981).

<sup>10</sup> As a regulatory technology, the HPV vaccine targets girls for prevention purposes (Casper and Carpenter 2008), which plays a role in the construction of sexuality. Women's bodies have long been the subject of medicalization (Illich 1975), where aspects of human life, such as childbirth and sexuality, the menstrual cycle, and menopause, are treated as gender-based medical conditions and women’s bodies become subject to medical study and intervention. Moving past medicalization (with its focus on controlling bodies), technoscientific advances in biomedicine have resulted in the present era of biomedicalization, emphasizing the transformation of bodies through technoscientific means (Clarke et al. 2003). The biomedicalization of women’s lives means technologies are constructive, where new individual and collective identities are constructed, such as “high-risk”, through the use and acceptance of health technologies (Clarke et al. 2003).

established that technologies like the HPV vaccine are embroiled within a culture of biopolitics, where women's bodies and lives are subject to regulation and medical surveillance (Carpenter and Casper 2009; Connell and Hunt 2010; Polzer and Knabe 2009). In fact, women's subjectivities, identities, and conceptualizations of their bodies and sexuality are constructed and reinforced through vaccination decisions (Polzer et al. 2014; Charles 2014). Mamo et al. (2010) argue that HPV vaccine marketing silences sexual subjectivities and "disempowers girls and women to enact their own sexual choices" (140). Carpenter and Casper (2009), find that discourses of sexuality not only shape the way we interact with technologies like the HPV vaccine, but that these technologies also shape meanings of gender and sexuality. In other words, sexuality and gender are co-constructed through how we take up and use technologies. Braun and Phoun (2010) point out that framing the HPV vaccine as a cancer vaccine and not a vaccine for STIs removed sexual activity from the conversation (54) and "made women as sexual agents invisible..." (41). Other researchers have documented the impact of health campaigns that prioritize particular interventions over sexual health literacy. For example, Gregg (2003) found that in the low-income neighbourhood Recife, Brazil, where the Papanicolaou (Pap) test was heavily promoted for cervical cancer screening, women turned to the Pap test as the main way in which to control cervical cancer, rather than look at their sexual practices, which were out of their control but also necessary for their survival.

Bringing together insights from literatures on science and technology, risk management, mothering and vaccine decision-making, my research offers unique insight into health decision-making, conversations on what constitutes responsibility, as well as the management of adolescent health, sexual health, and sexuality. By not collapsing responsibility and irresponsibility into one vaccine decision, I provide analytic space to talk about how mothers see themselves as responsible for their daughters' health, sexual health, and sexuality – which, as I will show, sometimes includes deciding to vaccinate but not always.

### 3. Methods

The data come from in-depth semi-structured interviews with 28 Ontario mothers with at least one daughter between sixth and twelfth grade (ages 11 through 17). Lasting about one hour, interviews were conversational and we discussed their upcoming or recently made HPV vaccine decision. I intended to interview mothers and fathers about their HPV vaccination decisions, but

mothers were more willing to participate. I did speak to four fathers<sup>11</sup> but they are not included in the analysis. I recruited participants through snowball sampling, recruitment posters, individual handbills, and online. I told potential informants that I wanted to talk to them about their thoughts, beliefs, and opinions on the HPV vaccine; what experiences shaped their decision; and, what they know about HPV and the vaccine. Finding participants was challenging, as this vaccine is controversial and explicitly tied to adolescent sexual behaviour. Some people who did not vaccinate their daughters (from HPV or other vaccines) did not want to participate because of previous criticisms, even after assurances of confidentiality and non-judgment.

Interviews took place between 2012 and 2015 in southern Ontario, Canada with most respondents from the Greater Toronto Area. Over this time period, themes and topics discussed in interviews remained consistent. Fifteen mothers had daughters who received the HPV vaccine, 12 had daughters who did not receive it, and one informant had one daughter receive it and two daughters who did not. For mothers with more than one child in this grade range, each child was discussed. Of the twelve who did not consent to this vaccine for their daughters, only four of them would be considered “anti-vaccination” and expressed opposition to vaccines in general during our interviews. Respondents completed a short, structured demographic form before being the interview. All mothers identified as heterosexual. Twenty-one were married, seven were single mothers who were separated, divorced, or now re-married. Seventeen mothers’ total household incomes were far above the Ontario’s median household income (\$76,510 CAD) (Statistics Canada 2015), ranging from \$100,000 to above \$200,000. Five were in the median range of \$60,000 to \$99,000, four far below the median, with several earning less than \$29,000 per year. The remaining participants chose not to disclose their income. Educationally, three mothers had high school diplomas, five had some college, eight held a Bachelor’s degree, eight held a graduate degree, and four held a professional degree. Informants were asked to self-identify their race/ethnicity. About two-thirds stated they were white/Caucasian and the other

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<sup>11</sup> One of the fathers I interviewed was a doctor. I interviewed him in his role as a physician as part of my larger research agenda on the HPV vaccine. However, he did speak in that interview about his thoughts on it as a parent. Two other fathers were home during my interviews with mothers -- I had a chance to talk with one for 10 minutes, and the other sat in on some of the interview. The fourth father I unofficially spoke to is a divorced father who I met through snowball sampling. He did not have primary custody of his daughter, and disagreed with his wife’s decision to give their daughter the HPV vaccine, yet felt he could not change the decision.

third identified as Black (Guyanese and Black African), Jewish-Mexican, First Nations (Indigenous), Finnish, Arab-Lebanese-Canadian, Filipino-Canadian, West African/Afghan, and South African. I purposefully interviewed a varied number of people by race and ethnicity, but I did not find substantive differences across their accounts in my sample and I do not present that data along those lines.

Guided by grounded theory (Glaser and Strauss [1967] 2006; Charmaz 2006), my data analysis was inductive and began by using NVivo software to open code interviews, followed by writing analytic memos. As a woman who is not a mother, I tried to remain reflexive about how my own life experiences, ideas about vaccination, and my academic training might influence my perceptions of these mothers. My analysis involved a deliberate effort to focus on mothers' points of view.

## 4. Findings

Despite being critical of a “responsible or not” binary where mothers are labeled based on vaccination behaviour, I present my findings in these conventional categories to showcase the ways in which they are unhelpful in understanding a full picture of the kinds of responsibilities and social norms that are enacted, or not, in HPV vaccine decisions.

### 4.1. “Responsible parents”: HPV vaccine-consenting mothers

A common theme in interviews with consenting mothers was the threat of cancer, with the vaccine is a way to exert some control over the risk of cancer. A typical example is Annette<sup>12</sup> (38-year-old mother of two girls who had childhood vaccinations like MMR), who saw cancer as the biggest variable in this decision. It was an obvious decision for her since the vaccine could “protect my child against something that is that, um, dangerous, health-wise.” Despite the obviousness of consenting to the HPV vaccine, she was unconvinced about other vaccines like the chicken pox vaccine (mandatory in Canada) because of the research on them. She felt that “chicken pox is not a huge risk” to healthy children, but that “the HPV vaccine is a different

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<sup>12</sup> All mothers have been assigned pseudonyms. Interview excerpts have been edited down to remove false starts, fillers, and the superfluous elements in the quotations.

thing because the health risks [of the virus] outweigh the um, well, potentially (pauses), because I don't know enough about it [HPV vaccine].”

While Annette was firm that HPV is a health issue and that the vaccine protects against cancer, her reaction to the chicken pox reveals the complicatedness of the HPV vaccine decision-making and her what this vaccine is about. Her mistrust in chicken pox vaccination research guided that vaccine decision, and yet, despite admittedly not knowing much about the HPV vaccine, Annette felt confident that the health risks of HPV outweighed any potential risks of the vaccine.

Since Annette identified cancer as the predominant risk of HPV, I asked her about the vaccine's link to sexual behaviour:

...calling it a promiscuity vaccine carries a lot of weight and taints the way people look at it. That alone is a problem. I think by the very act of saying [promiscuity], parents worry that this gives their kids the green light. They're telling their children that this is linked to sexuality instead of making it a health issue. So, they need to change that conversation, and to me, I think the conversation and the discourse around it... should be about their health, rather than what it is. Yeah, [HPV is] an STI, but [the vaccine] protects you now and later, whenever you decide to have intercourse or sexual contact. [...] And I'm not in denial. At some point my child will be sexually active, whether it's with a man, woman, sooner or later, it's going to happen. Obviously, I want her to take the appropriate precautions and practice safe sex. But you know, why not add on an additional protection?

Annette emphasizes the multiple discourses at play (cancer risk, sexuality, safe sex, technological solutions to cancer), yet consciously chooses to prioritize discourses of health and cancer, despite acknowledging “what it is.” Her stance downplays sexuality and aligns with public health framings that prioritize cancer discourses over sexuality discourses, seeing sexuality discourses as unnecessary to the conversation.

Despite Annette's downplaying of sexuality, a concern for cancer combined with a concern for sexual activity was common in consenting mothers' narratives. While some consenting mothers felt the vaccine itself posed risks, they decided these risks were justified given their concerns

about the risk of cancer or STIs. For example, Julia's (51-year-old mother of a son and daughter) concerns about cancer and "the unknown" outweigh her initial skepticism of the HPV vaccine and its necessity. Like several HPV-vaccine consenting parents, she cited Catholic morals, worrying about other people's risky sexuality as one reason to get this vaccine -- "you don't know who that person's slept with. Even if you just sleep with one person, they may have slept with 10 people. You don't know. So, just to protect her from that kind of thing." Similarly, Janelle, (46-year-old mother of two girls and one boy) who does not approve of pre-marital sex, described her thoughts on why the vaccine is needed:

[The vaccine] is just to have for when they grow up. So you know they are protected. You never know where he goes, the boy. ... It's not like they're going to do [have sex] that time [when vaccine is given]. It's for the future. You can protect them while they're in your hand, while I can decide what's good for them. For real. Later on, when she's 18, do you think I'm going to say, 'Oh before you have sex come do this [vaccine]!?' No (laughs). But while they're under my control I want to give them everything according to me. ... She's Catholic, but if she got married to him and before that he was going around, he will give it to her. So, that's the way you have to look at it. I look at it as for later on.

Julia and Janelle were among several mothers who believed their daughters' innocence was at risk from boys' premarital promiscuity, but that this risk lies in the future when their daughters become sexually active with their husbands. Their decision is tied to controlling the unknown – the unknown of cancer and "risky" people. Doing this, they aligned sexual health with risk avoidance, which could be accomplished through vaccination. They both draw on narrow ideas about gender and sexuality to justify the decision, constructing an image of female innocence, fragility, and virginal sexuality and imagines others (not her daughter) as having dangerous and threatening sexuality. This justification is important for them because it does not compromise their religious beliefs and maintains their daughters' innocence. It further allows them to be socially responsible (i.e., consenting to the HPV vaccine), religiously responsible, and accountable for her daughter's health, life, and religious obligations.

While consenting mothers occasionally mentioned having brief conversations with their daughters about this decision, such conversations were not central in their narratives. In fact, on

several occasions, these mothers told me that they assume their daughters would learn about the vaccine in school. For example, Janelle told me that they do not talk about boys and boyfriends at home “at all,” and that her daughters’ focus should be on school, studying, and good grades. Julia, who is a social worker for pregnant teens, told me that while she feels she has been “pretty open about sexual stuff” with her children in the past (having conversations about periods and condoms), she has had few recent conversations about sexuality with her daughter (aged 15) and no conversation about the vaccine, since she “think[s] they explained it a lot at school.”<sup>13</sup> This effectively passes some responsibility onto educators despite it being unclear how much, or even what, information teens are learning at school. This is especially important in contexts like Ontario, where school-based sex-education curriculum is extremely controversial, and is currently being reverted back to the 1998 version, a time when Ontario’s HPV vaccine program was not even in place<sup>14</sup>.

Beth (a 42-year-old mother of two girls) exemplifies the enactment of responsibility that is sanctioned by public health. Beth was in charge of what was, for her, a straightforward decision. Like the majority of mothers across my sample, she considered her relationship with her daughter to be open and frank, but as puberty approached, she noticed her daughter becoming shy and awkward about her body and conversations about it. Beth described her daughter as responsible, possessing emotional intelligence, and able to self-regulate some aspects of her health – such as when to take acetaminophen for headaches. Despite this, her 14-year-old daughter had no part in the HPV vaccine decision because Beth believed she would be afraid of the needle and say no. Beth expressed interest in having her daughter involved in the decision since it is her body, and yet, in the end, her daughter did not have a say. Beth talked to her doctor and did her own research about the vaccine. She expressed confusion about what exactly the

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<sup>13</sup> Schalet’s (2011) work is useful here to interpret this narrative of sexuality and sexual health. She finds that U.S. parents dramatize teen sexuality where Dutch parents normalize it. While Julia expresses openness about sexuality and sexual health, it is a dramatized and narrow view of teen sexuality premised on risk.

<sup>14</sup> In 2015, within weeks of winning a Liberal majority, Kathleen Wynne, Ontario’s first openly gay Premier, updated Ontario’s school-based sex-education curriculum to one where education is not just on sexual health, but also sexuality (see, Ontario 2015). Some parents and politicians expressed concerns over the introduction of topics like diverse families, masturbation, sexting, gender identity, and sexual orientation. In July 2018, recently elected Progressive Conservative premier, Doug Ford, announced he would revert the curriculum back to its 1998 version (Globe and Mail 2018). This raises concerns as to what content students will be learning, and to what extent.

vaccine protects against yet felt confident with her decision since “it’s supported institutionally” by doctors and schools, as mentioned elsewhere in the interview, “so obviously [it’s] a good decision because it takes a lot for something to become disseminated ... and supported in that way.”

Beth followed normative notions of responsibility (in this case, public health norms) by consenting to the vaccine and by placing trust in schools, doctors, and the state. Despite this, she had little to no conversation with her daughter about it, was unsure what her daughter knew about the vaccine, but was “pretty sure” she would have talked about it in health class at school. She wanted to raise a responsible, independent, and intelligent daughter, but did not trust her daughter with vaccine decisions, and saw only adults as able to make the right choice despite the need for girls to have autonomy over their body. This situation reveals how vaccination consent can become an end in itself for responsible mothering and for the management of adolescent health and sexual health. The difficulty of actually talking to daughters about sexuality and sexual health was masked or ameliorated by giving them the vaccine.

In summary, we learn from these HPV-vaccine consenting mothers that while they do enact responsibility (elided with public health norms) by consenting to this vaccine, some of their other actions question the scope and depth of their responsibility. For example, first, these mothers tend to erase sex and sexuality from this topic, avoid conversations with their teens on the assumption they will learn about this in school or that they do not need to know it now, and reinforce normative stereotypes about dangerous male and fragile female gender and sexuality. Second, these mothers tend to undermine adolescent autonomy with regard to this decision, despite seeing their teens as responsible and mature in other areas in life. Finally, these mothers tend to have incorrect and minimal literacy on this topic, which may be due to public marketing that downplays the biological complexity of HPV (Braun and Phuon 2010). In these ways, the mothers’ responsible HPV vaccine consent appears to be accompanied by a limited discussion of adolescent health, sexual health, and sexuality.

#### **4.2. “Irresponsible Parents”?: Non-HPV vaccine-consenting mothers**

Many non-HPV vaccine-consenting mothers (most of whose children had received other, mandatory vaccines) believed the risks of the vaccine were too high, and its preventative



potential too low even if these mothers had concerns about cancer. This organized what they felt they were responsible for in terms of their daughters' life, health, and sexual health. These mothers saw cervical cancer as fairly treatable since Canada has good screening mechanisms (i.e., Pap tests) in place. I asked these mothers if they worried about their daughters developing cervical cancer. Many responded that while that would be awful, they believed the risk did not seem large, and that cervical cancer is slow growing and treatable. For example, Tessa (33-year-old mother of two daughters and two sons) said:

My first reason that comes to mind, what are we going to do in 25 years when none of these women can have babies? [O]r they're having difficulties carrying babies to term? There's something unknown. Birth defects? I have no idea... I knew from what my doctor told me that early initiation of sexual intercourse with a boy increases the chance of cervical cancer, so one of the things you need to do is come in for regular check-ups to be tested. And that to me seems like a much more reasonable way to deal with things. If she decides to be sexually active, [I told her], you're going to go and have a Pap done with your doctor every year. You made that choice [to be sexually active], you now have to go do something you really don't like doing every year for the rest of time as far as I'm concerned.

Tessa's narrative references many themes in a short space: the need to protect her daughter's future fertility, the role of expert opinion and advice, the dangers of heterosexual sex, and gendered consequences and responsibilities for women in heterosexual sex. She also expressed skepticism with scientific research (although, could be an ignorance of vaccination science) on this vaccine, specifically the long-term effects, but a trust in other state endorsed health services like Pap tests. Refusing the HPV vaccine did not entail a mistrust of the state, writ large, but involves weighing out multiple sources of information from different state actors and deciding whom to trust<sup>15</sup>. Like other mothers, consenting or not, she wanted to best protect her daughter

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<sup>15</sup> See Brownlie and Howson (2005) for a discussion of trust and leaps of faith in MMR vaccination decision. They focus specifically on three aspects of this relational trust: "parents' personal networks, relationships with professionals, particularly issues of expertise, familiarity and governance; and parents' relationship with the government more generally" (225).

and saw “risks” in sexual activity and her decision was rooted in broad concerns about her daughter’s future, but focused on her future reproductive abilities.

Most non-HPV vaccine-consenting mothers felt a need to have conversations with their daughters, whether about the vaccine, sexuality, or sexual health more generally. Tessa admitted:

I told her that we needed to have a conversation about it, no matter how much she didn’t feel comfortable, and that it was important that she try to have that conversation with me... I needed to tell her where I was coming from and that ultimately it was her decision and either she could trust me to make the decision for her right now, or that she could make her own decision, or she could just go on believing that I was right for the rest of her life, which would be perfectly fine (laughs) with me!

I interviewed Lilly (42-year-old mother of one daughter, grade 7, aged 12) twice because she reached out to me upon changing her mind. In our first interview, she intended to have her daughter (who has all other childhood vaccines) vaccinated and saw it as the most responsible way to protect her daughter. She emailed me one year later and told me she changed her mind, deciding that her daughter should decide:

[I came to the] realization that she’s going to have to be the one to protect herself, not me. I’m not going to be in the room with her when she’s having sex with someone. Right? I’ve come to more of a realization that other indirect things are going to protect her more. Making sure she’s got a good self-esteem and good self-confidence.

Lilly did not want her daughter to be dependent on her but instead be responsible for herself. Striving to position her daughter as a sexual subject with agency, Lilly worked to increase her daughter’s self-esteem and responsibility through other means, such as conversations with her and encouraging extra-curricular activities. Lilly’s sentiment was common among non-consenting mothers, and depended on concerted (Lareau 2011) and intensive (Hays 1996)

middle-class ways of thinking about child rearing and responsibility<sup>16</sup>. These mothers did not want the role of primary protectors and controllers of health and sexual health, but rather the role of being accountable for creating responsible daughters able to protect themselves. In Lilly's case, when faced with the HPV vaccine decision, she contemplated *what* needs protecting and how she and her daughter might accomplish this:

...if it gets to the point where [she] starts having a boyfriend or starts you know, seeming like she's spending time alone with a boy, my big thing is like, ok, to have sex with someone you have to have the confidence to be naked in front of someone. That's when you know you're ready for sex when, you have the confidence to be naked in front of somebody... You have the confidence to go to the drug store to buy condoms... You have the confidence to ask someone to put on a condom. If you don't have those things, you're not ready. So, whenever people talk about when kids are ready for sex... they always say, 'oh if it's someone who loves you.' That has nothing to do with it! (laughs). You're ready when you have the tools to protect yourself against getting pregnant or getting an STI.

The HPV vaccine decision prompted Lilly to think about her daughter's health, sexual health, and life more broadly. In many ways, this can be seen as "responsible" in terms of sex-education and fostering her daughter's sexual health. Yet, these efforts may be deemed as "irresponsible" by normative public health standards since they are at odds with community protection at large.

Many mothers across the sample (consenting or not) described their daughters as responsible and mature. These mothers, like consenting mother Beth above, emphasized the work they do to instill a general independence in their daughters, yet they still made this health decision for their daughters. Non-consenting mothers in my sample usually worked hard to avoid undermining their daughters' bodily autonomy in the vaccination decision, "[b]ecause at that point, it's her

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<sup>16</sup> Reich's (2014) research highlights that these elite neoliberal and intensive mothering strategies that are invoked in vaccine refusal are premised on choice. Under "the guise of good mothering," these "choices" reproduce privilege and inequality.

body and if she decided for whatever reason she wanted to do it, to be safe, then I wouldn't take that away from her" (Ashley 45-year-old mother of a daughter and son). Non-consenting mothers expressed a desire to give teens a sense of control over and responsibility for their own bodies and health. Ruth (53-year-old mother of daughter and son, who is anti-vaccination in general) expresses this sentiment:

I think it's naive to think that your lovely daughter isn't going to participate in pre-marital sex as much as you don't want them to. At 18, there's not much you can do or say, or even younger. You [just] keep educating and hope they make the right choices, but in the end, they're going to make the choice. And that's how I put it to my daughter. I'm well aware what you guys are doing. But let's talk about respect and the responsibility that goes with that. [...] And my daughter and her boyfriend, we didn't discuss sexual diseases as such, but [we did discuss] the whole relationship and how you handle it. You don't just go with every guy. And [her current boyfriend] comes from a strong value base too. Even though she's very young, I'm not thinking they're going to get married, but her choice [in boyfriend] made me feel so much more comfortable in terms of letting her go because she's making wise decisions. I would be more inclined to make sure they use a condom and practice safe sex.

