

ANTI-BODIES

The Production of Dissent

Manuela Cunha and Jean-Yves Durand

Drawing on narrative interviews and ethnographic research in French and Portuguese settings, we examine a contemporary form of vaccine acceptability as it emerges in routine vaccination. Against a backdrop of manifestations that are circumscribed to particular cultural scenes or bounded systems of ideas, we focus on a diffuse tendency which resonates with wider contemporary transformations. Its analysis cannot be framed within the narrow limits of health and risk management. Health and the body are but one of the domains in which a same pattern of production of dissent arises. It is by exploring the political dimensions of such pattern that the production of consent and that of dissent stand in relation to one another as two sides of the same coin.

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The Changing Landscape of Immunization

Michel Foucault (2004) once used vaccination as an analyser of society. As he had done before with the prison institution, he considered it to express the general economy of power prevailing at a given historical moment. Foucault (2004) thus identified a shift from a “disciplinary society” to a “security society”. The disciplinary logic that produced docile bodies started to give way to – or to co-exist with – the actuarial logic of late modern societies, increasingly based on risk management (Simon 1998; Petersen [1997]2006). But this insight can be developed in yet other ways. If we are to consider not so much “mechanisms” of power, as the philosopher did, but the people who are their object, immunization can be an analyser of society inasmuch as it also reveals them in their agency, as political subjects. Vaccination is deeply anchored in relations of power

and authority between the State, expert systems, and citizens (Moulin 2007). These relations however, are not limited to matters of health, trust and risk. They are connected to other areas of citizenship involving the body, personhood and individual identity. They form coherent patterns of political participation which are central for understanding the production of consent and dissent. We thus set out to approach current engagements with vaccination both as an object in themselves and as a window onto these processes.¹

Immunization is one of the most globalized techniques of securitization used to address public health problems such as epidemics and infectious diseases, especially since the World Health Organization (WHO) launched the *Expanded Programme on Immunization* in 1974, and national vaccination programmes (hereon NVP) were implemented. People

worldwide have been confronted with state-imposed or state-sponsored vaccination for themselves or for their children against an ever-growing range of medical insecurity concerns. The classic sextet that has characterized national vaccination programmes (diphtheria, measles, pertussis, polio, tetanus, tuberculosis) has not ceased to expand and vaccines are now expanding beyond their usual target of infectious diseases. Cancers, chronic disorders, and contraception all become part of their aim. The very idea of vaccine is redefined.

But even when considering strictly its traditional profile – the prevention of infectious diseases – vaccination today assumes increased complexity on the biomedical and the public fronts. At the same time that vaccine technology and infrastructure have gained increasing scope and sophistication, the unlimited confidence and political allure which the principle of universal vaccination benefited from has waned.

On the biomedical front, the emergence of new or rejuvenated pathogens and the need to update many vaccines due to the genetic drift of pathogens in relation to the original vaccine prototype have contributed to the decline of the optimistic model of eradication, predicated on the triumph over smallpox. A new, less ambitious but more realistic model is adopted, based on the constant monitoring of diseases, on international surveillance and on the notion of “preparedness” – as the response to the flu pandemic exemplifies (Moulin 1991, 2011). In addition to this postmodern development, the acknowledgement of the diversity of individual immune systems has recast mass immunizations and the manipulation of the collective immune system (i.e., “herd immunity”) in a new light. Although on the one hand such strategies are advocated insofar as they aim to protect public health, on the other hand there is also a growing awareness that they are unable to take into account the uniqueness of individual biology, especially when the evolution of the immune system is considered throughout the course of a life span, or at critical stages such as early childhood and old age (Moulin 2011). Hence the claim for individually-tailored vaccines and emerging no-

tions of personalized immunity or personalized immunization, which are now set in contrast with the principle of universal vaccination.