Ruth acknowledges her daughter's inevitable sexuality, emphasizing the type of sexual responsibility she wants her daughter to develop. This comes off as laden with classed or religious morals, however, since she sees sexual responsibility involves activities with only particular men who have strong values, and emphasizes not engaging in activities with multiple men. Ruth is happy to let go of control over her daughter's decisions because she views her daughter as making wise decisions since she chose a boyfriend with strong values (both are from Mennonite families), but she emphasizes the extra monitoring work this type of mothering requires. She takes on this responsibility and also shifts responsibility by employing a child-centered focus to help her daughter set boundaries. In doing so, she gives her daughter the illusion of freedom and responsibility (when her daughter is making decisions she agrees with) while engaging in significant surveillance.

Carolyn's (44-year-old mother of four girls) daughters took the initiative around the vaccination decision, but Carolyn required them to make an informed decision and talk to her about it first. Two of them (aged 18 and 16) did not receive the vaccine, and one did (aged 13)<sup>17</sup>. All three of her daughters initially said no to the vaccine, but on vaccination day, her 13-year-old decided she wanted it, requiring Carolyn go last minute to her daughter's school and have office-administrators find a permission form. When I asked Carolyn why her daughter changed her mind, she told me:

[My daughter] said, 'well, what happens if I get attacked, what happens if I get raped?' I said, 'that is one of the reasons for getting the vaccine. Are you planning on being sexually active?' She said, 'NO! It's for the other reason!' But I think she also said she doesn't know what will happen in the future. And that was ok for me, to change her mind about that... She's not planning on being sexually active, but her rationale for changing her mind was she says, 'but what if I get raped?' For her, ostensibly it's a safety reason. She doesn't even like kissing on TV.

Her daughter's explanation echoes narratives put forward by consenting mothers -- that girls need protection from predatory males. It also emphasizes the intricacies of mother-daughter communication on this topic -- expressing interest in the vaccine might reveal girls' sexual activity to their parents. In this case, her daughter draws on rape narratives to justify why she might need a vaccine. Moreover, Carolyn still drew on gendered ideas of responsibility to justify her and her daughters' actions:

If the child is opposed to it, that should factor into the conversation. I don't think children are these non-entities without an ability to act. Certainly, adults have more knowledge, but I think kids have the ability to make decisions too... What you're trying to do is protect your daughter from negative consequences from their impulsive actions. And kids, especially adolescents, can't think through

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<sup>17</sup> The decision was not yet relevant to her 10 year-old daughter.

everything when they're in the middle of doing. And so part of your responsibility as a parent is both to help them set limits and also to help them stay safe.

Especially for girls, the negative consequences of sexual activities are so far reaching and long lasting. It's just not the same for boys.

Carolyn's strategy for negotiating who is responsible and for what is organized by her belief that (a) teens require parents to help set limits and to learn self-responsibility and (b) that girls are more sexually "at risk" than boys, which denies HPV-related risks such as anal, throat, and penile cancer, particular for gay boys and men. Carolyn did not go into detail about how she would prepare her daughters to make these decisions, but felt comfortable letting them take responsibility because she knew their character, believing her eldest, for example, would not be sexually active without "careful consideration and due process," and even then, probably not until she was married<sup>18</sup>.

In summary, looking closely at these narratives from non-HPV vaccine-consenting mothers brings some surprising, and contradictory things into view. From a public health and normative perspective, non-consenting mothers are not acting responsibly. However, these mothers do many different things to safeguard their children's health and sexual health. First, these mothers appear to have more conversations with their daughters about sexual health, relationships, and sexuality than mothers who consent to the vaccine. Second, they work to instill their daughters with a sense of autonomy and control, mostly to ensure they become self-confident and responsible adults. For these mothers, this process begins by having their children involved in the vaccine decision, but they also strive to teach them the importance of other health interventions like Pap tests, safe-sex in general, and condom use. However, just as with consenting moms, there are concerns. Some of these mothers draw upon narrow ideas about gender and sexuality, particularly around the female fragility and reproductive health. Some tie positive sexual health practices to narrow moral codes. Many non-consenting mothers express the desire to give their teens autonomy, but these mothers' accounts suggest that this autonomy also has its limits.

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<sup>18</sup> Relying on their knowledge of their daughters or their maternal instinct was common. "Knowing" daughters' character is an aspect of "maternal thinking" (Ruddick 1982) where caregivers apply intimate knowledge they have gained of the individual. Some mothers were comfortable with their daughters not receiving the HPV vaccine because they felt confident their daughters would be responsible because of their character as well as their efforts as mothers.

## 5. Discussion and Conclusion

The clear distinction between “responsibility” and “irresponsibility” becomes messy when looking in-depth at mothers’ narratives on the HPV vaccine decision. Mothers’ narratives disrupt normative public health discourses of responsibility, showing that the HPV vaccine is seen as one decision among others at the intersection of a complex network of sexuality, health, and sexual health. My data show that when tasked with the HPV vaccine decision, all mothers acted in ways they felt were responsible, which required they think about whom and what they are responsible and accountable for. This negotiation sometimes aligned with vaccination and other times, aligned with alternative practices and strategies that mothers thought would better foster, sexual health and responsible teens.

For consenting mothers, the HPV vaccine largely operated as a means to an end in terms of responsibility, disseminated between mothers, schools, and the state. These mothers, for a few reasons, generally forwent conversations with their teens – in some cases, conversations were deemed unnecessary due to expectations of abstinence; in other cases, mothers felt confident that their daughters already knew, or would come to know, about these topics from school. In contrast, for non-HPV vaccine-consenting mothers, this responsibility was firmly theirs, in part due to their dismissal of state recommendations. While they took on responsibility, they also expressed the desire to foster responsible daughters, which seemed to depend on a broad plan for managing sexuality, health, and sexual health. In some ways, these mothers engaged in responsible behaviours by seeing the scope of their daughters’ sexual health as not beginning and ending with a vaccine, speaking directly with their teens, and giving their daughters some autonomy and involvement in the decision. These alternate responsibilities, however, often problematically reinforced normative ideas about female and male heterosexuality, and their individual health management actions were at odds with community health, population health, and social justice initiatives (see Reich 2016).

These findings point to the need to consider how parents, girls, and public health see and approach health, sexual health, and sexuality. I propose that we can learn something from these non-vaccination narratives, particularly about how parents see themselves as being responsible, whether this aligns with public health approaches, and/or whether this involves speaking to children about this decision, fostering autonomy, and promoting sexual literacy. However, these

“alternate” enactments of responsibility should be considered complementary to vaccination, and not be seen as at odds with biomedical interventions.

In conclusion, I recommend that public health approaches to HPV, or other similar areas, broaden their view of intervention and prevention to one that not only recommends, but also goes beyond, vaccination. For example, public health may want to reconsider and emphasize the role of sexual health and sexual literacy for adolescents and parents. Relatedly, despite the vaccine now being offered to boys, it is also important to realize that for all the mothers I spoke with, regardless of their decision, there was little to no discussion of the responsibility of boys to be vaccinated -- either to prevent sexual transmission of HPV or to protect themselves against HPV-related cancer -- even for mothers who had sons. There was little to no discussion of sex beyond the risk of untrustworthy partners and the gendered responsibility to protect against it. The discussion of non-heteronormative sexuality was also largely absent and no one spoke of the prevention of anal, throat, or penile cancer. This is particularly important given that many people, who are at a higher risk for cancer and who may be less likely to access the HPV vaccine, are made invisible due to a “one-size model to cancer risk” (Mamo, Nelson, and Clark 2010: 140; Epstein 2010).

Public health should also take seriously the reality that there is a dissemination of responsibility between parents, the state, and schools. Adolescents may not actually be receiving education on these topics. For example, with recent controversy over sex-education in public schools in Ontario, and with some parents assuming their children will learn these topics at school, it is unclear where and what adolescents are learning about this topic.

Future social scientific research into vaccines in general should be conscious of responsibility binaries and reflect on what is epistemologically visible to them in how they conceptualize and categorize responsibility. In other words, they should be conscious of and reflect on what becomes lost with the prioritization of biotechnical interventions. Future research should also consider the inclusion of children in health decisions, an understudied topic needing further investigation. Most research related to this topic discusses doctor-parent-child communication opportunities (see Tate and Meeuwesen 2001), ethical tensions between parents, the state, and the child (Wadlington 1994), or advocates for rethinking the intergenerational division of labour in health decisions, arguing that children can be health care actors (Mayall 1998). This literature



predominantly debates the best and most “appropriate” amount of involvement, but does not necessarily focus on the actual attempts for involvement. Future research should investigate the ways girls themselves, whether HPV vaccinated or not, understand the role they have in their health, sexual health, and sexuality and what they see themselves as being responsible for. If youth have not received the HPV vaccine, what health, sexual health, and sexuality resources can they, and are they, expected to draw upon?

## Chapter 3

# “All I do is present what is given to us as the facts”: Progressive Sex-Education and the Reproduction of Inequality in Public School Classrooms

## Abstract

In the context of controversial sex-education curriculum, multiculturalism, and student diversity, this research analyzes the complexity of teaching sex-education in Ontario, Canada. Based on observations of four public school sex-education classes and interviews with Ontario teachers, I show that these sex-ed teachers deliver lessons in ways that align with key dimensions of “progressiveness” – *facts*, *choice*, and *promoting diversity* – as defined in the literature. This article not only outlines how teachers *use* facts, *teach* choice, and *promote* diversity, but also uncovers the outcomes of their efforts, explicating how systems of gender, sexual, class, racial, and ethnic inequalities are reproduced in their efforts towards progressive education. I highlight consequences of secularizing sex-ed, of employing neoliberal and rational-actor approaches to choice, and of teaching “bias-free” and decontextualized sex-ed. This research offers a point of reflection into progressive varieties of sex-education, reminding scholars and educators of the taken-for-granted inequalities that persist, despite best intentions.

## 1. Introduction

In 2015, Ontario’s first openly gay Premier, Kathleen Wynne, updated Ontario’s school-based sex-education (hereafter, sex-ed) curriculum to one where education is not just on sexual health, but also sexuality (see, Ontario 2015). Some parents and politicians expressed concerns over the introduction of topics like diverse families, masturbation, sexting, gender identity, and sexual orientation. Reigniting “culture wars” (see Irvine 2000; Lesko 2010) and old debates (See Zimmerman 2015 for a historical account of debates), where abstinence only and comprehensive sexuality education are placed in opposition to one another despite similarities, the new

curriculum sparked outrage among many Ontario parents and Conservative politicians. It incited moral and religious panic in parents about their children's "innocence," and after months of protests (which continue to occur), many concerned Ontario parents kept their children home from school in September 2015 because they did not want their children learning about topics such as same-sex relationships and gender identity. Some schools reported as many as half their students absent (Toronto Star 2015a) and as a result, had to "surplus" their health teachers (meaning that they no longer had work at that current school) due to low student enrolment (Toronto Star 2015b).

Teachers, tasked with carrying out sex-ed curriculum, are on the front lines of curriculum changes and sex-ed debates. While the Ontario government sets the curriculum, school boards are responsible for its implementation, and "teachers plan the units of study, develop a variety of teaching approaches, and select appropriate resources to address the curriculum expectations, taking into account the needs and abilities of the students in their classes" (EduGAINS n.d.: 1). Ontario is Canada's most populated province, and receives about 43% of Canadian immigrants (Statistics Canada 2016). In a highly diverse and multicultural context like Ontario, teachers must navigate official curriculum, personal beliefs and opinions, parental concerns and objections, and importantly, they are formally responsible for educating young people on this important topic. And yet, sex-educators continuously encounter hostility "at community, state, and federal levels... [and] face formidable obstacles to enriching and improving [teaching] practice" (Bay-Cheng 2003: 63-4).

In this paper, I present my observations from several Ontario sex-ed classrooms where I observed and explored teachers' lessons, goals, and reflections on their work. I worked with teachers in Spring 2015, right on the cusp of this curriculum update, a time when teachers' current lessons were under scrutiny, and they were beginning to think about formally transitioning out of the former curriculum into this new one. I ask, *what guides their teachings and sex-ed lessons? How are they teaching students about the HPV vaccine and sexual health more broadly?* My observations and interviews show that in general, these Ontario sex-ed teachers deliver their lessons in ways that align with key dimensions of "progressiveness" – *facts, choice, and promoting diversity* – as defined in the literature. I not only show how they *use* facts, *teach* choice, and *promote* diversity, but I also highlight the possible impacts of these approaches, outlining how they reproduce systems of inequality within progressive approaches.

A lot of previous literature on sex-ed focuses on how non-progressive sex-ed reproduces inequality, and tends to uphold varieties of progressive sex-education as one solution to this. Building from critical work by scholars like Rassumssen (2010) and Lamb (2010; 2013), my findings offer an important intervention into the literature by contextualizing and highlighting the ways these Ontario teachers go about educating their students, while also revealing the consequences and biases in some of their efforts. By critically examining progressive sex-ed, I do not mean to suggest a re-adoption of conservative sex-ed. Instead, my findings offer a point of contextualized reflection that can be used to not only develop, change, or refine *how* sex-ed is taught, but which also reveals the micro ways in which systems of racial, ethnic, classed, and sexual inequality can be upheld and reproduced in progressive education. Below, I situate my research in literature on inequality in sex-education, and critically look at what constitutes progressive sex-ed.

## 2. Sex-ed, Inequality, and Progressiveness

In the context of debates over sex-ed and policies, reports, and curricula promoting best practices, multiple forms of inequality persist despite many sex educators' best efforts. My research is part of a vast literature that looks at the ways in which education reproduces inequality. Often focused on the U.S. context, many scholars find that sex-ed is based on heterosexism and heteronormativity, which reproduces gender and sexual inequalities (Fields 2008; Fine 1988; Fine and McClelland 2006; Tolman 1994; Hughes 1996), as well as "essentialized notions of adolescence and sexuality" (Bay-Cheng 2003: 64). Women are most frequently constructed as sexually passive by promoting discourses of victimization and danger (Fine 1988; Fine and McClelland 2006). Sex-education curricula "reflect evolving ideas about gender, race, social class, and childhood as well as about sexuality" (Nelson and Martin 2004: 2), and are structured by race and ethnicity (Erickson and Steffan 1999; Fields 2008; Patton 1996). In sexual health education, purity is often associated with whiteness (Fields 2008), where "middle and upper-class white youth are seen as needing intervention to help them navigate their 'normally abnormal' hormone-ridden adolescence, [and where] youth of color are commonly positioned as 'at risk' as well as a source of danger" (Patton 1996: 43). Garcia (2009) finds that despite efforts to protect and help students, sex-education puts some youth who already face multiple inequalities, such as Latina and Latino youth, at risk due to the gendered, radicalized, and heterosexualizing lessons that are taught. The implications of these inequalities are serious

leading Connell and Elliott (2009) to remind us that, “the racist, classist, sexist, and heterosexist hidden curricula of schools have a significant impact on children’s life outcomes and senses of self” (90).

Much of this critical research on sex-education tends to focus on the inequalities that are produced in more conservative or abstinence only until marriage (AOUM) approaches, leading some scholars to advocate for progressive sex-education. “Progressive education,” developed in contrast to traditional education, is a pedagogical movement from the late nineteenth century that is historically contingent and reflects social, political, and economic climates, making a specific definition difficult (Kliebard 1986). It is commonly associated with John Dewey, and despite the varieties of progressive education, they all “share the conviction that democracy means active participation by all citizens in social, political and economic decisions that will affect their lives” (Dewey Project 2012: n.p.).

Post-WWII, sex-education became an exemplary subject to enact progressive education. In the 1950s, Swedish sex-education “sought to ‘make people of all ages relieved of their inhibitions and anxieties,’ ... [in an effort] to remove the sense of sin and shame that still permeated sexuality” (Zimmerman 2015: 66-7). As an archetype of progressive education, sex-ed was not simply about conveying information and knowledge, it was meant to address real-world concerns and prepare young people for life (Zimmerman 2015: 78-9). Globally, progressive sex-education became associated with sexual *openness, honesty, dialogue, frankness, confidence, and objectivity*. These are characteristics aligned with the Scandinavian model for progressive sex-ed which was, and continues to be, idealized by many progressive educators (Zimmerman 2015).

Despite its historical contingency, several common themes characterize its contemporary usage. In this paper, I view progressive sex-ed as firstly, underpinned by a desire to use objectivity, facts, expert knowledges, evidence-based lessons, science and “truth” (Lamb 2013: 450). This can be seen in Boonstra’s (2012) U.S. focused policy report that advocates for a “comprehensive” and “holistic” sex-ed, like what is common in Europe. One that encourages “practical,” “medically accurate,” “age-appropriate” sex-ed, that is not only guided by experts, but that is founded on evidence-based research. This relationship to truth and scientificity establishes a particular affiliation to religion, making progressive sex-ed usually secular,

established in opposition to traditional, conservative, right wing, and religious approaches (Rasmussen 2010).

Secondly, and tied to facts, I view progressive sex-ed is premised on *choice*, specifically individual “healthy” choices (Lamb 2013). It is rights-based, acknowledges that young people are sexually active<sup>19</sup>, and views young people as autonomous and agentic subjects – i.e., that young people have a right to information, and that they “can evaluate information given to them, and, hopefully, act on it in a responsible fashion” (Rasmussen 2010: 700). This aligns with neoliberal<sup>20</sup> discourses of risk where young people are seen as “at risk” for unplanned pregnancies and sexually transmitted infections. The emphasis of choice is implicit in Ontario’s former 2010 and current 2015 health and physical education curriculum (see Ontario Curriculum 2010; 2015a; 2015b), which aim to help students “develop a commitment and a positive attitude to lifelong healthy active living and the skills and capacity to lead and promote satisfying, productive lives” (K. Gill<sup>21</sup>). These formal curricula “take a skill-building approach to helping build students’ understanding about their health and develop and practice skills to make healthy choices” (ibid). The idea is that students should “demonstrate the ability to apply health knowledge and living skills to make reasoned decisions and take appropriate actions relating to their personal health and well-being” (ibid).

Thirdly, and despite secularization, I view progressive sex-ed is premised on *promoting diversity* in two ways. It is meant to i) encourage and promote the goals of tolerance and acceptance of diverse perspectives, particularly along ethnic, racial, religious, and classed lines; and ii) acknowledge “that not all young people are heterosexual identified” (Rasmussen 2010: 700). For

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<sup>19</sup> Bay-Cheng (2003) does an excellent job detailing presumptions about American adolescent sexuality in school-based sexuality education.

<sup>20</sup> Descriptions of neoliberalism and neoliberal subjects are well established by Bay-Cheng (2015: 280) who outlines the neoliberal influence – particularly agency – on girls’ sexuality. Neoliberalism is also well described in literature on mothering (see Reich 2014; Bryant et al. 2007). In general, neoliberalism is tied to concepts of self-interest, decentralization, and personal responsibility (see, Harvey 2005). Neoliberal subjects emphasize individual choice and individualized experiences, self-governance, autonomy, risk and risk management through information (and informed decision-making). As consumers, neoliberal subjects are entitled to information in order to make empowered, good choices, and are responsible for these choices.

<sup>21</sup> K. Gill, Director of the Curriculum and Assessment Policy Branch, personal communication.

example, Lenskyj (1990), speaking about Toronto's sex-ed at the time, uses the word progressive to describe a point of view, such as "progressive views on homosexuality" or against rigid sex-role conformity. While not directly aligning it with the word progressive, she advocates for a sex-ed program that would be "anti-sexist," "anti-heterosexist," "woman-centered, rather than gender-neutral," calling these a feminist model of sex-education. She describes Toronto's Board of Education as one of the most progressive on "sexual orientation issues" (ibid: 225) and credits much of this progressiveness to work by Olivia Chow (in 1986 a Ward 6 trustee), who advocated for lesbian and homosexual students and groups. Chow noted that the curriculum at the time (in 1986) had practically no material on sexual orientation, favouring heterosexual activity (ibid: 225).

Yet, scholars note that pedagogical advances do not always lead to the desired outcome (Connell and Elliott 2009). Ellsworth (1992) highlights that critical pedagogy, in general, is not easily sustained, and argues that that "key assumptions, goals, and pedagogical practices fundamental to the literature on critical pedagogy — namely, 'empowerment,' 'student voice' 'dialogue,' and even the term 'critical' — are repressive myths that perpetuate relations of domination", which reproduce Eurocentrism, racism, sexism, classism (298). Lamb (2010), investigating feminist ideals for promoting healthy teen girls' sexuality, argues that while feminist approaches may emphasize ideals of desire, pleasure, and subjectivity (topics commonly excluded from sex-ed; see Fine 1998), this type of sex-ed curricula may deny "the different historical meaning [of sex and sexuality] for girls from diverse backgrounds" (294). Rasmussen (2010), critiquing and discussing secularism, religion, and "progressiveness" in sex-ed, argues that U.S. based progressive sex-ed problematically reinforces religious/secular divides. Lamb (2013) explores how "progressives," as a type of person, have shaped sex-ed, focusing specifically on the hidden-biases in evidence-based sex-education, which passes for a neutral education. I build from the insights of literature critical of sex-ed, both progressive and conservative, forward into this research, allowing me to think about how despite teachers' intentions and best efforts, may still reproduce systems of inequality.