Besides the complexified landscape of vaccine science and vaccine policy, there is also a changing public engagement with vaccines that is destabilizing the model of universal vaccination in other ways. Social and cultural attitudes vis-à-vis vaccines are more diversified, and today they take on a variety of forms, especially in Euro-American societies. The way in which now part of the public questions the prevailing consensus around vaccination defies the grand narrative that presents vaccination as the result of the inexorable march of progress and reason (Moulin 1991). According to this narrative, instances of popular resistance to programs of mass vaccination tend to be located in the “third world” or the geopolitical “South”, and they are explained in terms of “traditional” beliefs and incomplete scientific rationality (Poltorak, Leach & Fairhead 2004).² However, and despite perceptions that associate non-vaccination with an “exotic” location and an incipient scientific culture, the “North” itself has been witnessing phenomena of vaccine uptake decline which do not fit such an evolutionist framework. Far from being a residual anachronism expected to fade away, the emergence of non-vaccination practices is part of wider social transformations which include, but are not limited to, their relation to science and to the State.

Research Issues and Methodology

We intend to examine the meaning and the experiential basis for some contemporary forms of vaccine acceptability as seen through the perspective of parents and as they emerge in routine vaccination, that is, integrated in regular healthcare services and administered by the State at precise stages of life. Vaccination campaigns involving extraordinary circumstances and/or new vaccines are considered only inasmuch as they may provide additional feedback on the way people relate to ordinary vaccination. The term *acceptability* implies a perspective that considers acceptance and non-acceptance as facets of the same phenomenon rather than as two unrelated phenomena,

thereby requiring an encompassing analysis to match both, instead of two separate approaches.

Between 2007 and 2010 we developed an ethnographic research in several French and Portuguese settings with different vaccination regimes (compulsory and non-compulsory, respectively) in order to identify the scope of variation in current engagements with vaccination, and try to understand how dimensions of consent and dissent can be traced to specific cultural locations and systems of ideas, or, on the contrary, resonate with wider contemporary transformations (cf. Cunha & Durand 2011). This paper will focus mainly on the Portuguese materials – and within these, on parents’ detailed narratives and on observations in healthcare centres – complemented by the French case, which acts as a background comparative reference.

We conducted 19 in-depth, open-ended interviews with a range of actors, selected using “snowball” techniques. The number of major interviews was decided by “saturation”, that is, recruiting continuously until no new themes emerged from interview data. Data were also derived from observation of ordinary vaccination practices and interactions between users and healthcare professionals as they routinely occurred in healthcare institutions. Finally, we conducted 5 focus-group discussions (with 10 to 15 elements each) in Portugal (Braga, Vila Real, and Lisbon) and in France (Forcalquier, Alpes de Haute-Provence) with frontline healthcare professionals, civic associations and participants in grassroots vaccination movements. Whereas the dimensions of consent were mostly accounted for through the observations in healthcare institutions, dissent was for the most part registered through interviews outside these settings; focus groups confirmed both aspects of consent and dissent. As in any ethnographic investigation, in some cases observation and participation produce richer and more revealing data than interviews, depending on what its goals and purposes are. In other cases it is the opposite. The complexity and the multiple dimensions of dissent explored in this paper – including its experiential basis – were in this case more fully grasped through discursive data and outside clinical situations.

The project’s general design was structured so as to diversify ethnographic settings and interlocutors along lines of region, ethnicity, and class. This diversification did not aspire to express statistical representativeness, but to identify the key themes that bear upon the acceptability of vaccination as they emerge in different contexts. We tried therefore to create different contact chains with a variety of entry points: schools and healthcare centres (leading to parents who decline to vaccinate their children), different social and professional milieus and social location in terms of generation, education, and income level. Some of these chains ended up intersecting one another, as the kinds of constraints that these parents face in light of their personal choices stimulate the onset of informal social networks enabling them to better deal with those constraints.

Interviews with parents who did not vaccinate their children were arranged and scheduled according to their preference and convenience, mainly in their homes, cafés and schools. They lasted on average between 90 minutes and 2 hours, but could also include previous or subsequent shorter conversations (e.g., following up on an episode, going over a specific point). The fact that interviews took place outside healthcare settings facilitated a conversational focus not restricted to health matters. Parents’ responses spontaneously led to a variety of other experiential areas involving their children, themselves, or both. Allowing them to articulate their experiences in multiple spheres of life, from health to education, from childbirth to naming, this wide focus enabled us to connect these seemingly disparate domains into coherent patterns. The common link between these areas was our interlocutors’ perception of their relation with institutional power and the State in light of notions of personhood and citizenry. Since we integrated new themes as they emerged, parents were invited to talk not only about vaccines and decision-making processes regarding immunization, but also about medication, health biographies and lifestyles; not only about their relationship with healthcare professionals, scientific information, and the mediation of family and friends in a variety of issues, but also about their relation-

ships and experiences with other institutions that as parents they also had to deal with. However, in most cases these core themes were not elicited through questions. They unfolded out of parents' narratives on their own initiative. Questions were used to clarify points, redirect the narrative, and introduce issues that hadn't been approached.

Anthropology and other social sciences have looked into the history of vaccination and of immunology (e.g., Darmon 1984; Moulin 1991) and have also produced cultural analysis of the rich metaphors generated by the notion of immunity (e.g., Martin 1994; Napier 2003; Haraway 1991; Tauber 1994). They have approached vaccination as one of several aspects that can give access to social understandings about the workings of the immune system. Leaving aside instrumental researches that focus on the factors hampering the acceptance of mass immunization programs in developing countries, ethnographical comprehensive attention to ordinary vaccination or non-vaccination practices has been relatively scarce, especially in Euro-American societies (see Streefland, Chowdury & Ramos-Jimenez 1999; see Streefland 2001 for an overview of varieties of vaccine refusal that includes industrialized countries).

Among the most notable exceptions are studies addressing the pressing scientific controversies raised over particular vaccines in specific countries, such as the research led by Poltorak, Leach and Fairhead (2004; Poltorak et al. 2005), in the UK (Brighton), in a context marked by a public controversy about the safety of the MMR vaccine (measles, mumps and rubella). As documented in Brown's et al. (2010) systematic review, this controversy has also shaped parental attitudes to combination vaccines, generating concerns about the risk of combined shots, beliefs in the safety of separate vaccines, and fears of immune overload in a variety of other contexts. Poltorak's team ethnographic research has persuasively shown the need to go beyond approaches founded on too static and too generalized dimensions of risk perception, science-society relations, and trust in state and global institutions (see also Frykman et al. 2009 for a related discussion). It also showed

that people's consideration of the trade-offs between individual benefits and risk is not only a matter of calculation influenced by information, but is mediated through cultural and experiential perspectives. Personal histories, notions of disease, infection, and immunity, personal and cultural perceptions of responsibility, parenting and parental reasoning concerning children, context-specific relations to health care providers, among other aspects, are all implicated in how risk enters people's practical reasoning in relation to immunization practices (Mills et al. 2005; Rogers & Pilgrim 1995; Serpell & Greene 2004; Streefland, Chowdury & Ramos-Jimenez 1999; Poltorak, Leach & Fairhead 2004; Poltorak et al. 2005).

Beyond Risk and Bounded Systems of Ideas

But even when considered in this light, that is, embedded in particular cultural and experiential worlds, risk may still remain an insufficient framework for capturing important dimensions involved in current engagements with vaccination. This is not to deny its analytical relevance as a structuring notion in contemporary societies (Giddens 1991; Beck [1986]1992; Caplan 2000; Douglas 1985). Risk may also be an adequate notion to characterize ethnographic realities such as the ones portrayed by Leach and Fairhead in the UK. Nevertheless, it may be too narrow as a comparative category applied to issues of vaccine acceptability in other contexts, such as the ones we have studied in Portugal and in France.