### 3. Data and Methods

My data are generated through interviews and observations of four public school teachers' sex-ed classrooms from the same school district in Ontario – Mr. Onuma, Miss Parker, Miss Roberts,

and Mr. Kang<sup>22</sup> -- and interviews with five additional Ontario health teachers. As part of a larger project, I set out to observe the teachings related to the Human Papillomavirus (HPV) and the HPV vaccine, which students would likely learn about in lessons on STIs and sexual health, or in high school during science class when learning about vaccines. With the HPV vaccine as an entry point into the classrooms and health lessons, I observed all of their health classes related to STIs (sexually transmitted infections). Due to the flexibility of lesson plans, I observed a broad range of topics such as naming and identifying types and transmissions of STIs, explaining reproductive anatomy, learning vaccination schedules, to lessons on poor reasons for having sexual intercourse.

**Table 1. School Profiles**<sup>23</sup>

Teacher	School Type	Class Taught	Classroom Organization	School Ranking in Ontario	Student Demographics	% of students whose 1 <sup>st</sup> language is not English	% of parents university educated
Mr. Kang	Middle School	Physical Education; Health Grade 7 and 8 Boys	Boys only Education (+ one co-educational class)	Mid	25% of students from low-income households	Approx. 25%	Approx. 25%
Miss Roberts	Middle School	Physical Education; Health Grade 7 and 8 Girls	Girls only education (+ one co-educational class)	Mid	Same above	Same as above	Same as above
Mr. Onuma	Arts Based Middle School	Homeroom Teacher – Split 7/8 class	Co-educational	Low	75% of students from low-income households	Approx. 60%	Approx. 20%
Miss Parker	High School	Grade 11 and 12 Science	Co-educational	Low	30% of students from low-income households	Approx. 50%	Approx. 25%

<sup>22</sup> All teachers in this research have been given pseudonyms. Aspects of their identity and teaching location have been withheld to maintain anonymity.

<sup>23</sup> Some of the school demographics are taken from realosophy.com in January 2016. School statistics are generalized (generously rounded) to protect the identity of the school.



In the spring of 2015, I observed 24 classes, totaling approximately 22 hours of classroom observations. As shown above in Table 1., one school was an arts-based public middle school, another a public school with gender-split physical education lessons (where I worked with two separate teachers), the final school was a public high school where I worked with a science teacher. I conducted at least one post-observation follow-up interview with each teacher, and analyzed the materials and content they used to teach not only their lessons on STIs, but also their health curriculum more broadly (e.g., health unit workbooks). To supplement my observational data, I interviewed five other Ontario health teachers (four from public schools, one from a private school) about their thoughts and experiences teaching sex-education and health.

This research was approved by the University of Toronto ethics review board and the ethics committee of the school board I worked with. I first reached out to school principals to find schools willing and interested to participate in this research<sup>24</sup>. For those principals who were interested, they then privately reach out to their school's health teachers to see if they might be interested, and if they were, principals then passed on a formal letter from me, introducing the study and myself. If teachers were interested, I then had email dialogue with them to further explain the research, the process, and what would be involved. A few weeks before they anticipated teaching this material, teachers distributed an information sheet that I provided to them to parents, letting them know about my research and that I would be doing observations of the classrooms, but not speaking directly with or interviewing their children. All teachers signed consent forms for classroom observations as well as their follow-up interviews. Before my classroom observations, teachers introduced me and let students know why I was there.

During class, I sat in a discrete corner of the room, so as not to distract from the regular flow of the class or everyday cohesion. I took notes mostly by hand, but also on a small quiet Bluetooth keyboard enabling me to take observational notes discretely. Students appeared excited to have

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<sup>24</sup> Using several recruitment strategies, I contacted over 60 schools to ask them to participate in this research. Many principals were slow to respond or unresponsive, even when prompted several times with an invitation letter (e.g., one by email, and one hand delivered a week later). Those who responded as not interested said that it was not something they wanted their school to be involved in. Some principals asked their teachers, but the teachers said that they were not interested in having me in their class.

me in their class and often enthusiastically (and somewhat mischievously) asked if I was there to evaluate their teacher. I got the sense that students were used to having other adults besides their teacher in the classroom, possibly a special education teacher, parent, or other teachers who are there to give feedback to their teacher. Due to ethical constraints, I did not engage with or interview the students of the classes I observed.

I began data analysis by open and inductively coding my observations and interview transcripts. Through this, I noticed many instances of teachers being fun, open, honest, frank, and where they taught in ways that were distinctly not conservative and that I interpreted to be more liberal, or “progressive” based on Zimmerman’s (2015) historical explanation of progressive sex-education. Reflecting on this, I analyzed what guides teachers as they navigate and implement the curriculum. I investigated how they interpret and practice what they were being asked to do. How they handled potential conflicts between what they are supposed to do, parental concerns, their own beliefs about the students, and what they thought is best for students.

It is important to realize that the teachers I worked with all agreed to be involved in this research. This self-selection tells me something about these teachers in particular. They were willing to have me observe their classrooms and were excited to have me there. These teachers may be viewed from a liberal perspective as “good” sex-ed teachers. They enjoyed teaching the material, tried to be “fun,” interactive, and creative, and felt it was important that their students learn about these topics.

#### 4. Findings: using facts, teaching choice, and promoting diversity

Three main themes stood out across the data -- facts, choice, and diversity – key characteristics of progressiveness as defined by the literature. In what follows, I introduce teachers and their classroom scenarios as exemplars of these themes. Doing this, I look closely at how teachers *use* facts, *teach* choice, and *promote* diversity, and the consequences of how they do this. I illuminate how progressive lessons can reproduce systems of inequality.

## 4.1. Using Facts: expert and everyday knowledge, secularism, and value-neutrality

According to scholarship, a discourse of science, or a focus on facts, is a central characteristic of progressive sex-ed. In several ways, I observed a focus on facts and expert knowledge (e.g., information from University, government websites, government health documents) in all the classes I observed. Teachers used these to emphasize the importance of giving their students facts, the truth, and the real knowledge on this topic so they can make their own informed choices in the future. Focusing on knowledge delivery of “the facts” is also a response or an effort to be neutral as a way to deal with this deeply controversial topic in a highly politicized environment. Additionally, it fosters legitimacy by secularizing the material (rejecting or separating it from religious teachings). Below, I introduce ethnographic scenarios from Mr. Onuma and Miss Parker’s classrooms to illustrate how facts and expert-knowledge are central to their sex-ed teaching. While teachers’ goals may be to offer a fact-based education, this is complicated by the classroom context and may reproduce inequalities.

### 4.1.1. Mr. Onuma: expert knowledge, student reactions, and secularism

Mr. Onuma, a homeroom teacher at an arts-based public school is responsible for all subjects of his co-educational split 7/8 class. Mr. Onuma is a jolly, charismatic, friendly, brass-tacks, say-it-like-it-is type teacher and was exceptionally welcoming to me. Upon meeting me, he immediately told me he stressed honesty in his sex-ed lessons, “even if it’s not PC,” because he knows that parents will teach traditional abstinence only until marriage, or that you can’t get STIs if you have “no sex until marriage.” Because of this, students are told they can ask anything, freely, “like on one of those court shows where people can say things off the record.”

With students settling into their desks after lunch, Mr. Onuma had students read over two information sheets, which would be the basis for answering questions. One was a teaching resource information page taken from The Society of Obstetricians and Gynecologists of Canada’s website titled, “Myths about HPV.” The handout gave information about HPV, what it is, how it spreads, and prevention. One after another, it presented 15 “myths” about HPV and then the “fact.” The second handout was a University news article discussing “why more boys don’t get the HPV vaccine.” Each group of students was given a different topic to cover and were asked to draw on information from the articles to address their topic: What is HPV?;

Myths; Prevention; Boys and HPV. Mr. Onuma told me that he chose these two pamphlets after sifting through the Internet, believing them to be age appropriate, mostly highlighting anatomy and transmission.

In response to this assignment and how they would be learning about this material, I heard one female student at the desk closest to me say under her breath, “because you don't want to teach us about sex,” suggesting that she felt his reliance on handouts to teach them was him avoiding responsibility. This was particularly interesting seeing as Mr. Onuma presents himself as open, frank, and honest when talking about sex-ed to his students.

In groups, students began reading the material in order to answer the question they had been given. In one group, a grade seven boy, unable to control his laughter, read one section of the myths (possibly not realizing it was a myth) and said: “mainly a problem among homosexuals! WHAT!?” Repeating this a few times, as if to get a response from the other group members, a grade eight girl in the group said, seemingly unimpressed while rolling her eyes at her classmates: “that’s a myth – that’s why you guys aren’t teachers.” The same boy continued reading and said loudly and flustered, “I CAN’T EVEN READ THIS! PENIS! Who can read this!?” This prompted another grade seven boy in the group to say, “It’s easy! It’s just words. You read it, just like words. And I’m mature” (saying “mature” with a sense of pride).

In this scenario, facts and expert knowledge -- in the form of handouts and information pages -- are presented in a loud, chatty classroom. They operate in a context of peer pressure, age-appropriate knowledge, misinformation, and a general age-related deep discomfort and embarrassment with all things related to sex. Students negotiate discomfort, trying to manage the information, save face, be cool, and show their compulsory heterosexual boyhood masculinity. Renold (2002) argues that “homophobic performances and misogyny seemed to offer a way of producing ‘heterosexual coherence,’ which in turn signals masculinity” (323). The presentation of compulsory heterosexuality can “have particularly damaging consequences for those boys and girls who are positioned as Other to the normalizing and regulatory (heterosexual) gendered scripts” (324). Because these facts are about sex, STIs, and body parts, they are used and taken up by students in ways that make them more than “just facts.” They are a mechanism for students to enact particular personas, such as mature, class clown, homophobic, etc. In the classroom context where time is short, (Mr. Onuma frequently glanced at the clock while fielding many

questions -- “if neither person has HPV, can you get it?”, “what about prostitutes?”, “so the vaccine protects against everything?”), there is little room to work with students as they learn and process this information.

In a follow-up interview, Mr. Onuma told me that his motivation for teaching health and sex-education the way he does comes from his opposition to what he described as the close-mindedness and homophobia of religiosity, particularly Christianity. Raised religiously by immigrant parents who adopted Christianity to be “good Westerners,” he is angered by religious teachings and wants to counter the religious approaches to sex-ed that students might learn at home. Along with the formal curriculum, his starting place is with these objective, fact and expert-based documents and saw them as protection from parents who might phone teachers to complain:

Certain families I have here, I know I’m going to get phone calls tomorrow -- ‘what are you doing teaching my child this?’ ‘Cause they come from very, very, very religious households.... [But] no, no, [I’m not worried about those calls]. ‘Cause my backing is the government document. I’m the employee of the government, and it’s my job to teach the curriculum, and that’s the curriculum and I will teach it. I am not going to be answering to a religious anything. And this is why I am in the public school and so that’s my backing.... All these kids that were not supposed to be exposed to this [education] have been exposed to it. So, they have the information somewhere in their minds now, and I’m happy about that. I’ll gladly take the phone call. And, ‘oh I didn’t realize [my child would learn this]’ (mimicking parents). Well, I’m happy they have the information to move forward.

Mr. Onuma’s use of facts appears to be a counter to religiosity, which could reinforce a religious/secular divide (see Rasmussen 2010). Such a situation has the potential to alienate students from the classroom context, and the material being taught as well. This can also create a distinction between students’ private home lives and public school-based lives, which may perpetuate inequality by denying students’ lived realities. As a consequence, this secular approach to neutralize the material can be regulatory in a sense and should be reflected upon by teachers. In fact, several teachers told me in our interview that students have actually expressed

concerns about learning sex-ed, in a way that mimicked parents' (from diverse religious orientations) concerns. In Mr. Onuma's case, teaching facts is not necessarily intrinsically problematic but is done within a broader politicized and charged cultural context, in which "the facts" are used to secularize the material. This may lead to a rejection or dismissal of "the facts" by some students who see these secularized facts as in opposition or in tension with their real-life religious contexts, and can alienate some students, particularly from their families. Mr. Onuma's goal is to ensure that students have this knowledge, but for many students, this knowledge is at odds with a lot of what they learn at home, and they are not taught how to approach this tension<sup>25</sup>. Elliott (2012) writes that "[s]ex educators who refer to parents as highly conservative and out of touch when it comes to issues of sex and sexuality potentially shape how young people think about their parents as sex educators" (153). She suggests that school based sex-educators must listen to students and support them, perhaps teaching youth how to talk to their parents or how to "make sense of their parents' lessons, including their silences, discomfort, and ambivalence" (154). While Mr. Onuma works to be progressive and teach fact based material without paying attention to religious parents, he may be alienating students in unintended ways, either from the lessons and or their families.

#### 4.1.2. Miss Parker: engaging everyday knowledge, medical information, and classed assumptions

Despite a formal curriculum, teachers discussed the struggle to know what exactly to teach, and what the balance should be between facts and everyday knowledge. Miss Parker (self-selected into this research as someone who teaches health, sex-ed, and the HPV vaccine) is a high school science and biology. I observed her grade 11-college biology course, which she loves teaching, and which comprises students who she describes as "not university bound," leading her to change the focus of the class. She explained to me that:

I usually overshoot [on how much I teach them]. I go into too much detail, and I've actually had to pull back. When I first started teaching the vaccines, I think I

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<sup>25</sup> While presenting an earlier version of this paper at the Society for the Study of Social Problems (SSSP) in 2017, Jessica Fields mentioned that my findings made her think about an idea Jen Gilbert is exploring where students are "schooled out of the family."

was going into too much detail about T-cells, active antibodies, and not enough detail about the everyday, what they need to know in their everyday lives about vaccines. Like, what ages do you get those vaccines, and that's why I had that graphic up there (on overhead projector). That's why um, I wanted them to have a copy of [the vaccination timetable graph]. I wanted to give the kids an actual [vaccination] schedule.

After showing and explaining the vaccination schedule, presenting statistics and tables on disease rates before and after the introduction of inoculations, and introducing the HPV vaccine, Miss Parker made an effort to explain Pap tests as one way to protect oneself from cervical cancer. Addressing her students, most of whom were students of colour, she asked: "Does anyone know what a Pap test is?" One girl in the back of the class responded, "Isn't that the one with duck lips?" "Yes. They stick a stick up your vagina," Miss Parker responded. Around the class, girls giggled and looked at the only male student in the class. Speaking to this male student, Miss Parker joked with him and said, "Aaron, don't listen!" With the girls laughing, Miss Parker continued, "They stick a speculum up your vagina. A speculum is a plastic instrument and they crank it open and it opens up your vagina." Sitting in front of me, I hear Aaron, the only male student in the class, groan, cover his ears, and look at the ceiling. Miss Parker spots his reaction and again says in a half-joking voice, "Don't listen!" Asking Aaron not to listen reproduces the idea that men and women are fundamentally different, and do not need to know about other genders and their sexual health. Then, addressing the rest of the class, "It opens up your vagina. And then they stick a stick up your vagina to see the cervix, the top part of your vagina and scrape a few cells off the cervix. They send those cells to a lab and they look at the cells, just like you guys have done. And they see if they look cancerous. That's called a PAP smear or a PAP test. Short for a Greek guy's name."

To give the conversation more real-life significance, Miss Parker showed her students a letter she received in the mail containing the results of a recent Pap test. She informed them that when girls are 21 years old, they should get the Pap test every three years. In response, a girl at the back of the classroom clarifies, in a very matter-of-fact kind of voice, that her friend had a Pap test because she's had a baby so she doesn't have to wait until age 21. Immediately, another girl asks, "how much does this [Pap test] cost?" Miss Parker replies saying that it's free. Aaron then asks if the Pap test is for girls or boys, prompting Miss Parker not only to tell him it's for girls, but to

also ask him, “how old is your mom?” After Aaron’s answer, she hands him a pamphlet and tells him, “She needs to get a Pap test every two to three years. That’s for her.”

These questions, comments, and Miss Parker’s responses are intriguing to me. They reveal Miss Parker’s efforts and approach to teaching information she sees as relevant to her students. However, the student’s question about the age in which you get Pap tests, and the other’s clarification based on knowing that her friend already gets them, illuminates how a teacher’s perception of her students and what facts, information, and knowledge they need, may be at odds with the diverse lived realities that students face experience. Moreover, her presumption that Aaron’s mom does not know about Pap tests or testing scheduling comes across as belittling to his mother, perhaps positioning Miss Parker as seemingly more knowledgeable than his own mother on these topics. Miss Parker’s perception of what everyday knowledge is relevant seems to begin from medical forms and information, as well as her own social location as a middle-class white woman familiar with standard ministry of health information/recommendations.

I asked Miss Parker why she decided to emphasize everyday details:

I’ve changed as a teacher (laughs). Back in the day, I used to focus too much on the science facts. But that’s partly because when I first started teaching a topic I had to learn it myself. And so then, my mind just gets hooked on the facts. So, when I’m learning it, that’s what I think they need to know. And then when I learn a topic better, I think, what can get pushed to the background. ... And for these kinds of kids, these are college kids [as opposed to university bound kids], they need to know applicable stuff to their lives. But having said that, some of them will come back to me, having gone off to Humber college, Seneca college, and they come back to visit..., [and] they said that high school didn’t prepare them for the rigors of college. So, I’ve got to keep that in mind. I can’t go so simple that they lose the rigorousness of the science behind it. So um, it’s trying to find a better balance.

The lessons that Miss Parker has chosen for this course appears to be guided by her own classed assumptions about her students, which she herself admits, have not served all her students well with some letting her know they were not prepared for college. This moment also exposes the tensions in progressive education. On the one hand, progressive sex-ed advocates for scientific,



fact based, informed information, but on the other hand, progressive education encourages knowledge relevant for students' everyday life. In order to make sense of this tension, Miss Parker rests on what facts *she thinks* this particular group of students need.

## 4.2. Teaching Choice: constructing an engaged, informed, and neoliberal student

Choice is a main characteristic of progressive sex-education, is built upon a foundational emphasis on “facts,” and is implicit in the ministry's use of skill-building approaches. In a neoliberal climate, progressive sex-education encourages students to individually acquire knowledge that will help them make informed “healthy” choices. Lamb (2013), critical of progressive-style sex-education, argues that evidence-based curricula and education makes the tacit assumption that “all students are equal in their capabilities, situations, and resources to make healthy choices using a variety of strategies” (453). At their foundation, these curricula assume that all students have a “wide array of choices” available to them, when in reality, many students' choices and lives are constrained by their class, race, gender and other factors (Lamb 2013: 453). By emphasizing individual choices, students are taken out of context, and assumed to be young people “who rationally can make choices from a selection of options and as someone who might be called the neoliberal subject” (Lamb 2013: 453).

### 4.2.1. Mr. Kang: restricting, decontextualizing, and moralizing choice

Mr. Kang, a physical education and health teacher, presents himself to his students as a fun teacher, but who is strict and demands order in his class. Reflecting on what he described as his own inadequate Christian-based, abstinence only sex-ed, he wants to ensure his students were more equipped so they can make informed choices. Consequently, his goals are to establish a “knowledge base” for his students in order to facilitate choice making:

I always tell them at the start of sex-ed: ‘I’m not here to tell you what’s right or wrong. I’m here to give you factual information, to give you the tools to make decisions on your own, and make the right decisions.’ But the focus is to make sure that students know that having intercourse and children at this age really isn’t a smart idea. Right? So, we try to give them thoughts of responsibility, understanding the future, financially what happens in the future, what happens to

your family and friends in the future if that, [teen pregnancy], were to happen. And, we don't say it's bad. We just say, these are the consequences to your actions. Like, cause and effect type of thing.

Mr. Kang's goal to give students choice is premised on facts. The goal of equipping students with knowledge in order to make them responsible presumes that everyone can and wants to make the "right" choice, and can (or will) if only they are just given the "right" information or tools. I saw this in Mr. Kang's classes on a few occasions, but the following instance stands out to me in particular.

On a Monday morning, I noticed that one of Mr. Kang's classes had many students absent, and I soon learned that many were away on an extra-curricular school trip. As a result, Mr. Kang postponed the scheduled lesson on STIs until the following day when there would be more students present: "I don't want to teach this lesson [the STI lesson] twice. Not sure what I am going to do with them." Addressing the class, Mr. Kang asked, "what do you think the percentage is of tweens having sex – any kind of intercourse?" One student blurts out an answer and Mr. Kang corrects this student's classroom behaviour by reminding him to put up his hand. With their hands raised and being called on, students guess at an answer – "about 10%," "about 1%," "13%," "5%." Mr. Kang replied, "it's less than 2%." Seemingly surprised by this, students burst into chatter amongst themselves. One yelled, "how would they collect that data!? I think it's a little bit higher!" Mr. Kang did not respond to that student or elaborate upon that statistic. Instead, he instructed students to open their health workbooks to an assignment titled, "You're not ready to have sex if..." The instructions for this assignment read:

Think you're ready for intercourse? Are you sure? Emotional consequences as well as sexually transmitted diseases and unplanned pregnancies are all good reasons to consider your decisions carefully. Before you go too far, take a look at this list...

There are 50 reasons listed, including some references to abstinence, such as: "You think sex is the same thing as love...you're afraid to say no...you don't know the facts about how pregnancies occur... it goes against your moral...religious beliefs... your idea of commitment is a three day video rental...you think that it will make your partner love you... you're drunk...you

haven't thought about tomorrow... you can't communicate with your partner out of bed...". The second section of the assignment is titled, "Some poor reasons for having sexual intercourse" and includes 13 reasons like, "curiosity, to feel loved, to rebel, to feel independent, to prove that you're a woman or that you're macho."