To begin with, public anxieties generated by controversies over specific vaccines vary in type and intensity across countries. While in the UK the object of a high profile controversy was the MMR vaccine (suspected of inducing autism), in France it was hepatitis B (suspected of inducing multiple sclerosis). In Portugal neither of them gave rise to a debate besides a few short journalistic pieces mentioning events witnessed in other countries. Our monitoring of this public non-debate is consistent with the country's relative imperviousness to other recent scientific controversies around other "new risks" reported by Gonçalves et al. (2007). The controversies over MMR and hepatitis B did not have an impact on the public acceptability of such vaccines, nor did

they reflect on the way parents went on interacting with healthcare institutions or healthcare professionals. Our fieldwork and Saavedra's (2011) showed that this interaction is usually characterized by the near absence of questions regarding possible vaccine side effects. Concerns voiced by parents, or anticipated by frontline healthcare professionals trying to reassure them, are focused mostly on immediate and superficial consequences such as fever, local swelling, and rash.

Moreover, health professionals anticipate parents' anxieties almost exclusively in terms of the pain caused by the injection on the child. As one nurse put it, "it's for her own good, it will hurt a little but it will soon be over". Other concerns may be exoticized in terms of cultural differences, as in the case of immigrant parents. Another nurse summed up several cases of reticence towards vaccine administration with the following comment: "With immigrants we start to learn that, within each culture, concerns are always of the same kind." She was specifically referring to a Brazilian mother who preferred waiting to go to Brazil to vaccinate her 3-year-old daughter against rubella with a separate vaccine, rather than doing it in the combined variety of MMR; she also included an Eastern European father who did not allow the simultaneous administration of more than one vaccine per day – in her words, "here we usually apply two vaccines, but in Eastern European cultures they're not supposed to take more than one per day, nor take a bath that same day".

The compared examples of Portugal, France, and the UK regarding the effects of scientific controversies on the acceptability of vaccines suggest the need to take into account national differences which reflect – but are not necessarily limited to – different vaccination regimes, scientific literacy, and public engagement with scientific expertise. More importantly however, non-vaccination does not emerge exclusively within the context of episodic vaccine science controversies and involves other dimensions besides risk, like those expressed in the form of dissent that is analysed below.

Within Euro-American societies, the more visible refusal of dominant views on vaccination has been

associated mostly with small groups of proponents of alternative immunological theories and therapeutic systems, or with adepts of specific religious views (cf. Streefland, Chowdury & Ramos-Jimenez 1999; Streefland 2001). While sharing this tendency, France nevertheless has a long history of resistance against vaccination even among physicians (at least since the nineteenth century, Darmon 1984), and currently there are quite a number of groups that actively fight public policies on vaccination, mainly through the organisation of public talks. The issue of vaccine mistrust has a diffuse visibility that cuts across specific cultural or religious backgrounds.³

The same does not happen in Portugal. Anti-vaccination is much less vocal, and it has been comparatively invisible. In addition to high rates of vaccine coverage (Direcção-Geral de Saúde 2009), just in the last three decades Portugal has gone from seriously problematic child mortality rates (80 per 1,000 children in 1974) to being one of the top four countries with best rates in the world (the third within Europe): 3 per 1,000 (Direcção-Geral de Saúde 2009). Not surprisingly, extensive vaccine coverage takes an important part in the public narrative of this evolution.

Some breaches or specific nuances in this wide consensus around vaccination are connoted with particular groups, such as Roma communities (Casa-Nova 2011) and adepts of alternative dietary systems like macrobiotics, insofar as their attitudes towards vaccination – whether or not uniformly shared within the group – tend to be informed by specific and relatively bounded systems of ideas about health and the body, and/or by symbolic strategies that are fairly specific to a social scene. The system of practices and perceptions about the body involved in macrobiotics leads to a type of questioning which promotes vaccine avoidance, although resistance to vaccination is not extensible to all of its practitioners. Considering health as a process, and as the natural capacity to overcome disease, the macrobiotic social scene studied by Virgínia Calado (2011) singles out food and lifestyle as the fundamental aspects for having a strong immune system. This is perceived in terms of a particular balance in

blood chemistry. Diseases could thus be naturally prevented, as well as defeated, by means of a diet providing this balance. Nonetheless, some diseases, such as measles, would ultimately be beneficial by triggering “elimination processes” considered essential for building a resistant organism. From this point of view, biomedicine blocks these processes and vaccines are a damaging aggression, since they prevent the body from spontaneously creating its own natural defences. This system of ideas is also often combined with an atmosphere of suspicion towards biomedical knowledge and the profits of the pharmaceutical industry, thereby fostering general doubts and mistrust directed at the global institutions’ securitization policy.