During this lesson, there is no discussion while students read these pages. Instead, students mostly read the passages out loud to each other, many laughing or mocking what was written. In this exercise, students are only presented with one side of the choice, or "decision." There was no discussion or explanation on why students might have sex, or when you are ready to have sex. This does the work of alienating any students who are sexually active from the lesson, or who might be considering it. Moreover, by aligning individual decision-making with lists outlining right and wrong, appropriate and inappropriate, this lesson moralizes and decontextualizes students and their choices. This "moralizing ideology" (see Fine and McClelland 2006; Bay-Cheng 2003) present in Mr. Kang's lesson teaches the "correct" approach to sexual health and sexual expression, such as abstinence only, as well as sex-ed that is generally concerned with risk and negative outcomes associated with teen sex and sexuality (Bay-Cheng 2003). This moralizing makes "bad" choices individual and private, removing public institutions from responsibility and accountability in the poor sexual health outcomes of students. This highlights the neo-liberalizing of sexuality and sexual health, the blurring of the lines of public and private, and leads Elliott (2003) to argue that sex-education policy should not conflate morality and health. This lesson and exercise was part of a health workbook that he had not developed, but which was used by all the health teachers in his school. His lessons were predominately organized around the content that given in this workbook.

#### **4.2.2. Miss Roberts: stressing heterosexual, deviant, and sanctioned choice**

Miss Roberts is a gym and health teacher. After many years of teaching health and sex-ed she is now comfortable with it, but that was not always the case. Today, her teachings include a "choose your own adventure" style story that she initially got from a public-health nurse several

years ago, which she uses with all of her grade seven classes<sup>26</sup>. Sitting on the edge of a desk, facing the class with her feet up on the seat of a plastic chair, her elbows leaning casually on her knees, she began reading this story. The class is early in the morning, 8:45, and initially, students are sitting quietly listening to Miss Roberts. The story focuses on heterosexual teen dating and relationships, and some choices young girls could make in various scenarios. As it progresses, there are “forks in the road” where students can choose what Tricia, the main female character, does. The story begins:

Story: My name is Tricia and I am in grade eight and I’m goin’ out with this guy Sean. I’m not really going out, I’m not sure. I’m not really going anywhere with a guy by myself. Because he’s in high school, my folks really would go nuts. They’re so strict. I think about my sister Jenny who has been sneaking around with her boyfriend, Dave. I worry about her sometimes. You know I can hardly concentrate in school because I’m thinking about Sean. Oh my goodness, I just got a text message: ‘Trish, meet me at the baseball diamond after school.’ I sure want to but I hope it doesn’t make me late. My mom makes me call her as soon as I walk in the door. Of course, I can call her from my cell, she’d never know.

Miss Roberts: Ok, you guys decide -- does she meet Sean or does she go straight home?

At the opportunity to give choice and input, the room comes to life. The previously quiet students all shout their answers to what they want Tricia to do. Most of the kids who are shouting answers want her to go meet up with Sean. Some students are sitting quietly, but have worried looks on their faces while others, upon sending Tricia to go meet Sean, are giggling and smiling mischievously with their classmates.

In a pedagogical move, students are presented with the dilemma, a “fork in the road,” where they must choose between what seems to be an obedient choice (i.e., going home, as her parents prefer) and a deviant or a daring choice (i.e. “sneaking around” and meeting with a boy).

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<sup>26</sup> Observing many of Miss Roberts’ classes, I was lucky to hear her teach this story many times, allowing me to transcribe passages of it.

Students can have Tricia choose the unconventional path, what might be seen as a deviant or dangerous path, or the obedient and “safe” path, each of which would be interpreted differently depending on the students’ own background and upbringing. This is also a gendered dilemma, where girls are asked to choose between conformity, obedience, and disobedience. Laughing, jumping out of their seats, and being very interactive and excited, students seem to be aware of the dilemma at hand. They appear to be enjoying sending Tricia down the daring/deviant path. And yet, there is little explanation, discussion, or elaboration from Miss Roberts as the story progresses.

As Miss Roberts continues with the story, students overdramatize their faces and reactions to the less “wholesome” choices Tricia is making. The students also have smiles on their faces and seem to be enjoying the turn of events, enjoying the risk of it and the choices the character is making. As the story progresses, students continue choosing the deviant or daring options until one point in the story, where they opt for her to make what appeared to be the safe, right, agentic, empowered, or informed choice for a young girl:

Story: Then we snuggle and kiss. He even French kisses me! I’ve never felt like this before. My face is hot. It feels funny between my legs. I’m breathing hard. I push him away a little. I ask him if he wants anything to drink. He smiles and says he has to go. See you Saturday night at the movies, he says.

It’s Saturday night. I have been just dying to see this movie. A bunch of us are going, but I don’t care who’s there when I’m with Sean. We sit down with our popcorn. The movie starts. My attention is divided between the screen and his hand in mine. I never knew holding hands could feel so good. He rests our two hands on my thigh. Kind of rubbing. Tickling my jeans. I get the feeling between my legs again and hold my breath. His hand is moving a little higher. Now all my attention is on his hand. Should I stop him, or should I wait to see what he does.

Miss Roberts: Who says stop!?

Many students yell, encouraging Tricia to keep going.

Miss Roberts: Who says wait to see what happens?

Other students yell to make her stop. Miss Roberts continues the story with Tricia stopping him:

Story: I push his hand away and he stops. He won't hold my hand anymore and the movie is ruined for me. When we get outside I ask him if he wants to talk. 'What is there to talk about,' he says? 'You think I am trying to take advantage, cause I'm older?' 'Sean,' I say. 'I do trust you.' 'You have a funny way of showing it,' he says. 'I would have stopped you know.' I didn't know that.

A lot happens at this point in the story: questions of consent, trust, relational sexuality, feelings of pleasure, saying no, relationships, older boys. However, Miss Roberts does not break the story down and have a conversation with the students about what is going on, nor does she at other points throughout the story. The story is meant to provide information and scenarios for learning how to handle choice and decision-making, but without dialogue from Miss Roberts to the students, it is unclear how students interpret this information, or what they have learned to carry forward in their lives. Moreover, this understanding of choice is premised on the assumption that people are rational actors and will make thoughtful decisions after weighing their options (Lupton 1999b).

As the story progresses, students want Tricia to continue to make choices that would be more daring for the story line:

Story: When I get home my sister Jenny is looking upset. I ask her, 'what's up?' She says she's got these bumps on her: 'It's probably just razor bumps.' I say, 'I don't know why you shave, Jen. Yuck. But maybe you have something. You should go to the doctors.' 'No way. The doctor will probably tell mom and dad. It's probably nothing. I'm sure it'll go away.' I ask her, 'have you and Dave been doing it?' 'Ya, but he pulls out.' I freak out on her and say, 'you guys haven't been using condoms!?' 'Look, I know what I'm doing. It's no different than when I was with Trevor and nothing happened.'

Miss Roberts: If Jenny goes to the doctor, turn to page [x]. If she waits to see, turn to page [x]

Many Students shout: Risky! Risky!

The story continues with Jen waiting to see, rather than going to the doctor. Eventually students discover that Jen has warts and all appear grossed out, yelling “ew!,” scrunching their faces and noses. Given the symptoms of genital warts, Miss Roberts asks the students what Jen has contracted. This prompts a slew of responses with students shouting answers. One loud voice yells, “HIV,” leading Miss Roberts to correct him and say, “HPV.” Like with facts (emphasized in the section above), (mis)information, decisions, and choice in the classroom context operate in an environment of confusion, emotion, excitement, and misinformation, making it unclear how this information is understood or how choice is conceptualized or understood by students. The language in the story is also rather vague as well. Short class times and the need to cover other information leave little time for Miss Roberts to go into detail about a lot of the information in the story, such explaining and discussing “pulling out,” “funny feeling between my legs,” “bumps,” or even what the decision options mean.

Interpreting the implications of this story and classroom setting is complicated. On the one hand, Miss Roberts presents heterosexual choice in the context of right/wrong and safe/dangerous behaviour where risky and disobedient behaviour is associated with boys, STIs, missed periods, pleasure. On the other hand, the story also appears to celebrate girls’ agency. However, and similar to what Bay-Cheng (2015) might describe as a hegemonic agency, this is a type of choice that actually brings “social sanction” (283). In the story, girls are presented as being liberated, as having freedom and autonomy and yet, they are also confronted with a choice that is not safe and goes against authority (parents). The result, using Bay-Cheng’s (2015) language, is an individual “freedom” and responsibility that is like a “liability waiver: do what you will, but at your own risk” (283). This is a neoliberal choice, where girls are given the illusion of choice without “fences or external obstacles,” but in reality are sanctioned. Any outcomes resulting from these choices then, can be seen as “deserved or even self-inflicted” where girls, or students, end up being blamed instead of liberated by their choice (Bay-Cheng 2015: 283).

#### **4.3. Diversity and Inequality: promoting diversity, reproducing inequality**

The tolerance and acceptance of diversity is a central tenet of progressiveness. All teachers discussed the diversity in their schools and classrooms, and were cognizant of the need to

“address it” in their classrooms, yet in practice, fell short in their efforts. While diversity has come up throughout this paper, this section focuses specifically on how teachers attempted to respect diversity, and how this relates to inequality. I first discuss diversity along the lines of race, ethnicity, and culture, as it relates to sexuality. Second, I draw on Miss Roberts’ class to exemplify the way in which diversity in sexuality is a part of the classroom. I close this section by highlighting a conversation I had with Mr. Onuma, describing how he works to respect diversity in his classroom in an effort not to perpetuate inequalities.

#### 4.3.1. Socio-cultural Diversity: ethnic, cultural, religious, class

All the teachers I worked with acknowledged the diversity of their classrooms, but discussed the challenges of having diverse students in their classrooms in terms of religion, race and ethnicity, and class-backgrounds. Reflecting on who the students are at her school, Mrs. Mason, head of a physical education department (whose classes I did not observe), told me:

I would say the school is 90% Asian. There’s a lot of ESL, or English language learners.... most of our students are Chinese and it may be that 10% are a mix of other cultures. It’s also very academic, not as many behavioural problems [as other schools I’ve been at]. Speaking about sexual health and that sort of thing, we don’t know if they do anything. Like, they’re really cute, and you teach them, ‘ok, so you go to a party and you walk in and there’s beer there. Do you stay or do you go?’ and they say, ‘we go as soon as we arrive.’ ... And so they’re kind of, they’re shy and culturally. They really obey their parents. Like, I asked my gynecologist, or, my obstetrician, I said, ‘I teach a lot of Asian students. And they’re very, they say they’re not going to have sex because of their parents, or whatever.’ And she said, ‘oh we see an influx after they go to university because they are away from the house and they can let loose.’ So, I think for a lot of the kids, it’s not an option because their parents say ‘don’t do it. While you’re in my house, don’t do it.’ So they don’t. ...

Mrs. Mason acknowledges the racial, ethnic, and cultural backgrounds she perceives to be in her class, as well as her perception of those backgrounds in relation to sexuality and how she teaches sex-ed. She seeks out expert advice on how to manage this diversity, particularly in relation to what she believes these students learn in their homes. However, this constructs a generalized and



homogeneous image of “Asian” [sic] sexuality that reinforces cultural, ethnic, and racial stereotypes. Barcelos (2018), discussing what they call a “gendered racialized project,” makes a similar observation when looking at the racialization of young Latina’s gender and sexuality. In their case, they argue that stakeholders rely upon culture and “cultural narratives” as “an explanation for high birth rates among young Latinas...” (252). Mrs. Mason’s treatment of “Asian” sexuality as a-sexual, disciplined, and parent-abiding erases their sexuality and removes their agency.

#### 4.3.2. Sexual diversity: sexual orientation, sexuality, and gender identity

Speaking casually with teachers before and after classes, they highlighted the inclusivity of their schools, some pointing to posters, banners, and murals in the hallways that showed the school’s commitment to diverse sexualities. And yet, this was not present in their lessons. In fact, their lessons only discussed or were framed towards heterosexuality. When they did speak about sexual diversity in our follow-up interviews, it was rather haphazard. One teacher brought it up diversity in relation to a trans bathroom that would soon be designated in the school to accommodate the arrival of a trans student next year, admitting she was excited about this student coming to the school, but also uncertain about how to “deal with” this as a teacher. A few teachers told me that they don’t suspect any students in their classrooms are gay or lesbian. When I prompted teachers in our interviews about boys and the HPV vaccine or transmission of HPV in non-heterosexual interactions, they admitted they hadn’t thought about that. So while outwardly, at least, sexual diversity and positive spaces were encouraged throughout the school, they were not present in the classrooms I observed. This reveals a kind of “evaded curriculum” (Fields 2008:87) where honest discussions and lessons are not had, or a “layer of silence” (Friend 1993: 211) where the organization of things like class materials prioritizes heterosexist ideologies.

A conversation with Miss Roberts about how she respects diversity in her classroom reveals the way sexual diversity is haphazardly treated and integrated into her classrooms, meandering in and out of focus:

I use the example of abortion. So, I say that some people think it’s murder, it’s killing an innocent being, and some people think that it’s the mother’s choice and she should be able to decide. So, I say that there’s a gray area. What if someone

gets raped, should she be responsible for keeping the child? So, I try to be aware of that. And same with heterosexual[ity], cause mostly, cause we're talking about boys/girls, fertilization, I just need to be more aware of if it was a lesbian couple or, so, using, so the story [the choose your own adventure] didn't work. I should use gender-neutral names and stuff. And I do, at the beginning. I do say, 'don't ask personal questions. If you have a comment, I don't want you to say, 'my brother and his girlfriend or boyfriend'. So, I am conscious of it, but I don't know if, if my biases are in there.

This conversation with Miss Roberts is important to unpack. She presents the topic of sexual diversity as being part of a larger conversation about tolerance and bias (for example, similar to the topic of abortion. You might not agree with it, but you have to tolerate it). Topically, Miss Roberts respects diverse perspectives and does tell her class that they must as well. But beyond that, her awareness of diversity and her topical acknowledgment of it does not translate into other inclusive practices. Having a rule about personal questions functions almost like a “don't ask don't tell policy” where she doesn't want to know if you are or are not, heterosexual. This is particularly evident in her exclusion of sexual orientations from her lessons. In Miss Roberts's eyes, the task of respecting diversity means excluding her own opinions and having students do the same, which does not necessarily translate into encouraging and promoting the goals of tolerance and acceptance of diverse perspectives. In fact, I would argue that it is important that teachers do not assume that removing their own biases and being neutral, or creating a “neutral” classroom environment, equates tolerance and acceptance. Rather, it is more likely that these attempts can actually reproduce and maintain inequalities in the classroom by reinforcing taken-for-granted notions of heterosexuality.

#### 4.3.3. Respecting Diversity: Mr. Onuma

With all the teachers I worked with, Mr. Onuma was the most vocal about the diversity of his classroom and students. Below, I highlight a conversation I had with him where he explains the complexity of diverse student classrooms. This is not a scenario outlining tolerance or acceptance of *diverse perspectives*, but illuminates the ways in which he attempts to respect the different social worlds and diverse backgrounds of his students. This is an important interaction to focus on given that social context, such as class (see Tolman 1994), shapes the ways students

subjectively experience, “conceptualize and make choices around their sexuality” (Bay-Cheng 2003: 69).

[This school] is a range. It’s a great snapshot of the city because you have students who are from really well-to-do families, parents who are lawyers, and then you have students who the mothers, who come from single parent homes, and a couple of them are really struggling to make ends meet. So there are a lot of very different socio-economic backgrounds.

Mr. Onuma’s understanding of his students’ socio-economic background organized what he decided to teach his students, even if that meant changing, or differently emphasizing, typical lessons put forward in health and sex-ed:

*Because* many of the parents, many of the kids that I’ve been teaching, I would say that a quarter of the kids, they know, they’ve been told that they were an accident. So, if I have to say, ‘you don’t want an unwanted pregnancy’ (mimicking a commanding voice then pauses), I’m speaking to them. So, if I make that, if I keep pushing that, I will make them feel more unwanted. And that’s what they’re carrying around. Right? So, I have to tread carefully with that topic. ... I will talk about contraception, but not too close together with the pregnancy part. I will say you can do this, that, you can take this, that [to prevent pregnancies], but I am not going to beat them over the head with the consequences of unwanted pregnancies. The first two years when I was teaching I was saying, ‘oh you don’t want to be pregnant!’ and I said things like ‘your life is over!’ (said in an authoritative voice)! And then the second year I thought, ‘oh!’ because I realized. ... And then the parent teacher interview happened in November. And, you know, [the parents would tell me] ‘it’s really hard ‘cause, I’m working two jobs and I had to leave school at 14.’ And I’m like, oh man, I talked about that (whispering, under his breath to me). So, that’s why that’s the most sensitive to me.

This sensitive moment by Mr. Onuma is based on his understanding of who his students are, and their social realities, possibly recognizing the classed and moralized aspects of some of the information he was required to teach. It also shows how, through his application of the material,

he has changed his understanding of his students. Contrast this with Mr. Kang, earlier, who despite not wanting to teach right and wrong, emphasized the negative life consequences of early pregnancy and “the consequences” of certain teen actions. As he became a more experienced teacher, Mr. Onuma began to see the social demographics and inequalities present in his classroom, which affected what and how he taught and conveyed information and knowledge. Consider this in contrast to the progressive tendency to view young people as “at risk” for unplanned pregnancies and STIs.

Mr. Onuma’s actions here are particularly interesting given a wealth of research exposing the unchecked biases present in seemingly neutral curriculum and pedagogy. Fields (2012), for example, discussing sexuality education in the U.S writes that “[c]urriculum and pedagogy that pursue and claim rational and unambiguous knowledge routinely affirm oppressive values and norms about gender, race, and sexuality, even when presenting what appears to be rational, medically accurate information about bodies, diseases and pregnancy prevention, and puberty” (8). Moreover, Bay-Cheng (2003) emphasizes that “concerns of unwanted pregnancy, infection, and assault are certainly well-founded and substantial,” but this narrow focus “constrains our understanding of adolescent sexuality and hinders our ability to provide teens with needed knowledge, guidance and support” (65; see also Ehrhardt 1996; Tolman 1999; Welsh et al. 2000). Rather than only emphasizing the negative aspects of sex and sexuality, Bay-Cheng (2003) reminds us that these authors argue that students must also learn about positive sexual health, particularly over the lifecourse. Mr. Onuma appears to be aware of the importance of context in teaching his students these topics, and the delicate dance of timing the information he gives his students in the classroom.

## 5. Conclusion

Sex-education in Ontario is socially and politically controversial, creating a complicated environment for teachers to work in. Teachers are tasked with navigating formal curriculum, parental concerns, religion, students’ best interests, and their own comfort with and approach to the topic. In this article, I use my observations and interviews to make two main contributions. I not only show what guides teachers’ work and how they grapple with the modern socio-political climate, but I also discuss the implications of their efforts, particularly for discussions of inequality. I find that all the teachers I worked with taught in ways that they thought was best

and they did this by emphasizing facts, choice, and engaging diversity, all aspects of a larger rhetoric and ideology of progressiveness. Yet, despite these approaches or strategies, systems of inequality are maintained in school classrooms.

The practice of teaching sex-education intersects with a myriad of complicated factors causing progressiveness to break down, or even foster situations where inequalities persist. Current literature on the progressive sex-ed often employs a taken-for-granted use of the term, presuming it may be conceptualized as self-evident and as an idealized approach for contemporary sex-ed. However, my research shows that in practice, it is messy, complicated, and needs to be interrogated. For example, my research raises the issue of secularizing or neutralizing sex-education, contributing to conversations started by scholars like Lamb (2013) on what role facts have in our sex-ed. It highlights how teachers should be wary of secularizing their lessons as a way to combat the religious teachings of parents, which might alienate students from the lessons and/or their families. As mentioned above, Elliott (2012) suggests that sex-educators might want to open conversations about how their students might talk to their parents and help them understand their parent's approaches to sex-ed. My research is also critical of neoliberal, individualized, and rational-actor approaches to teaching choice, and the inequalities that are inherently reproduced in this type of approach. Reich (2014: 6), researching mothering and health choices, points out that neoliberal notions of individualized choice facilitate and "masks" inequality, since many people may lack the necessary resources to make informed and good choices. Furthermore, this research suggests that teachers' attempts to remove themselves or "their own bias" is misguided, and may end up decontextualizing this important education. Rather than removing one's bias, teachers may want to consider how their own values (even their secular ones) are a part of their formal and informal lessons.

Throughout this research, I do not support a return to more conservative school-based sex-education. My critical eye towards progressive education is a reflexive look at some of the taken-for-granted biases and inequalities that persist, despite best efforts. Moreover, with the looming changes to public school sex-ed in Ontario and the return to a curriculum from the 1990s (see Globe and Mail 2018), future research should investigate what content and messages are taught as teachers as asked to revert to an older curriculum. The teachers in this research were self-selected, meaning that I saw and worked with a particular type of teacher, confident enough to have me observe and reflect on their teaching. This also means that there are likely a lot of sex-

ed teachers who are less than progressive in their efforts. In fact, during my recruitment (as well as a different research project interviewing teens about their sex-ed experiences and the topic of the HPV vaccine), I have come to suspect (based on my interviews with girls, below) that many physical education and health teachers are not teaching this material. Future research would benefit from talking with the students observed in the classes in order to uncover what they learned, took away from, or remember from these classes.



## Chapter 4

### “The decision was made for me and I was okay with that”: The HPV Vaccine and Patterns of Adolescent Girls’ Selves

#### Abstract

Based on 19 qualitative interviews with girls (aged 11-17; grades 7-12), as well as separate interviews with their parents (mostly mothers), this paper investigate the “push and pull” of girls’ narration as they discuss themselves, their families, mothers, schools, and teachers as it relates to conversations on the HPV vaccine, their health, sexual health, and sexuality. I find that other people, negotiations of independence and autonomy, and trust (as in, who girls look to) are main themes in all the interviews. Reading girls’ narratives with these themes in mind, three particular types of selfhood emerged. Some girls: 1) prioritize their mother’s narratives, presenting a type of “tethered self”; 2) explore enactments of agency, autonomy, and independence (although, with varied success), presenting an “autonomous self”; 3) have confidence in the accountability that is diffused between their parents, schools, and doctors -- instilling trust in these institutions gives them a sense of assurance in their stance on these topics. This is the “trusting self.” Highlighting four girls as exemplars of these types, this research reveals the patterns through which girls’ subjectivities, sexual health knowledge, and thoughts on the HPV vaccine are intertwined and operate in relation to other people and larger sociocultural structures. In short, this research focuses on how girls’ sense of self emerges in relation to topics like the HPV vaccine, health, and sexual health.

#### 1. Introduction

Across Canada, the Human Papillomavirus vaccine (HPV vaccine) is publicly funded and offered through school vaccination programs between grades four and nine, depending on the province. HPV is one of the most common sexually transmitted infections (STIs) in the world. Some strains of HPV are linked to cancers of the vagina, cervix, vulva, penis, anus, and oropharynx (Chaturvedi 2010). Catch-up programs exist for those students who may have missed



receiving the vaccine during its initial rollout (MHLTC 2017)<sup>27</sup>. In Canada, this vaccination requires parental consent and each year in Ontario, parents of children who will receive the HPV vaccine in that year receive a consent form for their child, accompanied by some information on HPV and the vaccine. This information given varies depending on what health district the school is in.

In Canada, and globally (Wailoo et al. 2010), there has been spirited controversy and debate about the HPV vaccine, and vaccines in general (See Colgrove 2006a), by parents, educators, researchers, and politicians. Multiple actors and stakeholders create a complicated web of complementary and conflicting goals and agendas. For example, some parents raise questions of parental rights and responsibility to make decisions for their own children without state intervention (Reiter et al. 2009; de Visser and McDonnell 2008); Public health has goals for herd immunity; Medical researchers strive to invent a “cervical cancer vaccine” (see Gericke 2008)<sup>28</sup>; Teachers are tasked with the responsibility of educating teens on STIs; Marketing engages tropes of neoliberalism and promises individual empowerment vis-à-vis vaccination (Lindén 2016); Critical feminist scholars warn that the HPV vaccine is another form of surveillance of women’s bodies, biopolitics, and biomedicalization (Mishra and Graham 2011; Polzer and Knabe 2009; see also McKie 1995). Underrepresented in this discursive landscape are adolescents themselves, despite being confronted by parents, teachers, and media with a range of opinions and discourses on what they ought to do, and how they ought to think about themselves in relation to topics like STIs, sex, vaccinations, and their health.

To respond to this context, I investigate girls’ narration of this topic. I explore *patterns of how they discuss themselves, their families, mothers, schools, and teachers as it relates to conversations on the HPV vaccine, their health, sexual health, and sexuality*. I find that other

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<sup>27</sup> In Ontario, girls had previously been given the HPV vaccine in grade 8, but as of September 2016, both boys and girls now receive the vaccine in grade 7, the same grade in which they also receive the Hepatitis B (Hep B) vaccine.

<sup>28</sup> Gericke (2008: 1049) remind readers that, “[a]s about 30% of cervical cancers are not caused by the current HPV vaccines against HPV types 16 and 18, there is a real risk of increased cervical cancer incidence and mortality in women who do not take up screening, counterbalancing the positive effects of the HPV vaccination. This is fuelled by health promotion material from manufacturers, cancer councils, and Cancer Research UK, all of which market the HPV vaccines as ‘cervical cancer vaccines.’ This is reflected in the general media and even in some leading scientific journals.”

people, negotiations of independence and autonomy, and trust (as in, who girls look to) were main themes in all the interviews. Reading girls' narratives with these themes in mind, I find that three particular types of selfhood emerged. Some girls: 1) prioritize their mother's narratives, presenting a type of "tethered self"; 2) explore enactments of agency, autonomy, and independence (although, with varied success), presenting an "autonomous self"; 3) have confidence in the accountability that is diffused between their parents, schools, and doctors -- instilling trust in these institutions gives them a sense of assurance in their stance on these topics. This is the "trusting self."

When discussing health information and knowledge, highlighting patterns of narration and centering girls' voices is unique. In the literature, the focus is often on the HPV vaccine in terms of vaccine uptake and acceptance using the models such as the Health Belief Model (HBM) (Rosenstock 1974). The HBM aims to explain health-related behaviour where "decisions are viewed as the product of cognitively-driven, rational individuals who engage in a series of cost-benefit calculations in which they consciously weigh the pros and cons associated with adopting or not adopting a particular behaviour" (Polzer et al. 2014: 285). This research tends to emphasize the "perceived susceptibility, severity, and efficacy on HPV vaccine acceptance" (MacArthur 2014: 19; for example, see Brewer and Fazekas 2007). The literature on adolescents and the HPV vaccine tends to reveal what girls know more technically about things like HPV, the vaccine, STIs in general, but I show that it cannot speak to the *non-linear paths that decisions, information, and health knowledge takes as adolescents learn about these topics*. This is especially important to look at since this vaccine comes during adolescence, a time of potential change, puberty, a time when teens may be experiencing new influences, gaining new friends, teachers, and going to new schools. There may also be changes in their dynamics with their parents. A lot is potentially changing at this point in adolescent's lives, while simultaneously being told, or becoming aware, that topics like the HPV vaccine are important. As such, their health and sexual health knowledge is wrapped up in these life dynamics and their sense of self. Focusing on the patterns their narratives take exposes how girls grapple with topics they are told are important, as they navigate their own selves and lives.

This research is in one part a story of knowledge, health, sexual health, and sexuality. But it is also a story of subjectivity formation, testing out agency, trust, or independence. Putting these two stories together provides insight into the relationship between knowledge, health, sexual

health, and self and subjectivity formation, perhaps not even formation, but a journey or development, since this formation is always in progress. Broadly speaking, bringing together this contextualized journey of self with how girls think about these topics matters for public health interventions, sexual health education, and reflecting on parent-adolescent dynamics. It reveals that how adolescents make sense of these topics is not a matter of linear information transmission. These narrative patterns show the complicated ways that girls take up this knowledge, imbricated through parent-child dynamics, school dynamics, perceptions of self and others, trust, distrust. Identifying these patterns, my research adds something new to the literature. It centers girls' voices (as opposed to young college-aged women's) on this topic, and it complicates an understanding of how health knowledge operates, not in a linear fashion, but as part of a sense of self, which is tied to trust in others. Only by following these patterns can we i) build health programs that work with girls and their lives, and ii) understand the complex factors that inform how girls relate to their own sexuality, sexual health, and the HPV vaccine.

## 2. Moving Beyond Information Transmission and What Girls Know

Research from several national contexts investigating girls' knowledge of HPV and the vaccine consistently finds that girls and young women have a limited understanding of HPV (Mays et al. 2000; Pitts and Clarke 2002; Holcomb, Bailey, Crawford, and Ruffin 2004). This literature focuses on adolescent girls' (Zimet 2005) or university students or young women's (Yacobi, Tennant, Ferrante, Pal, and Roetzheim 1999; Waller, Forrest, Cadman, Wardle 2003) knowledge and understanding of the HPV vaccine, with the goal of improving adolescent health through vaccine uptake. Caskey, Tessler-Lindau, and Alexander (2009) surveyed 1,159 U.S. girls (aged 13-26) to discover girls' knowledge of HPV and the vaccine, any barriers they might have to adopting the vaccine, and correlates of early vaccine receipt. They found that 30% of girls reported knowing they had received the vaccine. They also found that 95% of the girls in their sample knew that they still needed regular cervical cancer screening and safe-sex practices despite being vaccinated. Robbins et al. (2010) found that Australian parents and girls both lacked knowledge about HPV and the HPV vaccine regardless of age and school type (public, Catholic, independent).

This body of research tends to center its inquiry on health behaviours and linear health decision making, where it is assumed that individuals will make the right decisions after rational calculations weighing out pros and cons (see Lupton 1999b and Polzer et al. 2014 for a critique). Moreover, this research is primarily concerned with understanding girls' knowledge in an effort to identify predictors of vaccination uptake and acceptance, or to correct girls' behaviour that is deemed incorrect from a biomedical view (Polzer et al. 2014). Polzer et al. (2014), whose research uses positioning theory and narrative analysis to investigate how college-aged women construct their identities in relation to master narratives on HPV and the vaccine, do an excellent job reviewing and critiquing this literature. They point out that this literature operates from the "underlying assumption that having more objective knowledge will lead to greater [vaccine] acceptance," that it assumes people will make the correct decision "follow[ing] from the communication of sufficient amounts and appropriate framings of risk information, and that it moralizes individuals and their vaccination decisions" (284-285). Like Polzer et al. (2014) my research aims to go beyond explanations of vaccine acceptance and of what girls know. I take from this literature the findings that girls know little about the HPV vaccine technically, but rather than focus on information transmission to increase vaccine uptake, I instead uncover how girl's sense of self emerges in relation to topics like the HPV vaccine, health, and sexual health. I focus on the patterns through which girls make sense of this vaccine as it relates to the people, institutions, the contexts of their lives, and their own sense of self.

### 3. Contextualizing Girls: Families, Parents, and Schools

While there is controversy about vaccines in general, the debate around the HPV vaccine is distinct due to the fact that the HPV virus is spread through sexual and intimate contact, making the HPV vaccine take on unique social meanings unlike other childhood vaccinations (Casper and Carpenter 2008). The HPV vaccine provides protection for an "absent disease," rather than direct therapeutic relief or drugs for active diseases, that may not be urgent for all adolescents (Mishra and Graham 2011: 64). In Canada, the vaccine was only originally publically funded for girls and was framed as a "women's health issue" (see Mah et al. 2011) and a "girl vaccine" (Mishra and Graham 2011). Despite efforts to market it as a "cancer vaccine," to reduce stigma around the fact that HPV is a sexually transmitted infection (STI), many parents were, and continue to be, concerned over the HPV vaccine's link to sexual behaviour, complicating their decision to consent to the vaccine or not. Marlow et al. (2007) point out that some parents feel

that choosing to approve the vaccine will give the perception of permission or consent to sexual activity for their daughters, with other groups calling this vaccine the “promiscuity vaccine” (Colgrove 2006b).

Family context, particularly the role of mothers, is important to focus on since research finds that mother-daughter communication is influential on vaccine uptake and identity-narratives in female college students (Roberts et al. 2010; Kreiger et al. 2011; Polzer et al. 2014). For example, Roberts et al. (2010), using a paper-and-pencil questionnaire with 972 college women (aged 18-25), found that “perception of their mother's approval and mother-daughter communication about sex were important predictors of [HPV] vaccination” (982). My findings in Chapter two provide some insight into what mothers might communicate with their children. I show that some mothers fully endorse the vaccine, almost routinely consenting to it as an obvious form of protection and risk aversion. Other mothers look to alternate forms of protection for their daughters (such as Pap tests or instilling self-confidence) and opt not to consent to this vaccine. Some of these latter mothers may strive to provide broad resources or tools to their daughters to foster sexual health and sexuality beyond vaccination (see chapter 2). Outside of vaccination and health decisions, Schalet's (2011) work is insightful into how parents might think about adolescence and sexuality in the home, and across national context. She finds that U.S. parents dramatize teen sexuality where Dutch parents normalize it.

Outside of the family context, Ontario's formal school curriculum requires that students receive some education on HPV and the vaccine at several points throughout their schooling as part of the Health Curriculum (Ontario 2015a; Ontario 2015b; see Chapter 3, above). For example, students might learn about HPV in grade seven and eight health class, during general lessons on sexually transmitted infections (STIs) and safe sex. In high school, the HPV vaccine may come up in biology classes when learning about vaccine science. Implementation of formal curriculum is at the discretion of individual teachers and is not standardized between teachers, schools, or school districts. Moreover, limited class time to teach the entire health curriculum may result in the prioritization of particular topics over others; some topics may be missed entirely, not taught, or only briefly mentioned. Currently, in Ontario, there is controversy around and a change in public school Health (and sex-ed) curriculum, with the 2015 curriculum being shelved and a curriculum similar to one from the 1990s being implemented. This makes it unclear what

students will learn about the HPV vaccine, STIs, health and sexual health in general (see Globe and Mail 2018).

#### 4. Constructing Self and Subjectivities: Neoliberalism, Vaccines, and Sexuality

Youth and adolescence are a time of rapid physiological and emotional change. During this time, significant others may fade as the *main* source of meaning and moral direction, as young people internalize the voices of “society” to help them make moral decisions and determine who they are as citizens. Mead (1934) referred to this stage as taking on the generalized other. Here, young people’s morals, values, and sense of themselves as citizens are stabilized through the meaning they attribute to the many and varied interactions they have with a wide variety of people.

Cooley (2009 [1902]) argued that our selves are through the “looking glass” (183-184) where we take our meanings about our selves from what we think others thinks about us. Giddens (1991) attempts to merge human agency and the micro level of interaction with the macro level of social structure (e.g., capitalism, globalization). Through his theory of structuration, he explains the ways in which individuals are fused with structures (e.g., traditions, moral codes, common ways of doing things), and focuses on how self and self-identity are both shaped by and shape the institutions of modernity (Giddens 1991). Giddens theorizes “identity projects,” showing the malleability of modern identities, and emphasizes social location, personal meaning, and conscious choice (Callero 2003: 115). Yet, Budgeon (2003), drawing on Mestrovic (1998) and suggesting a move towards Rose (1996a; 1996b; 1998) who emphasizes meaning and experience, reminds us that, “Giddens has been criticized for not granting enough significance to the chaos and irrationality that is at play within modernity... [leaving] out people’s histories, habits, customs, feelings, and other aspects of non-agency, all of which are essential to understand social process of human behaviour” (40).

In his *Sources of the Self*, Taylor (1989) argues that the most salient mechanisms of selfhood are morals, values, and our assessment of the world. He argues that there are inward and outward turns of self that contextually construct identities: “wide range of practices – religious, political, economic, familial, intellectual, artistic – converged and reinforced each other to produce it” (Taylor 1989: 206 in Callero 2003: 122). Seemingly correcting symbolic interactionism, although erasing the agentic actor, Foucault (see 1979, 1988b) stressed the role of power,

arguing that the self must be understood historically and as part of systems of discourse (Callero 2003: 117). Foucault argues that the self is caught up in “technologies” (think, techniques) and disciplinary practices on the body. Similarly, Rose (1996b) presents a “‘genealogy of subjectivity’ that would be concerned with localized attempts to produce meaning, especially as this occurs through professional vocabularies and technologies of practices of science, medicine, government, and workplace” (in Callero 2003: 218).

There are many schools of thoughts on the construction of self, and this is not an exhaustive overview<sup>29</sup>. However, and despite the differences across these theories and their corrections of each other, they all emphasize the essential role of interaction in forming the self. Taking the theories together, we learn that our selves are constituted in and through social interactions in a wider social context, alongside a range of discourses, powers, values, morals, and structures. In fact, Tait (1993) argues that in adolescence, youth participate actively in different kinds of “work on the self” that is historically contingent, making it important to focus on the social context (42. Laura Carpenter (2010), researching sexual subjectivities over the life course, argues that research must view subjectivities as constructed in particular socio-historical contexts. Budgeon (2003), investigating the process of self-identity in young girls (ages 16-21) and critiquing the ontological assumptions underlying Giddens’s reflexive modernization (especially the idea of an autonomous, choosing self), post-structuralism, and feminist theory, argues that we must locate “young women within particular contexts, practices, and relations” (47, see also p. 15-17)<sup>30</sup>. Building from these traditions and theoretical insights into the self, my work shows that the particular realities of girls’ lives and their understanding of their own sexuality are inextricably intertwined in social contexts that shape their self-work or experiences of self.<sup>31</sup>

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<sup>29</sup> For an overview of the theories, debates, and future direction of the sociology of self, see Callero (2003).

<sup>30</sup> See Budgeon (2003) for an indepth and insightful overview and critique of theories of self and identity, particularly chapter two, “Theorizing Identity.”

<sup>31</sup> As Callero (2003) points out: “Hochschild (1983, 1989, 1997) is particularly strong in this regard. Drawing from macro-economic indicators, structured questionnaires, and in-depth interviews, she has produced insightful descriptions of workers who struggle with new and ambiguous self-understandings and self-meanings that are being constructed in response to powerful changes in the capitalist labor process” (122).

Neoliberalism is one contemporary socio-political context in which girls, parents, schools, and medicine are situated. Neoliberalism began as a “theory of political economic practice” based on “individual entrepreneurial freedoms..., free markets and free trade” (Harvey 2005: 2). It has since become a hegemonic discourse, part of the “common-sense way many of us interpret, live in, and understand the world” (Harvey 2005: 3). This discourse promotes tropes of entrepreneurial personal empowerment and self-interest where individuals are entitled to informed and autonomous choice and are personally responsible for themselves (Bay-Cheng 2015: 280).

Scholars have focused on the political embeddedness of the HPV vaccine and the marketing around it. For example, Davies and Burns (2014) find that in the United States, girls and their mothers, are conceptualized as neoliberal citizens who are responsible for not only managing their health, but also promoting public health. Neoliberal discourses of risk, choice, and self-management are emphasized in order to promote the values of empowerment, freedom, choice, and rights (Davies and Burns 2014). In doing so, the main manufacturer of the HPV vaccine has co-opted postfeminist discourses of empowerment, freedom, choice, and rights “in order to produce girls, young women, and their mothers as a niche market of health consumers and as agents of their own health” (2). Ultimately, the HPV vaccine “contributes to individuals questioning their own bodies, sexualities and beliefs, and those of their children. This interrogation of self and others renders HPV immunization a site of anxiety and contestation rather than the outcome of simple acquiescence” (Mishra and Graham 2011: 59).

Neoliberalism has infiltrated our ideas about sexuality as well. Sexuality is something that is organized and constructed in relation to expert discourses (Foucault 1978), power, and social, cultural, and political settings. Contrasting the United States with the Netherlands, Schalet (2011) not only illustrates how social and cultural contexts shape sexuality and sexual experiences, but also how social and cultural systems impact how we *interpret* sexuality. Bay-Cheng (2015: 279) argues that neoliberalism has influenced the construction of girls’ sexuality and that “U.S. girls are now judged on their adherence not only to gendered moralist norms, but also to a neoliberal scripts of sexual agency” and “personalized responsibility” (279-280). The co-opting and neoliberalizing of sexuality is important to emphasize since the HPV vaccine (a vaccine for an STI) and its marketing are tied to scripts about female adolescent sexuality, as discussed above. These literatures and insights into neoliberalism paint a scene of the socio-



political context within which girls, families, and schools are situated, outlining the context, norms, and values alongside which girls live and develop their sense of self.

## 5. Methods and Methodology

Data for this paper are derived from semi-structured interviews with 19 Ontario girls, aged 11-17 (grades 7 through 12) and separate interviews with their mothers (and in one case, father) (16 parents in total since some girls are siblings). Three girls opted to do the interview through an in-depth focus group. Recruitment occurred after interviews with the girl's parent, where I asked if they would be okay with me interviewing their daughter, pending their daughters' interest, of course. Out of the 28 mothers I had previously interviewed, not all wanted me speaking to their daughters. Some said their daughters were too busy, and others had daughters who did not want to be interviewed. This sampling procedure may have impacted on the sample that I drew, particularly in terms of what types of girls participated in this research, as well in terms of their relationship with their parents. Interviews with girls lasted 40-70 minutes and were semi-structured, conducted between 2015-2016. While it would be analytically rich, mothers' transcripts are only minimally drawn upon in this paper to protect the anonymity of the girls. As such, the main analysis focuses on girls' narratives.

Interviews were recorded on a digital-recording device then transcribed verbatim by the author. Pseudonyms were assigned to each girl to protect their anonymity. Field notes were written immediately after each interview to record details about the interview: conversation dynamic, girl's ease or discomfort speaking to me and about this topic, body language, and other household dynamics that were at play before, during, and after the interview. Interviews were transcribed to include pauses in speech, delays, and hesitations, and emotions.

To establish rapport and to get to know the girls, it was important that I began with easy to answer questions about their lives: hobbies (music, art, sports, games), favorite subjects at school, extra-curricular activities, favorite video games/books, things to do with friends, etc. Then, I moved to ask girls about their relationships with parents and siblings. I then asked conversational questions about what girls know about HPV, then the HPV vaccine, and where they learned this information. We then discussed what they remembering learning in school health class in general, then specifically about the virus and the vaccine. Overall, the interviews were relatively open, allowing girls the freedom to discuss things they wanted to. However, due

to the topic of the interview itself, girls were sometimes shy when discussing these topics and needed prompts to get the conversation going.

Both parental and girl consent were individually obtained for these interviews. Interviews with girls occurred in a private space in the girls' homes, and one was held in a coffee shop (which was the girl's choosing). Most interviews were conducted in girls' bedrooms, family living rooms, or kitchens. I requested that the parents not be present for the interviews, although in a few interviews, parents milled about the house in other rooms, but even in these cases, girls had privacy during the interviews. Prior to the interviews, girls were informed that their parents would not have access to their interviews or anything they said to me. With that in mind, I am conscious of how I present these girls below and take care not to reveal their identities.