However, whether expressed in attitudes of reticence, ambivalence, or active rejection, a distinct and more diffuse tendency of vaccine avoidance is emerging beyond the cultural locations or systems of ideas described in this section.

Lay Reflexivity and “Pluralistic” versus “Alternativist” Practices

Although in Portugal vaccination is not compulsory by law, there is a widespread assumption that it is. It is fed both by healthcare authorities that deliberately let the ambiguity linger on, and the combined workings of several institutions (e.g., government institutions, civil service, schools). They create a pressure in favour of vaccination, for example by requiring vaccine certificates for purposes of school enrolment, to obtain a driver’s licence, or apply for a job as a public servant. In the case of schools, parents who refuse to vaccinate their children have to sign a declaration supported by a medical doctor. Since there are not many doctors who will easily stand by this choice, those who do, find themselves being sought out by several parents, who rapidly circulate the information about them through informal networks. The same happens with the information about schools that accept unvaccinated children without further requirements.

Such parents usually belong to highly educated middle-class urban (mostly professional and art) milieus: they are teachers, psychologists, engineers,

computer experts, lawyers, doctors, actors, painters, post-graduate students, and researchers. This does not necessarily imply that they are wealthy. Even though all our interlocutors have a college degree, many have unstable and precarious job situations and an irregular income, which is a combined effect of their relative youth (most are in their early or mid-thirties) and the eroded, highly dual Portuguese job market.⁴ This will be a relevant aspect for framing their agency as political subjects. The emerging trend expressed by these parents in relation to vaccines is not coterminous with a specific social scene, nor is it predicated on a pre-given particular philosophy like macrobiotics. Although some features may coincide with the latter, such as concerns about the aggressiveness and allergenic effects of an excessively precocious, massive, and concentrated administration of vaccines in early age, they are not articulated in the same way, as the contrast between the following two cases illustrates.

Isabel, a macrobiotic 33-year-old mother of an unvaccinated child tells us how she immediately adhered to the anti-vaccination philosophy that she came across in lectures taking place within the macrobiotic social scene.

The normal theory of disease doesn’t make sense to me. Now, this theory of disease as a cleansing, a kind of balance – and not the other way around, as a virus that attacks us ... It’s we who have to be healthy in the first place, because the viruses are out there anyway. That made every sense to me. And I was confident. I felt that my decision. ... I was not afraid. If I was afraid I would vaccinate. (...) At the time it was not even a decision, I listened and I felt: OK, this is what I want to do. I didn’t even think. It was something that just made sense to me. When I got pregnant, I began to look for books, information (I met homeopaths, naturalists...). But for me it was more a matter of showing it to people, to justify myself, than to make a decision. Because for me it was like ... like those things that just make sense to you. (...) There was a book by an American doctor who helped me a lot. For me that book was like a Bible.

In this case, the adoption of an anti-vaccination stance was part of an entire, direct, and almost identitarian adherence to a philosophy on health and disease (*the theory of disease, referred to in the singular*) that was originated as a revelation (*I was not afraid. At the time it was not even a decision, I listened and I felt: OK, this is what I want to do. I didn't even think*). The search for specific information on vaccination was instrumental afterwards, that is, not so much as the basis of her decision, as to justify it before others. The almost “biblical” use of a medical book is consistent with this disposition. This narrative clearly matches the bounded system of ideas described in the precedent section. However, it is not the one that predominantly informs the diffuse tendency focused in this paper.

Another mother (30 years old) presents quite a different narrative about the decision not to vaccinate her two daughters. Even though both narratives share some vaccinophobic themes besides a general objection to vaccination, she particularizes the circumstances, contexts and risks of each vaccine.

It just troubles me that a newborn baby takes vaccines against hepatitis B, tuberculosis ...⁵ These were things that I read. The immune system of a baby is formed during the first two years of age, so until then the body is not ready for this. Apart from exceptional cases, up to two years there is no reason for this.