Talking with young girls about HPV, sexual health, sexuality, health can be a difficult topic, especially in terms of the language I would use compared to what they might. Their comfort level discussing these topics also came into play. During each interview, I made sure to let the girls determine what language was used. For example, when I asked one 11-year-old girl if she knew how HPV was spread, she responded quietly and bashfully, "through physical contact with boys." "Physical contact" was the language used for the duration of the interview. It was important I use girls' language in order to establish comfort and some ease in the interview.

## 5.1. Demographics

Based on information gleaned during the interviews as well as a short demographic form which girls filled out at the start of the interviews, I learned that nine of the girls had received the vaccine, with one girl having a severe adverse reaction to the vaccine. Ten girls had not received it, with a few parents still undecided. Two girls were 11 years old, three were 12 years old, two were 13 years old, five were 14 years old, three were 15 years old, one was 16 years old, and three were 17 years old. Ten girls were in grades 7-8, five were in grades 9-10, and four were in grades 11-12. Girls self-reported their race and ethnicity. Sixteen girls self-reported themselves as white, one girl as Chinese-Canadian, one girl as Lebanese, one girl as Guyanese. Eleven girls attended English schools (9 public, 1 private, 1 Catholic). Seven girls attended French school (3 public, 2 private, 1 immersion, 1 Catholic). In the Canadian context, attending French schools can indicate a marker of a middle-class background of the families. All of the girls identified as heterosexual, and none of the girls admitted to being sexually active at the time of the interview.

None of the girls fully rejected their parents' opinions, wishes, and belief systems. In other words, none of the girls were fully "oppositional." This could be because of my sampling procedure. Parents with truly oppositional girls may have not wanted their children to participate in the research, although based on my interviews with parents, none of their children were portrayed to me as truly oppositional.

## 5.2. Narrative-Informed Inquiry

Analysis was guided by key tenets or qualities of narrative inquiry. Carless and Douglas (2017: 307-8) outline six main qualities of narrative inquiry. It 1) "offers rich insights into lived experience"; 2) "shed[s] light on the *meaning* of personal experience"; 3) considers life trajectories; 4) focuses on "the *personal* and the *social*"; 5) "offers insights into what life is like as an *embodied* – living, breathing, feeling – human being"; 6) is an "*ethical relational engagement*" based in open and frank dialogues between researcher and informant. Narrative research provides an opportunity to "[examine] subjective, discontinuous, and local truths about groups of people and individuals who might not otherwise have a voice" (Block and Weatherford 2013: 511). Through my analysis, I center girls' voices and uncover the ways in which their understandings, knowledge, and experience with the HPV vaccine unfold alongside other sociocultural structures (such as family dynamics), as well as their sense of self.

To analyze the data, I used open and inductive coding of the interview transcripts and wrote memos emphasizing the understandings and knowledge that girls had of HPV and the vaccine. This first step helped me analyze the actual content of the interviews, uncover what discourses were present, the context of the story, and allowed me to focus on insights and understandings girls had (Ezzy 2002; Barusch 2015). I re-read girls' transcripts, as well as those of their mothers, to compare and contrast each of their narratives and discourses, to uncover overlapping themes, related ideas, or moments where girls and mothers were on the same page, or at odds with each other. I paid particular attention to girls' age, to understand this dimension in girls' narratives. I draw heavily on direct quotes from girls in order to provide a detailed account of their stories. This detailed account and heavy use of direct quotes was stylistically and methodologically inspired by Polzer, Mancuso, and Rudman's (2014) narrative research on the HPV vaccine and university-aged women's identity negotiation.

## 6. Findings: Patterns of Narration Accounts

When looking at girls' narration of the HPV vaccine, health and sexual health, I find that other people, negotiations of independence and autonomy, and trust (as in, who girls look to) were main themes in all the interviews. Reading girls' narratives with these themes in mind (see table 1., below), I find that particular types of selfhood emerged. Some girls: 1) prioritize their mothers' narratives, presenting a type of "tethered self"; 2) explore enactments of agency, autonomy, and independence (although, with varied success), presenting an "autonomous self"; 3) have confidence in the accountability that is diffused between their parents, schools, and doctors -- instilling trust in these institutions gives them a sense of assurance in their stance on these topics. This is the "trusting self." Alongside each of these types of self, girls often drew on sexual scripts (e.g., innocent, consciously celibate, rational-calculation), seemingly as a narrative device that facilitated their larger self-narrative. In what follows, I explore each type of self, outlining the intricate thought processes that girls take as they think about the HPV vaccine, their health, sexual health, and sexuality.

**Table 2. Types of Selves and Patterns of Trust Among Adolescent Girls**

Types:	Looks to:	Parents	Medicine/Science	Gov./ School	Self <sup>32</sup>
<i>1. Tethered Self</i>		Yes	No	No	Partially
<i>2. Autonomous Self</i>		Partially	Partially	No	Yes
<i>3. Trusting Self</i>		Yes	Yes	Yes	Partially

### 6.1. Type 1: The "Tethered" Self

The "tethered" self is a subjectivity that emerged in girls who looked to their mothers when it came to their narratives on the HPV vaccine and their health. These are girls who prioritized their mother's narratives, often mimicking the type of language and themes that their mothers

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<sup>32</sup> While I am analytically presenting emergent patterns of self, there is still a category of self here since girls are not a "tabula rasa" at this point in their lives. I do not want to suggest that before this moment and time in their lives they did not have a self and that a self is only emerging in adolescence. Girls may look inwards or to themselves. Moreover, looking to or trusting in oneself would be a part of the self work they are doing in their adolescence.

had previously told me in interviews. Most of these girls were ones who *did not* receive the HPV vaccine. This was often accompanied by mistrust in the science behind the vaccine, as well as schools and doctors who might recommend it. Their presentation of self was established through their active acknowledgment or commitment to prioritizing what their mother told them and taught them on these topics. For these girls, health, sexual health, and sexualities knowledge operated in the realm of the family, usually in relation to their mothers. Below, I highlight narratives from Stacey and Chantelle, two sisters who exemplify this narrative and type of “tethered” self. However, some girls who *did* receive this vaccine also prioritized their mother’s narratives on the topic more than other people (like teachers or doctors), mostly out of a lack of access to or an interest in reaching out to these sources of information. This makes these girls distinct from type three – the “trusting” self. They did not take an active stance on these topics, more passively prioritizing their mother’s narratives. Most of the girls who presented a “tethered self” were younger in age and may shift to other self types as they get older. However, some older girls also articulated this “tetheredness,” and were girls who had not received the HPV vaccine. Their stance on why they did not get or want the vaccine depended on and reflected how their mothers spoke about it.

Sisters Stacey and Chantelle are 12 and 13 years old and in grade eight and nine at public French school. Interviewing them individually, I learned that they both received mandatory childhood vaccines, but they did not receive the HPV vaccine. Their narratives help set the stage for thinking about the role of mothers, schools, friends, and girls’ own thoughts in conversations about health and sexual health protection vis-à-vis the HPV vaccine. Their own narratives on the topic prioritize and mirror their mother’s. However, despite their prioritization of their mother’s narrative, there were moments in our conversations when they expressed conflict or confusion in how to think about the HPV vaccine, particularly when the topic of sex came up. They reconcile this by turning back to trust in their mother, almost ignoring the realizations they had during our conversations.

Stacey, the younger of the two sisters, described herself as nerdy and someone who likes school, while Chantelle described herself as someone who likes to help others, as friendly, competitive, and disciplined. Their mother, Natasha, researched this vaccine extensively and was passionate that her daughters do not receive it due to her perception of the unknown risks associated with the vaccine itself. Describing her daughters, Natasha told me that Chantelle was extremely smart,

does not do “crazy things,” and is highly respectful of others and rules. She told me that Chantelle is organized and will not “contradict a word of authority” which may be why she has a hard time asserting herself. In contrast, she described her Stacey as a social butterfly and very assertive.

Both Stacey and Chantelle spoke fondly of their parents and the work they do to raise them properly, a theme (proper, good, hands-on parenting) that was present in their mother’s earlier interview with me as well. Stacey told me that she feels her parents “educate [her] properly,” unlike other parents who don’t care if their kids only play videogames and not do their homework, and that “talking to [her parents] is really important.” Chantelle shared this sentiment, telling me that she is very open with her parents and that they give good advice. She admits that she’ll<sup>33</sup> tell them everything about her social life, except, she whispered to me, about boys. In general, Stacey and Chantelle’s narratives reproduced and affirmed normative expectations about good parenting for their own parents.

Both girls remember their mother talking to them about their health and this vaccine, and mirrored their mother’s voice on the topic. Stacey told me:

Well, my mom does email me websites on [the HPV vaccine] and I read them. And for instance, one said that um, 213 women, well that [research] was in 2010, so probably more, a lot of them are living but are permanently affected from HPV vaccine. Like they were in a wheelchair. Like they were permanently affected.

It is unclear to me where exactly Stacey got this information from, and if it is true. Regardless, Stacey’s general concern was about an ambiguous risk of the vaccine itself, worrying about being part of the “small percentage” of girls that “could be affected” or die from this vaccine. With that in mind, she was confident that she could protect herself from “sexual sickness” in other ways. Similarly, her sister Chantelle told me, “People die from it. People get paralyzed. They can’t walk, they can’t talk. They can’t do anything.” For Chantelle, the HPV vaccine

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<sup>33</sup> While it is not the norm in academic writing, I sometimes intentionally use contractions in my descriptions and prose outside of direct quotes to capture the spirit of how girls spoke to me, especially when I am paraphrasing girls.

presented a more an omnipresent risk that could jeopardize her future goals of being a dancer, advocate, and scientist. This risk was reinforced by her experiences with the flu vaccine, which she described as making her arm feel numb. Notably, both brought up risk and a mistrust of the government and pharmaceutical companies, and questioned their fellow students' knowledge on the topic, saying that they "do not know the full story." They even questioned doctors' knowledge as well, with Stacey asking me, "Like, do our doctors who come to our schools, do they know there's a risk?" Chantelle told me:

I didn't know any of the risks [of the vaccine] before my mom talked to me about it. I didn't know what it did exactly. And I didn't learn about it in school. And the pharmaceutical companies and the people who invented the vaccine and who are selling them, they only talk about all the good stuff about it. So, the parents and the girls and some of the boys that take it, they say, 'well they say it's good.' But they're not seeing the full story. And there's a lot of bad in that full story. ... And there's other ways to make sure you don't get [HPV]. One, get your partner checked and get your self checked. Two, protection. It's there for a reason, so use it. Like condoms. Like if you start with the stuff that you know will work and will easily ensure like, health and like safety. And then, if that doesn't turn out to be what you want or that won't work, then you can go to the vaccine.

Chantelle's explanation here and throughout our interview is interesting for, on the one hand, she expressed an active mistrust in expert advice and authority presented by pharmaceutical companies and scientists, and yet on the other hand, her mother describes her as someone who never contradicts authority. It appears that she *does* question and assert herself in relation to some people, but will not contradict or question the main authority figures in her life – her parents, and notably, her mother.

Both girls remember the day the vaccine was given at school, a time when they had to actively consider and defend their stance on it:

Stacey: Everybody seemed to take the vaccine at school and I thought um, I didn't really want to take it. And everyone in my class asked me, 'why aren't you taking it?' And I told them, 'well, there's a percentage that I could be affected by it.' And I don't think that their parents were interested or didn't have any time to tell

them that. Cause I think they like trusted the like government on the vaccine. But you can't trust everything, so.

Stacey and Chantelle were the only students in the class who did not receive the vaccine. Girls in other national contexts (such as the US, where vaccines are not given at schools), might not be confronted with having to reflect on or defend their stance in public or to their peers. Part of how Stacey defends and justifies her views is by referencing parenting norms. In other words, part of her confidence in her own stance comes from being assured with the good parenting her mother does. Stacey recognizes that her stance on it is not the dominant or popular one and that other people might view her as “crazy:”

I think they kind of like, just said, ok. I don't think they took me seriously cause like, um, I know that like there's a risk, and the risk is bigger than having a certain cancer. But because they didn't do the research, and cause like, I don't have a lot of friends in my class, they might think that I'm crazy or something, I don't know. ... But, it's ok. Um, I know that I'm safe. Um, like, cause I don't have a chance of like dying cause I didn't take it. But I'm not uh, I'm not safe in a way, 'cause I didn't take the vaccine, from HPV.

Stacey's recognizes that she feels safe and not safe, and that her understanding of the HPV vaccine goes against the grain. Based on her tone discussing this though, she appeared to be okay with this label. In fact, she appeared to be proud of her standpoint on it and confident because she's done the research (with her mom) and knows what she considers to be the truth on the topic.

Her self-narration, developed through information she garnered from her mother and scripts she speaks to her classmates, reveals a subjectivity of active and informed rejection (see Robbins 2010)<sup>34</sup> that is established through opposition to the vaccine as biotechnology. Yet, Stacey did

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<sup>34</sup> Robbins et al. (2010) conducted focus groups and interviews with parents, girls, teachers, and nurses. They categorize types of decision making in a five-fold matrix: active decision/vaccinated, passive decision/vaccinated, active decision/not vaccinated, passive decision/not vaccinated, and anti-vaccination. They produce a continuum of vaccination behaviour, outlining reasons why parents are more or less likely to consent to the HPV vaccination (e.g., “I just signed”), and conclude that attitudes, past experiences, and worldviews contribute to the decision making process.



recognize that she was technically at risk for contracting HPV since she was unvaccinated. When I followed up with her on that, she told me, “well, if you like stay away from relationships, you’re ok. Uh, in health class we learned things about like, condoms, um, and well, you can ask people if they have a sexual sickness.” Her stance on the vaccine also requires a sexuality narrative of “high agency and low activity” (see Bay-Cheng’s (2015: 280) “Agency Line”), one that depends on the conscious rejection of sex, which constructs her as “good,” innocent girl. She reconciles the risk of not having the HPV vaccine through her good girl persona as uninterested in sex -- her conscious celibacy (see, Bay-Cheng 2015). Stacey has pride in her identity, which is based on her agency, aligned with a calculated and unapologetic nonconformity and personal responsibility, but is predicated on a trust and belief in her mother. Yet, telling me of students in her grade who “kiss on the face,” she thinks the vaccine might be a good choice for them. However, Stacey felt a tension and said, “I think they could get the vaccine, but they don't know if they're affected by it because you don't know if in the future you’re going to die from that vaccine. But they probably should get it (the vaccine) to protect them[selves from HPV].”

At 12-years-old, Stacey feels conflicted between the narrative of risky vaccines and real-life scenarios where a person (being sexually active, or even kissing) might need it. Trying to make sense of this, she told me that for her own life, it’s not worth risking either way -- getting the vaccine or starting sexual relationships young. Although, when thinking about other girls at her school, reconciling this wasn’t as straightforward. Based on what she hears from older girls on the school bus, she believes that girls in grade nine and ten might be sexually active and would need the vaccine, despite this being at odds her stance that the vaccine itself is risky.

This is an interesting moment for Stacey, where she is of two minds. In her initial description of it, Stacey was very clear and confident in her stance on the vaccine -- No, because it’s dangerous. However, when considering the sexual behaviour that she sees as girls get older, she worries that girls might need the vaccine, but no longer knows how to reconcile that possibility with her initial perception of the vaccine’s risk: “My mom didn't want me to have it. But, like, I agreed with her.... But if I really really really wanted to have it, um, I don't know what she’d say, (pauses then says hurriedly) but I didn't want to have it anyway. I trust her.”

When her stance is rooted in her family context, Stacey talks confidently and assuredly. However, when her understanding of the vaccine comes into the realm of school, older girls, and

or girls and boys her age who are “kissing on the face,” Stacey’s begins to see the grey areas in how her understanding of the vaccine, sexual health (“just don’t do it” – the vaccine or sexual behaviour).

In summary, Stacey and Chantelle’s thoughts on the vaccine are aligned with their mother’s thoughts, but also the trust they have in their mother in general. If any time their stance was challenged on it (perhaps by classmates), or if they started to understand why one might get the vaccine, they brushed those concerns and thoughts aside by reiterating what they learned from their mother. A “tethered” self-narrative emerged throughout our interviews. Moreover, this trust in their mother’s concerns about the vaccine itself depends on Stacey and Chantelle presenting sexual subjectivities as a-sexual, innocent, and safe. They planned on just not being sexually active, or if they are, they imagined themselves being calculating and safe about it.

## 6.2. Type 2: The “Autonomous” Self

The “autonomous” self is a subjectivity that emerged in girls who strive to have some say in this decision, despite it ultimately requiring parental consent. They felt that since it was their body, they should be involved in some capacity. These girls do often look to their mothers, but unlike “tethered selves,” they do not situate their self and stance on the HPV vaccine, health, and sexual health solely in line with their mothers. These girls’ narratives are insightful for they highlight the development of self that might be expected in adolescence -- testing out a personal independence, agency, and trust in themselves. However, these girls often have difficulty enacting this autonomy due to a lack of power and knowledge. Below, I introduce Charlotte who exemplifies the “autonomous” self and how this relates to her thoughts the HPV vaccine.

Charlotte is a 15-year-old girl in grade nine public French school. She is a very active teenager and a highly athletic person. Charlotte’s narrative centered on themes of independence, autonomy and agency, the importance of being informed, and the intricacies of parent-child communication. Her self-narrative is interesting for it highlights her attempts and desires to be independent, have autonomy and control over decisions, but also reveals her inability to accomplish those things due to a lack of information, leading her to fall back on her mother’s decision on the HPV vaccine. She acknowledges the importance of teens having autonomy over things that happen to their bodies and lives, but also realizes the impracticality of this due to their age, but also because of parent-child relationships.

Throughout my data, parental intentions, influences, and hopes were prevalent and impacted girls' self-narratives. For instance, Charlotte's mother, Pam, raised Charlotte to be self-autonomous and was proud of Charlotte for this. Pam describes Charlotte as well-rounded, taking pleasure in her accomplishments to date. Unlike when raising her much older son, Pam intentionally tries not to hover over Charlotte, letting her do things for herself and giving "her space and privacy." She told me: "I take my cues from her about what we'll talk about. I try not to ask probing questions. I'm grateful that she lets me in on what some of the problems are that her friends are having." This is reflected in Charlotte's presentation of self, particularly her self-assuredness. Sitting cross-legged on her bed, wearing retro 90s jeans, Charlotte confidently told me about her athletic achievements, her interest in music, and explained her scholastic aptitudes, actively choosing what high school she wanted to go to. Only in grade nine, she had already begun saving money for a post-graduation road trip across Canada.

Throughout their interviews, both Charlotte and her mother Pam purported that their communication channel was open and good. Charlotte reaches out to her mom to talk when she needs to but relishes in her ability to talk to her core group of two or three friends about things she just wouldn't tell her mom. Rolling her eyes, Charlotte remembers her mom's attempts to have the "weird and obligatory parent talk... It's usually just, 'do you know these things?' I say, 'yes. Ok, good. Done.' Like, nah, [not interested]. 'The talk' hasn't happened in a while and what was, was just an intro."

Despite limited communication on particular topics, Charlotte took pride in being close with her mom, especially when comparing how things are between other girls and their parents:

I know that a lot of parents don't know their children at all. And they say, 'I'm going to go study.' It's all a lie. [They're] going to go party and go drink a lot of alcohol. So, I think a lot of parents have a very skewed version of what their children are like.... I know girls that aren't close with their mothers at all and don't tell them anything. So if things were left to their parents' discretion, they wouldn't know what to do cause they don't know what their kids would need.

This pride in her ability to talk with her mom was more of a feeling of trust between the two of them, premised on the "space" her mom gives her. This dynamic came across in Charlotte's presentation of self as autonomous and independent. Yet, Pam's trust in institutions like schools

to educate students about things like the HPV vaccine is reflected in Charlotte's minimal knowledge of HPV.

Pam wasn't sure what Charlotte knew about the HPV vaccine and "just assumed" the school would do the job of teaching them about it. She admitted that she didn't talk to Charlotte about it beyond telling her that she's in favor of it, but was sure she would have heard about it "one way or another." Charlotte doesn't remember talking much with her mom about it, and her knowledge on the topic was sparse:

Charlotte: [The public health nurse] gave me the spiel before I got the vaccine. It kind of went over my head, but it seemed like it was doing all good things.

Me: Okay. Do you remember learning anything about it in health class?

Charlotte: I might have. There was totally an STI section in grade seven, but I don't remember anything. Nothing is popping out at me right now. Not at all.

Me: Do you know what HPV is?

Charlotte: (pauses then says very hesitantly and with upvoice, indicating that she's guessing) Genital warts?

Me: mhm

Charlotte: I'm right with that one? Alright! (Said enthusiastically with a smile, then changed to a low, serious voice), you don't want those. Um, [the vaccine] will stop that, um,

Me: Do you know what else it's related to?

Charlotte: um... (pauses) cerv...(pauses)...ical cancer?

Me: Yup

Charlotte: See! I know more than I think I do. Is it anything related to HIV, despite those two letters?

Me: No

Charlotte: Ok, nope. That's all I know about that then.

As our interview progressed, her thoughts on the HPV vaccine and this decision evolved and changed as she grappled with topics like sexuality, maturity, and agency. This was particularly the case when animatedly discussing the importance of teens having bodily autonomy and a say in the HPV vaccine decision, especially since parents don't know what's best for their kids:

Yes. Most certainly [they should be involved]. This should be up to girls. But um, well (pauses), okay. Grade eight, there are, well, see no. Simply cause of the amount of people who said, 'I wish I didn't have to do this. Cause this will hurt me.' See, grade eight girls don't have their priorities straightened out, or reasoning behind their logic. So, in that particular case (pauses), I gotta say no [it shouldn't be girls' decision]. I personally would have said absolutely [if it were my choice], because I could end up with an STI or cancer if I didn't get this vaccine. Sure, it would hurt. But I can't speak on behalf of my age group on that one.... I think that the level of development varies entirely in grade eight. There's some people who are fully capable of being independent and making their own decisions. But there are certainly also people who [have a] grade six mentality that are kind of just coasting along.

Charlotte expressed narratives of maturity, self-autonomy, and the importance of girls' making their own choices. Yet, she felt that other girls her age would not make the right choice because of their immaturity or, because they do not actively participate in their lives. Her narrative draws on neoliberal ideologies of self-determination and individual personal responsibility. These inform her own self-narration, but also (almost judgmentally) her perception of other girls who just coast along, not actively taking responsibility for the important things in their own lives.

Despite knowing she'd have said yes to this vaccine (unlike other girls who lack the maturity to "do the right thing"), she also felt the vaccine had to be given in grade eight, since by grade nine, teens will definitely need it because they'll be sexually active. Complicating this, she thinks parents make the wrong choices for their kids and send "them out into the world unprepared," especially those parents who think the vaccine encourages sexual activity, or those who think

their kids aren't sexually active. She told me that these parents are harming their children because of their "backward ideas." Charlotte feels that this creates a precarious situation for teens since they have no say in the HPV decision, but if they had to ask their parents for the vaccine, parents would become suspicious of their teens' sexual activity:

Some kids would not want to talk to their parents about those things. Therefore, when the time did come, and it was like 'I do need this now,' they won't want to talk to their parents 'cause that would lead to further questioning like, 'why do you need this now?' blablabla. So, they'd be stuck in a predicament where they'd have to ask their parents but they wouldn't, so they wouldn't end up getting it.

Her answer again reveals the complicatedness of how this decision should be handled, by whom, and at what age. She does think teens should have a say in the decision, but in grade eight, they may not be mature enough to make the choice, but she also realizes that you cannot push this vaccine later since sexual activity is prevalent in grade nine.

Charlotte also acknowledged the importance of informed decision-making (another key aspect of neoliberal ideology), but this was complicated by the inadequacies of her school-based sex-education:

My sex-ed so far was pretty much like, 'these are pretty much all your contraceptives. Use them wisely.' And it was generally the idea of like, they didn't use any kind of fear tactic. Well, they obviously did for a couple of them, but there were pictures of things when stuff goes wrong. But like, they presented the information to you, but they weren't like shoving it down your throat. It was very medical language. Like we were given some good assignments where it was like, pretend you're an advice columnist. The person is debating having sex with their partner, what should they do? But as far as the STI section, it was like, 'these are the facts, copy them out, write them down, do a two minute presentation on a disease of your choice.' Then it was like, move along.

Speaking about information and vaccine decision-making, Charlotte stated:

If it were the decision of the girl or boy or the kid, there needs to be more education about it and they need to be more informed. ‘Cause in order to make an informed decision, they need to have something to base that [decision] off of. Like, I suppose, like, they totally talked about it [at school], but maybe they should have emphasized to us that we need to absorb this information.... ‘Cause, [our teacher] was just like ‘you’re going to get a vaccine to stop this.’

Upon saying this, Charlotte realized such a suggestion might not be possible:

I suppose knowing to what extent you’re protected from HPV would be a good thing to know so that you have other measures in place. But, loading young grade eights up on facts will not help, cause no one is going to listen. I think it should be touched upon [in grade eight], but when you get to grade 11, 12, the ship has sort of sailed for some people. And your chance for having protective measures in place is kind of out the window. So, I think it’s difficult cause when they’re younger they certainly don’t know a lot, but they also don’t need to know a lot. But then, like ‘cause if it were like, if you knew when everyone would go about doing it (sexual activity), then that would be a whole lot easier. But, ‘cause it can vary a whole bunch of ages, it will vary knowing when they’d need this information.

Charlotte grapples with when and how students should learn about these topics, and when this information might be most useful. Despite feeling like she did not learn much in school, she did feel like it is the right environment to learn about it. She did not think doctors were appropriate for transmitting this information. This stemmed from her bad relationship with her own doctor who “doesn’t have his priorities straight for [her] health,” suggesting weight loss and prescribing her acne medication when she would consult him about leg pain and difficulties breathing. This experience influences how she thinks about and trusts doctors to know what’s right for her health.

Charlotte’s difficulty in knowing where, when, and how it would be best to learn this information in order for adolescents to be able to make such a decision, was also related to the fact that girls all have different priorities:

Well, like, there's certainly a whole group of girls that go to my school whose sole purpose is like, let's go find all the boys and do things with boys. And I, on the other hand, am not looking for that stuff right now. So, what I'm in need of is completely different than what they're in need of. That whole group of girls also doesn't seem like the most informed about how to keep themselves safe. 'Cause you get a lot of like, when it's young girls who are willing to have sex, they're the same girls that are willing to get drunk all the time, and make poor decisions. Plus, intoxicated-poor-decision-making, will not lead to good in-the moment-decision-making. So, anything you can do prior to that would be good and necessary.

This excerpt reveals how being informed and the personal responsibility of keeping oneself safe plays a role in Charlotte's sense of self and is established in opposition to how she viewed other girls at the school. Her own sense of self as an independent, agentic, and a good girl was premised on her ability to know what was right for her self, including the HPV vaccine, but also depended on refraining from "risky" teenage behaviours, which involves avoiding boys and drinking alcohol.

In summary, Charlotte presented herself as mature, outgoing, as having her priorities straight, as an advocate of choice, autonomy. She emphasized the importance of being informed (despite not knowing much about HPV and the vaccine), especially since parents don't know what's best for teens, but that (some) teens may not know what's best for themselves either. With all of these thoughts and stances in mind, it was interesting when near the end of our interview, I asked Charlotte finally if she was content with the amount she knew about the vaccine:

I don't feel like I needed to know more because, honestly, the decision was made for me and I was okay with that. And as far as I was concerned, if you can do something to prevent [HPV], I might as well and I was A-Okay with that. But if I were told there were any negative side effects, or anything like that, (pauses) I suppose I should have done some looking into it. But it really didn't seem important at the time. 'Cause, it was just kind of like, it was not forced upon me. I wasn't getting vaccinated against my will. It was something that just happened that I was okay with.



At that moment in our interview, her narrative switched from active, autonomous, and stressing the need to be informed, to a passive, yet contented, acceptance, where she conceded the decision to other people. This conceding to others was due to her inability to actually enact agency as a young woman, part of which is the result of barriers (e.g., poor school-based sex-ed and a lack of information) that inhibit her from being more involved. Charlotte's narrative highlights how some girls desire to be in charge of their bodies and decisions, but realize that they cannot do it alone. In Charlotte's case, this "autonomous" self was accompanied by neoliberalist scripts and moralist norms of personalized responsibility and control over her sexual agency (e.g., avoiding boys altogether) (see Bay-Cheng 2015 for more on this).

### 6.3. Type 3: The "Trusting" Self

The "trusting" self is a subjectivity that is associated with a trust towards experts and authority, like parents, medicine, education, teachers, and the state. These are girls who really felt that the decision and how to think about these topics was best established by other people, not themselves. Their presentation of self as responsible is established by trusting the experts and authorities that are in place. This type of self is distinct from the "tethered self," in that these girls look beyond their parents and families, to a more widely distributed group of people, experts, and systems that are in place (such as school based sex-ed). These are girls who, on the one hand, look to their parents to make decisions for them about their health and sexual health, but who also, and on the other hand, promote and draw on public health and broader social structures to do this as well. Below, I introduce Becky who exemplifies the "trusting" self.

It was near the end of the school year when I interviewed Becky, who was just finishing grade 12. A well-spoken and polite girl, she sat with perfect posture and tidy hair pulled round into a bun. Describing herself to me, I learned that she is a dancer and classical musician, but hoped to become a doctor, like her father. Becky is close with her parents, closer with her mother, but doesn't talk very much with them about topics other than school. She told me:

Um, I'm generally not too open about that stuff (health and my body) but that's just because, 'cause the stuff I learn, I learn in school. And sometimes [my mom] tells me things about sanitation, stuff like that. But other than that, it's not too open. But I feel like I don't need anything else.

Becky's narrative is important for it exemplifies girls who have good relationships with their parents, but are not open and highly communicative. Despite this, Becky feels assured that her needs are being looked after by other people and institutions that are accountable to her and her health. This perspective comes from a trust that she has in these institutions (like school and medicine), likely from her upbringing in a medical family. While some of the other girls I discussed above turn to their mothers for information or were skeptical or frustrated of what they learned at school, Becky placed trust and confidence in school for this type of education. This trust extended to the science behind vaccines in general.

Becky was very well spoken, and while her knowledge of the HPV vaccine was minimal, she did know what it was. When I asked her what she knows about HPV and the vaccine, she told me very confidently and matter-of-factly, "So I basically just know that it's a virus. A sexually transmitted virus. Um, that causes cervical cancer. And you get vaccines at school. Mainly to prevent the cancer." Becky's interactions with her parents on this vaccine and decision were limited, in part because of her father's occupation as a doctor and as someone "who believes in vaccines," making it a taken-for-granted topic or conversation in her household. When I asked Becky if she remembers ever talking with her parents about this vaccine, she promptly said:

[The conversation] was just that 'you're getting the shot.' Period.... I would have given [the consent form] to them, they would have signed it. I remember grade six, we had gotten a couple of shots. And my memory is not that good, but I remember that there are shots for girls, and for guys, and for some reason I thought I wouldn't be getting this shot, but my parents were strict that I was going to get it. Definitely.... [My parents] may have said like the basics, just that it's a virus, sexually transmitted, and just that it protects against that. That would have been the extent, and that's the extent to which I know now (laughs awkwardly).

Becky's understanding of the virus and the vaccine are technical, and her knowledge and understanding of them operate in an environment where this vaccine, like other health interventions, are automatic and a taken-for-granted, which may be why broader discussion of HPV and sexual health were not likely to occur.

Aligned with the decision her parents made, Becky would have gotten the HPV vaccine if the decision were hers alone. For her, it was about protection:

It's just one more thing you can get to protect yourself against the virus, first of all. Even though it's rare for me to get the virus, um, any situation, you know, there could be a number of situations where you could get the virus, so, just having that kind of protection. Just kind of something there. Just in case.

Becky spoke with ease, using normative language about vaccines, viruses, protection, but was less comfortable discussing sex and sexuality. When I followed up with her as to why it would be rare that she'd get that virus she laughed a bit, hesitated, looked down at the table, and said, "Ya (chuckles). Um, ya, not (laughs awkwardly and pauses). I'm not doing anything like that. Like, no relationships or anything. More for long-term protection (laughs awkwardly)." While on the one hand, she demonstrated maturity and poise in discussing the technical aspects of the vaccine, on the other hand, she exhibited shyness on the topic of sexual behaviour. Like many of the girls interviewed, their sense of self as discussed in relation to the HPV vaccine was accompanied by sexual scripts of innocence, conscious celibacy (for now), and being safe.

Becky's knowledge of HPV and the vaccine came from school, having no memories of learning about it anywhere else. She was happy with the amount of information she did have, and having received the vaccine, she feels "pretty much safe from it." When I asked Becky if she knew what the vaccine specifically protects against, she responded by saying, "Um, all I know is that it would prevent you from catching the virus." Becky had no knowledge that the vaccine protected against four kinds of HPV. When I gave her that information, she laughed awkwardly told me, "Okay, I didn't know that." Despite knowing some technical information on the vaccine and initially describing what HPV and the vaccine are, Becky's knowledge of the vaccine was limited, but this did not affect her stance on the vaccine, or on her decision. In fact, she was fine with knowing as much as she did:

Well, for me when you first told me (it protects against four strains), I thought [about] why this vaccine probably only protects against four. It is probably because those are the four most common, and it's rare to get all of the other kinds. So for me, I don't think it lessens my choices if I were to choose the vaccine, 'cause I know that it's a government thing, and it's in schools, so they would have taken the time. Like, they would have thought through it and realized that this is the priority. This is what we're going to give you.

Becky's personal experience with the HPV vaccine operates in relation to her father's authority as a physician and the taken-for-grantedness of it within her family, but also in relation to a general trust in government and school processes for doing what's right for citizens. Her sense of self is tied to how best to be healthy, and reflects Rose and Novas's (2005) description of biological citizenship, with Becky establishing her sense of self vis-à-vis her trust in biotechnologies and a larger social landscape of people and institutions that will do what is best for her. My previous chapters show that accountability for girl's health, sexual health, and sexuality is often dispersed between multiple institutions (families, schools, the state). Becky's comfort in how much or little she knows, and her ease with the decision, is rooted in the fact that these other people and institutions know what's best for her.

In terms of girls' responsibility with this topic, Becky believes this vaccine choice should ultimately be a parent's decision and not a girls' decision. She justified this stance by framing the decision in relation to other parents and kids. Referencing minors, she ties responsibility to legal-rational understandings of responsibility for adolescents and adults:

I think it should be the parent's choice. Like, since they're still minors. It has to be the parents obviously. But I think I see kids not wanting to get it cause it's a shot. ... So, rather, the parents would evaluate the situation and um, like understand the benefits of the shot and say, 'you have to get this.' I think more parents would say yes rather than kids saying yes.

Rather than a discussion of responsibility being around girls' autonomy as was the case with Charlotte, responsibility in Becky's narrative was tied to what would more likely lead to vaccine uptake. This is a more biotechnical treatment of responsibility and reflects parental influence. When I asked her about her own involvement she told me:

Well, I was fine with their choice. Like, I trust my parents with whatever their choices are and their decisions. I trust my dad as a doctor to know what's best for me. So, I was fine not fully knowing what was happening. I knew I was getting the vaccine. I knew my parents thought it was good for me. Then, it would be good for me. So, I was fine with that.

In summary, when discussing others girls and parents, Becky justified the decision as one that parents should make because of girls' irrational fear of the shot. With herself, she justified it being her parent's decision because of her trust in them. This is interesting since Becky has some technical knowledge and would not have said no because it was 'a shot' like other girls might have. Instead, she was fine with her parents deciding and knowing what's best, deferring authority to them. Yet, Becky was not close or open with her parents, and decision making aside, she was okay with having minimal knowledge on the topic since she feels assurance her health is being taken care of not only by her parents, but by other institutions like schools, medicine, and the state. This position establishes her subjectivity as a "trusting," one who listens to authority (parents, medicine, schools, and the state), and accepts recommended health interventions.

## 7. Discussion and Conclusion

In this research, I start with the HPV vaccine as a point of entry to understanding how girls grapple with complex topics about their lives, health, and futures. Doing this, I provide a contextualized account of the social organization and processes of how girls' sense of self emerges, demonstrating the ways in which their sense of self is tied to other people and health interventions like the HPV vaccine. To that end, my research goes beyond explanations of discovering what girls do or do not know. Instead, it illuminates how they come to think about these topics the way they do, given that they are embedded in schools, families, and are primed by marketing to be independent, agentic, and neoliberal subjects.

When speaking to these girls about the HPV vaccine, health, and sexual health, Stacey and Chantelle exemplify a "tethered self," revealing how girls prioritize their mothers' narratives, at all costs, even when they begin to think things that divert from their mother. Charlotte exemplifies an "autonomous self," highlighting how girls, transitioning from young girlhood into later teenhood and raised to be independent and assertive, might struggle to enact those qualities because of their lack of information or even their maturity. Lastly, Becky, raised as part of an upper-class medical family, exemplifies a "trusting self," revealing the ways in which some girls trust the intuitions and dominant groups that are in place to account for her health. In Becky's case, she placed trust in institutions like school and medicine, in part because she is not close or open with her parents. Alongside her belief that teens are minors and should not be responsible for this decision, she found assurance in state interventions that are in place. With variation in the

details, the other girls in my research broadly fell into these patterns as well. They looked to their mother (like Stacey and Chantelle), attempted to look to themselves (like Charlotte), or looked outward to other dominant institutions and people (like Becky) (see Table 1, above).

This research speaks to broad sociological and feminist discussions about subjectivity and the formation of self. It speaks to how neoliberalism, marketing, health knowledge, and parenting styles and relationships are “taken up,” internalized, rejected, or negotiated by girls. The HPV vaccine is a particularly interesting case to think about these things because it occurs at a time in girls’ lives when they are transitioning out of young girlhood, into adolescence and teenhood, and are perhaps thinking about their bodies and selves in this way for the first time. This research reveals the ways in which girls come to understand and make sense of topics like the HPV vaccine, sexual health, sexuality, and also a story of subjectivity formation. Previous research establishes that girls do not know much about the topic of the HPV vaccine. While this is clearly the case, girls’ path to understanding is more complex than this. Their lack of information and knowledge on the topic will not be remedied by simply giving teens more information. As these findings show, the narrative pathways girls take to make sense of these topics is tied up with their own subjectivity formation, their perceptions of other teens, who they trust or look to, and their relationships with parents, teachers, doctors, and institutions. With this in mind, I argue that what girls think about the HPV vaccine is less about the vaccine itself, but more about the interpersonal relationships and contexts that girls are in as they negotiate a sense of self. It is more about their trust in their mothers, their efforts to be autonomous and make decisions for their own bodies, and/or their broader effort to be a good citizen and listen to expert advice.

Future research should also more clearly investigate the link between parent and child subjectivities. For ethical reasons, and due to my small sample, I chose to limit the analysis and links between parents and children so not to reveal the identities of the girls. However, looking at the linking of lives, subjectivities, and knowledge is important, not only in the context of children and parents, but also across other life points, such in a relationship, between people in a couple or partnership. A life course perspective would be beneficial for future research in this area. This perspective brings “linked lives” (see Elder, Johnson, and Crosnoe 2003) into focus, emphasizing “that people in salient relationships with each other, such as parents and children, occupy mutually influential interlocking developmental trajectories that extend throughout their lives” (Greenfield and Marks 2006: This would allow one to focus on the trajectories of ideas,

contexts, interpersonal relationships, and how knowledge (whether health or otherwise), operates in these linked spaces, places, and relationships. This perspective is often used to study health outcomes (for example, see Greenfield and Marks 2006: 2) but can be applied beyond that. For example, Bengtson, Putney, and Harris (2013) use the life course perspective to investigate families and faith. They seek to look at the intersection of families and religion, across time, arguing that our “our religious identities, for example, develop in ways that are linked to our parents’ religious identities—which might change over time. ... This goes beyond the picture of a passive child receiving religious input from a parent” (12). Their work goes on to look at intergenerational influences as well, and if parental influence continues into adulthood. Future research on adolescent subjectivities as they relate to health technologies and health interventions, should investigate the transmission and influence of intergenerational knowledge and the role that adult subjectivities play. My research contributes to our understanding on how this occurs. Future research should further investigate *why* it does.

The implications of this research extend into many domains. Public health and public policy should address marketing and avoid neoliberal frames that narrowly posit girls who vaccinate as can-do girls, agentic, and independent. The findings from this research show that girls lack resources and ability to enact this type of subjectivity, leaving them without the tools to be active in their health decision-making. Moreover, and regardless of a girls’ ability to achieve this neoliberal subjectivity, Lindén (2013: 94) reminds us that this type of marketing decides girls’ wishes, desires, and futures for them, leaving girls burdened with achieving or accomplishing this particular (and arguably unrealistic) vision of themselves, their health, and sexuality.

In terms of parents and parenting, I do not simply suggest asking them to be more involved in their children’s lives. Instead, I suggest that parents need resources and tools available to them to help them talk with their teens about these topics, or resources that can assist or accompany their efforts. This is related to the role of school-based health and sex-education. As an additional resource to parents, schools (and individual teachers) need to be conscious of how this material is taught at school, not just in terms of knowledge transmission, but in terms of how this material relates to students’ lives. This is particularly important in contexts where adolescents do not receive health, sexual health, or sexuality education at home.

In terms of doctors and health professionals, findings show that young girls have conflicted experiences with these actors. Charlotte's doctor, for example, drew attention to and prioritized her acne and weight (which she did not see as a problem), leading her to dislike her doctor. These types of interactions can have a lasting impact on adolescent's experiences with medical professionals, and may alienate them. This is important to realize as girls get older and may need to turn to medical professionals for information on things like HPV and this vaccine. Doctors should be reflexive of the normative ideals and messages implicit in their care and how this influences doctor-patient trust and dynamics.

In summary, with the HPV vaccine as the point of entry, this study makes a contribution to the understanding of the relationship between biotechnologies, subjectivity, knowledge transmission, culture and society. It uncovers how adolescent girls, as contextualized and developing actors, negotiate their subjectivities while making sense of their health and sexual health.



## Chapter 5

### Conclusion

In this dissertation, I investigate how mothers and teachers (situated in the context of vaccine politics and controversial sex education) work to manage adolescent health, sexual health, and sexuality. I contextualize adolescent girls' sense of self and subjectivity, and explore how it emerges as they think about the HPV vaccine, their health, sexual health, and sexuality. In three related, yet stand-alone papers, I examined schools, families, parents, teachers, and girls as they interact, grapple with, and make decisions around the HPV vaccine, health, sexual health, and sexuality. Based on qualitative interviews with 29 Ontario mothers, I explored how mothers conceptualize their responsibility for this decision and their daughters' health, sexual health, and sexuality, questioning the dichotomous binary between "responsible" and "irresponsible." Drawing on observations of public school sex-ed classrooms and interviews with health teachers, I sought to understand and explain how the progressive teaching practices and approaches of sex-ed teachers, despite their best intentions, may unintentionally reproduce existing forms of gendered, ethnic, and classed inequalities. Finally, and based on interviews with 19 adolescent girls (aged 11-17), I deployed a typology of three types of adolescent self to understand the varied social contexts and interpersonal dynamics that inform girls' understanding of the HPV as well as their health, sexual health, and sexuality.

Building from the theoretical and empirical insights of feminist medical sociology and science and technology studies, that show how technologies and discourses reproduce meanings of gender, sex, sexuality and the body as well as responsible citizenship (see Balsamo 1996; Casper and Carpenter 2008; Polzer and Knabe 2009; Carpenter and Casper 2010; Connell and Hunt 2010; Charles 2013, 2014), this dissertation serves as a call to challenge and reflect on the taken-for-grantedness of biotechnical health inventions, like the HPV vaccine, as well as sex-education in contemporary Canadian society. I find that while parents and teachers work to be responsible to girls' health and sexual health, their efforts may not support adolescents in ways they imagined. Mothers may be too narrowly (either through vaccination, or through alternate responsibilities like encouraging self-esteem) envisaging how best to protect their daughters, or may have limited conversations with their teens on the assumption that they will learn this

material at school. At school, some teachers may not even be covering this material (as some of the girls I spoke to told me), or may be aiming to provide a comprehensive education, but do so in ways that decontextualize their lessons in ways that can alienate and individualize their students. At the heart of these adult deliberations and efforts to best manage these teens are girls themselves, many of whom do not know very much about the HPV vaccine, and who understand these topics in relation to these structures and people. Their memory of conversations with their parents is usually minimal, and many consider their school-based health and sex-education to be inadequate. Reading across the cases of mothers, teachers, and girls highlights the diffusion of responsibility and accountability across actors and spaces, gleaned some light on the complicated social organization of health/sexual health knowledge, decision-making, and the HPV vaccine.

In what follows, I reflect on the broad contributions of this dissertation. I then move to discuss the limitations of the research, while also providing suggestions for future research that build on the suggestions at the end of each preceding empirical chapters.

## 1. Contributions

### 1.1. On Decision-Making and Responsibility

The first contribution of this dissertation is that it offers unique insight into health decision-making, conversations about what constitutes responsibility, as well as the management of adolescent health, sexual health, and sexuality. As demonstrated in chapter two, by not collapsing responsibility and irresponsibility into one vaccine decision, I provide analytic space to talk about how mothers see themselves as responsible for their daughters' health, sexual health, and sexuality. Vaccine politics (as outlined in chapter two) are established in relation to normative public health ideals and expectations about responsible parenting and health management (Crawford 1980; Roy 2008). These normative guidelines set the stage for the "proper" management of girls' health, sexual health, and sexuality, with the HPV vaccine positioned as the "right tool" for parents and mothers to engage in order to normatively protect their children (see Fosket 2010; Clarke & Fujimura 1992 on the "right tool for the job"). While medical research clearly establishes that vaccination is beneficial, my research reflexively points

out the tendency to narrowly manage and positions adolescent health and sexual health in relation to biotechnical interventions<sup>35</sup>.

An attendant contribution to the one above focuses in on some scientific literature on HPV vaccination that contributes to the discursive and normative construction of what constitutes responsible/irresponsible parenting and health management. Much research on the HPV vaccine operates from a techno-scientific view (see Polzer et al. 2014 for more on this) and engages the Health Belief Model (see Brewer and Fazekas 2007; Ingledue et al. 2004; Allen et al. 2009) to investigate women's knowledge and health decision-making behaviours on this vaccine. This research tends to focus on identifying people's incorrect knowledge on the vaccine, parental concerns, decision-making processes, indicators, demographics, uptake/refusal/delay, and initiation of vaccines by mothers and parents (for examples, see, Dempsey et al. 2006; Gilkey et al. 2016). This discursively positions the HPV vaccine as the ideal and responsible biomedical intervention to address "at risk" bodies. This literature focuses on parental beliefs about the HPV vaccine, emphasizing individual opinions and attitudes, and identifies characteristics of parents most/least likely to vaccinate (Barnack et al. 2009; Griffioen et al. 2012). These studies identify topics frequently emerging in parents' (although usually mothers') consent decisions: perceived risk of infection, age-related factors, amount/quality of knowledge and information, vaccine safety, illness prevention, physician recommended, religiosity, child's susceptibility to HPV, and perceived negative consequences. Understandably, this literature prioritizes HPV vaccination as the ideal outcome, explaining who is more or least likely to vaccinate and why, with discussions what could be done to increase vaccination uptake.

While helpful in understanding vaccination behaviour and parental health decision-making, this research positions vaccination as the ideal behavioural outcome and is tied up in moral assumptions about people's health behaviours, and limits an understanding of how responsibility looks and plays out for these mothers. This type of research contributes to a normative landscape

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<sup>35</sup> The focus on protecting or managing future health and risk vis-à-vis pharmaceuticals and biomedical interventions aligns with neomedicalization where, in a neoliberal social context (see Polzer et al. 2014), aspects of everyday life or "natural experiences" are the grounds of future disease (Batt and Lippmann 2009: 50). These approaches support Canadian goals for health protection and a "risk management framework," which aim to prevent disease and other causes of disability, but which rely on pharmaceuticals for disease prevention rather than true primary prevention or "non-drug-based public health strategies that focus on removing (or reducing) risks at their source" (see Batt and Lippmann 2009: 55 for more on Canadian health protection).

and scenario where girls' health, sexual health, and sexuality are narrowly managed, with broader efforts minimized due to a biotechnical view of health management. In this dissertation, I show that some non-HPV-vaccine-consenting mothers engaged in alternate enactments of responsibility (such as actively talking with teens about health, ensuring a broad understanding of complementary and alternative health care interventions, such as the Pap test, and building a sense of autonomy and agency in teens), which may be complementary, but are outside contemporary normative biotechnical interventions. These normative expectations can be regulatory and can shape the way girls' health, sexual health, and sexuality are managed. For researchers utilizing a more techno-scientific epistemology, my insights require that scholars be reflexive of the categories that are implicit in their research, many of which are value-laden and part of larger socio-politics.

## 1.2. On Self and Subjectivity

The second contribution of this dissertation is that it offers a unique investigation into the topic of self and subjectivity, particularly adolescent subjectivity. Theoretically, and as outlined in chapter four, my work is rooted in classical and contemporary theories of self. My analysis brings together separate yet interrelated theories of self from symbolic interactionism, social constructionist, structuralist, and post-modern traditions (Cooley 2009 [1902]; Mead 1934; Giddens 1991; Taylor 1989; Foucault 1979, 1988b) in an effort to produce a contextualized typology of adolescent girls' self. Bringing together these schools of thought, I am able to focus on constructions of self as they relate to interpersonal relations as well as through social interactions in a wider social context, alongside a range of discourses, powers, values, morals, choices, and structures. In this way, my work produces insight into self and subjectivity by "hooking up" girls' micro realities and the conditions girls are tasked with negotiating as young people, with macro-level structures, discourses, morals, values, and social exceptions. Bringing together these schools of thought, my research contributes to a broader theoretical and empirical conversation on subjectivities and self. I analytically situate girls' subjectivities in the particular local conditions of girls' lives, but also look beyond them, providing analytic space to understand the social organization of adolescent subjectivities and how girls act in the world. This is analytically inspired by Smith's (1987) epistemology on knowing and seeing the world, which helps me to understand adolescent subjectivities as part of a particular time and place.

Empirically, this theoretical and analytic focus on self is unique within literature on the HPV vaccine and health knowledge. As outlined in chapter four, the majority of research on adolescents and the HPV vaccine tends to focus on what girls know more technically about HPV and their health. This body of research tends to center its inquiry on health behaviours and linear health decision making, where it is assumed that individuals will make the right decisions after rational calculations weighing out pros and cons (see Lupton 1999b and Polzer et al. 2014 for a critique). Moreover, this research is primarily concerned with understanding girls' knowledge in an effort to identify predictors of vaccination uptake and acceptance, or to correct girls' behaviour that is deemed incorrect from a biomedical view (Polzer et al. 2014). Polzer et al. (2014), do an excellent job of reviewing and critiquing this literature. They point out that this literature operates from the "underlying assumption that having more objective knowledge will lead to greater [vaccine] acceptance," that it assumes people will make the correct decision "follow[ing] from the communication of sufficient amounts and appropriate framings of risk information, and that it moralizes individuals and their vaccination decisions" (284-285). My findings in chapter four show the ways in which girls' sense and presentation of self -- "tethered," "autonomous," and "trusting" selves -- are constituted in relation to other people and institutions, impacting the way health knowledge operates in their lives.

### 1.3. On Inequality

A third contribution of this dissertation is that it begins to shed light on some of the inequalities and systems of oppression that may persist, despite parents' and teachers' best efforts. In chapter three, I begin with sex-education politics, which are caught up in long-standing debates (See Zimmerman 2015 for a historical account of debates), and "culture wars" (see Irvine 2000; Lesko 2010), where abstinence only and comprehensive sexuality education are placed in opposition to one another. These debates, and the curricula that result from them, are discursive and regulatory, not only shaping the way teachers interact with their students, but also shaping the way they teach and have adolescents think about the health, sexual health, sexuality. My analysis reveals the inner workings of progressive sex-education, revealing some of the taken-for-granted aspects of scientificity and facts, choice, and promoting diversity. Building from scholars like Rasumssen (2010) and Lamb (2010, 2013), who are critical of "progressive" sex-ed efforts, I show the ways that these characteristics of progressive sex-ed may be built on, and also reproduce gendered, classed, racialized, religious, and heterosexist systems of oppression.

My findings from this research contribute to a body of literature that focuses on inequality in sex-education (see Fields 1998), offering data from inside the Canadian public-school health classroom. There are a number of scholars who research anti-racist theory in sex-education arguing that students must be seen as more than “neutral, context-free youth” (Whitten and Sethna 2014: 415; see also Dei 1996). Whitten and Sethna (2014) for example, conducted a content analysis of Ontario’s 2010 sex-ed curriculum and 2008 Canadian guidelines for Sexual Health. They critique curricula that “emphasise that culture, religion, race and ethnicity are essential to young people’s lives but must be overcome for the purposes of sex education” (422). They argue that this individualizing process assumes that young people can just “cast off the influences of culture, race, ethnicity and religion” which requires that they “become literally raceless.” In chapter four, I argue that the neoliberal emphasis on choice, as well as Ontario’s “skill-building” approach to sex-ed, engages a similar process of individualizing which can result in de-contextualizing and can remove institutional and structural responsibility to students’ health. Whitten and Sethna (2014) argue that this type of education is a result of white supremacy where “[r]ace, ethnicity, culture and religion additionally are considered as static, individual factors that are not influenced by colonisation, racialisation or assimilation” (ibid: 423).

In both the cases of mothers and teachers, inequalities and systems of oppression can result from how they attempt to manage adolescents. In the case of mothers and public health HPV vaccine promotion, the overreliance on biotechnical intervention (while responsible in some ways), might under-prepare their children in terms of their health and sexual health. While my research cannot speak directly to this, it could result in unequal health outcomes for some teens, especially for girls and women of colour. In fact, recent research by Beavis et al. (2017) found that mortality rates of black women due to cervical cancer are higher than previously thought. Moreover, Vidal et al. (2014) find that the common strains of HPV covered by the HPV vaccine (types 16/18) are most common in European American women, while African American women are two times less likely to have these strains, and more likely to have strains not covered by the HPV vaccine. At the end of chapter two, I ask (and it is worth repeating here) whether girls and youth in general, HPV vaccinated or not, understand the role they have in their health, sexual health, and sexuality and what they see themselves as being responsible for? If youth have not received the HPV vaccine, what health, sexual health, and sexuality resources can they, and are

they, expected to draw upon now and in their futures? A narrow focus on responsibility rooted in biotechnical interventions could be related unequal health and sexual health outcomes for girls, youth, and women<sup>36</sup>.

## 1.4. Recommendation to Public Health

The fourth contribution of this dissertation comes in the form of recommendations to public health more broadly. As written above<sup>37</sup>, in my conclusion of chapter two (p. 37-38), I recommend that public health approaches to HPV, or other similar areas, broaden their view of intervention and prevention to one that not only recommends, but also goes beyond, vaccination. For example, public health may want to reconsider and emphasize the role of sexual health and sexual literacy for adolescents and parents. Relatedly, despite the vaccine now being offered to boys, it is also important to realize that for all the mothers I spoke with, regardless of their decision, there was little to no discussion of the responsibility of boys to be vaccinated -- either to prevent sexual transmission of HPV or to protect themselves against HPV-related cancer -- even for mothers who had sons. Organizations like public health, but also the schools and school districts, should consider the role of fathers. Few of the fathers I spoke to in passing had ever heard of HPV, and several told me this was something their wives dealt with. Fathers had never seen consent forms. In one interview, when a daughter had missed the deadline to submit her consent form, the school reached out to the family – the mother, since her name was on the emergency contact. This came as a surprise to the husband and father, seemingly disappointed that he was not “in the loop.”

Future research into the HPV vaccine should not only look at vaccine uptake now that the vaccine is regularly offered to boys, but also what boys think about it and how it interacts with their subjectivities and sense of self. It would be interesting to consider if tethered, autonomous, and trusting selves hold up when thinking about boys. I suspect that different subjectivities and

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<sup>36</sup> Gregg's (2003) research on the Pap test in Brazil offers a good example of health outcomes when there is a narrow focus on one health intervention. She found that in the low-income neighbourhood of Recife, Brazil, where the Pap test was heavily promoted for cervical cancer screening, women turned to the Pap test as the main way in which to control cervical cancer, rather than also looking at their sexual practices. In a context where condom use was discouraged, the Pap test became the ideal way for women to protect themselves from STI (Gregg 2000).

<sup>37</sup> This recommendation is mostly taken verbatim from the conclusion in chapter two.

senses of selves would emerge alongside boys' understanding of this vaccine. Moreover, now that it is offered to boys and available to men, are fathers becoming more aware of this vaccine? Will they have more of a role? If so, what might that look like?

There was also little to no discussion of sex beyond the risk of untrustworthy partners and the gendered responsibility to protect against it. The discussion of non-heteronormative sexuality was also largely absent and no one spoke of the prevention of anal, throat, or penile cancer. This is particularly important given that many people, who are at a higher risk for cancer and who may be less likely to access the HPV vaccine, are made invisible due to a "one-size model to cancer risk" (Mamo, Nelson, and Clark 2010: 140; Epstein 2010).

Public health and the Ontario Ministry of Education should also take seriously the reality that there is a dissemination of responsibility between parents, the state, and schools. In short, adolescents may not actually be receiving education on these topics. Moreover, with recent controversy over sex-education in public schools in Ontario, and with some parents assuming their children will learn these topics at school, it is unclear what adolescents are learning, and where they are learning it. This insight requires that public health consider its approach to risk management, which Batt and Lippman (2009) argue aim to prevent disease and other causes of disability, but which rely on pharmaceuticals for disease prevention rather than true primary prevention or "non-drug-based public health strategies that focus on removing (or reducing) risks at their source" (see Batt and Lippmann 2009: 55 for more on Canadian health protection). Moreover, Ontario's Ministry of Education should reflect on its "skill-building approach," which aim to help students "develop a commitment and a positive attitude to lifelong healthy active living and the skills and capacity to lead and promote satisfying, productive lives" (K. Gill<sup>38</sup>). These formal curricula "take a skill-building approach to helping build students' understanding about their health and develop and practice skills to make healthy choices" (ibid). The idea is that students should "demonstrate the ability to apply health knowledge and living skills to make reasoned decisions and take appropriate actions relating to their personal health and well-being" (ibid). This is arguably has neoliberal undertones to it, is individualizing, seemingly promotes

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<sup>38</sup> K. Gill, Director of the Curriculum and Assessment Policy Branch, personal communication.



rational-actor approach to health and well-being, and overlooks the reality of social inequalities and health care access. Consequently, this approach may remove public institutions from the broader responsibility. Combined with public health's risk management framework, this seemingly creates a scenario that under-emphasizes a more holistic and broad management of adolescent health and sexual health (one that includes biomedical interventions, an ethics-based or social justice-based school education (see Lamb 2015), more robust public health "marketing" and media etc.), that consciously and reflexively roots responsibility in both individuals and larger institutions.

## 2. Limitations and Future Directions

Even with the contributions described above, there are several limitations to this research. It is important to note that the mothers in this research are particular kinds of parents: heterosexual, most are middle to upper-middle class and were born in Canada. The work may be different for mothers/parents who are LGBTQ, or who come from different cultural and religious backgrounds. A strong intersectional analysis is recommended and needed for future research to illuminate other discourses and types of responsibility that are at play in these types of decisions. Speaking with recent immigrant mothers would also be revealing as they may be faced with discursive dilemmas specific to their histories and background. This would help generate culturally specific understandings of "responsibility" in relation to parental health behaviours. Future research might also begin by speaking to immigrant daughters about their roles and responsibilities, as I anticipate that they are tasked with unique forms of responsibility, such as making the decision for themselves (and/or their sisters), acting as language brokers during these types of decisions due to parental language barriers.

As written and suggested in the conclusion of chapter two, future research should also consider the inclusion of children in health decisions, an understudied topic needing further investigation. Most research related to this topic discusses doctor-parent-child communication opportunities (see Tate and Meeuwesen 2001), ethical tensions between parents, the state, and the child (Wadlington 1994), or advocates for rethinking the intergenerational division of labour in health decisions, arguing that children can be health care actors (Mayall 1998). This literature predominantly debates the best and most "appropriate" amount of involvement, but does not necessarily focus on the actual attempts for involvement.

Another limitation of this dissertation is that it was conducted at a time when the HPV vaccine was only offered to girls in grade eight. As of September 2017, all Ontario students can now receive this vaccine through school vaccination programs, and at a younger age and grade (now, grade seven). Future research should investigate how the discursive landscape of this vaccine has shifted or changed now that boys are offered this vaccine. It may be the case that now that this is no longer exclusively a vaccine for girls, the role of fathers, or the awareness of HPV by fathers, might shift, despite health decisions being usually “shouldered” by women (Salganicoff, Ranji, and Wyn 2005: 40). It would also be interesting to understand how a broader range of youth, such as boys and gender non-conforming youth make sense of this vaccine, particularly as it relates to their subjectivities and self.

Regarding my research with teachers and schools, it is important to realize that the teachers I worked with all agreed to be involved in this research. This self-selection tells me something about these teachers in particular. They were willing to have me observe their classrooms and were excited to have me there. These teachers may be viewed from a progressive perspective as “good” sex-ed teachers. They enjoyed teaching the material, tried to be “fun,” interactive, and creative, and felt it was important that their students learn about these topics. Future research might try to access a broader range of teachers and health classrooms in general. Based on what many girls told me in the interviews, I suspect that in many sex-ed and health classrooms, this material is being skipped over and not taught. It would be insightful to see the way that this material is taught across a broader range of teachers.

Given the current changes to the health curriculum in Ontario with Premier Ford, future research should also talk with teachers about their teaching and classroom strategies. Recently, Premier Ford has announced that the health curriculum would revert to one similar to a 1998 curriculum (Globe and Mail 2018), removing lessons on topics like gender identity, same sex families, and sexting – topics and issues that were not addressed in the 1990s. Premier Ford even announced that teachers who continue to teach this curriculum would face consequences (Global News 2018a) such as suspension or termination. One teacher has anonymously stated to the media that they would continue teaching this material despite there being a “tip line” to report teachers (CBC 2018). In fact, their union also encourages them to teach the 2015 modernized curriculum (Global News 2018b). Given this political climate and tension, it would be insightful and important to talk with teachers about their own anxieties, strategies, and plans to teach a modern

health and sex-ed curriculum in these situations. For example, how might teachers deal with these topics if students ask about them in class? Do they fear that other students in the class might report this to their parents, and then to the principal and school district?

### 3. Closing Remarks

In closing, this research is an exploration into health, sexual health, and sex-education. Reading across these chapters, like a point-of-view novel, reveals the messy and complicated ways lives, bodies, health, and sexual health are organized and managed by many actors and institutions. Parents worry about their individual children, doing what they think is best. Teachers work to do what they think is right for their students, but are themselves teaching amidst controversy and politics. Adolescents and teens try to live in ways that make sense to them: this could be as good daughters, innocent girls, sexually responsible, agentic, cool, or healthy etc. They do this while having their own dreams, hopes, and plans for their futures. While there are normative public health and “best practices” that exist for all these actors, the management of health, sexual health, and sexuality is not straightforward. By investigating tough topics – like being critical of what constitutes responsibility and progressiveness -- researchers can glean light into the persistent problems and politics on these issues. By interrogating the categories and concepts around best practices (such as what constitutes responsibility or progressiveness), the scope of scholars’ insights can be broadened. Future researchers should find inspiration and grounds for investigation in these instances of tension and where confusion continues to exist, despite the normative ideas of what is best. This confusion might signal a flaw in health care access, a narrowing of what constitutes best care practices, conflict between stakeholder positions, and/or how policies and agendas are built on or around implicit or taken-for-granted assumptions that perpetuate inequalities and unequal health care outcomes. Doing this creates analytic space to uncover the ways in which people’s health, sexual health, and sexuality are being supported, or not. This analytic reflexivity automatically turns a gaze towards current practices and assumptions, and will allow us -- as researchers, health practitioners, parents, teachers, youth, policymakers -- to ask, is this where we wanted to end up? Is this how we wanted this to unfold? Is this how we want things to be? How else might it be?

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