[So the problem is that it is too soon?]

Too soon, too many at the same time – in the MMR the body has to react to three vaccines simultaneously – (...) and also unjustified vaccines. The one for tuberculosis is obsolete, that strain no longer exists, and the one for hepatitis B is controversial, it makes no sense to give it to people who are not at risk. So we must ponder. Not to vaccinate is a risk, but to vaccinate can also be a risk. If it is justifiable, yes. A vaccine for AIDS, when my daughters are teenagers, I'll probably go for it... The papilloma I don't know yet. I consider vaccine by vaccine. For example, we are considering going for the meningitis one, because it can be a fast and deadly disease. Tetanus, we're also thinking

of perhaps doing it. I know that this leaves us [me and my husband] in a position of anxiety, we're never relaxed, permanently having to decide. I'm not against vaccines; I think it is an advantage for public health. Vaccines were a fantastic discovery. What I don't agree with is the way vaccines are administered in the NVP, the lack of public debate about it, that no information is provided for people to base their decisions on.

The reflexive trajectory followed by another couple (Luis, a teacher, and Susana, a researcher) regarding vaccination decisions was marked by a long and cautious consideration of the risks and circumstances involved. It started with a “foreign” scientific controversy over the MMR vaccine.

At first we had decided not to vaccinate our elder [son]. My husband is American and at the time there was this big controversy over the MMR there. It then spilled to the UK and there was that thing about Tony Blair not having his child vaccinated. Then we decided not to. He had taken the first dose, he didn't take the second. The younger one didn't get any. But we went on mulling over it, reading, researching, trying to follow the information, because we wanted to vaccinate according to the NVP. And last year came out a study that said there was no connection with autism after all. So we talked to the pediatrician to see if there was a problem with giving the vaccine out of schedule. And meanwhile other studies came out on the seriousness of some diseases prevented by the MMR, and we decided to vaccinate. And that's it; after this long process, the boys now have all the vaccines.

Although in this case questions about vaccination have stemmed from doubts about the safety of a particular vaccine, the type of reticence prevailing in most cases is of a more general nature. It is anchored in notions about the immune system and about a multiplicity of pathogens against which the number of existing vaccines would not provide enough guarantee anyway. Says another mother:

Take for example, the 12 vaccines in the NPV. People think: there are 12 diseases, if I vaccinate my child against these diseases, he is protected. But there are thousands of diseases. The kids are protected from those, but then they are less able to resist the others. Then comes a little flu and that's it, they are immediately ill. And they become prone to lots of things, allergies, asthma...

Following the rationale that vaccines cannot protect against everything, and that while protecting against a limited range of problems, they could undermine the ability to withstand a variety of many other, these parents feel themselves obliged to manage a stake that resonates with the effects of the dissemination of knowledge about pathogens pointed out by Herring and Swedlund (2010: 1). As this knowledge increases and enters public consciousness, so would the sense of vulnerability and uncertainty grow in individuals as an intimation of the responsibility of choice: how and from what to protect themselves and their children. This also resonates with the ambivalence generated by the widespread presence of expert systems in everyday life, whether producing trust, or on the contrary, skepticism and uncertainty (Giddens 1991).

As to the parents we interviewed, it would be hasty and misleading to assume from the outset a connection between non-vaccination choices and alternative lifestyles or systems of ideas impervious to biomedicine. Unlike Isabel, the macrobiotic mother mentioned previously, whose "alternativist" stand tends to be highly coherent in terms of therapeutic ideologies, expert systems, and types of consumption, for example circumscribed to the "natural" and excluding the "pharmacological", the latter's practices express instead an eclectic and pluralistic pattern in which different therapeutic logics coexist. This pattern is not dissociated from a wider reconfiguration of therapeutic worlds of lay health management, increasingly characterized by a plural combination of therapeutic models and resources (Lopes 2010). This includes the relationship with expert authority. Instead of being a matter of choosing an alternative authority over an instituted one,

these parents adopt an active questioning before *any* authority. They subject it to a personal scrutiny according to their specific situations. Complemented by the reflexive use of expert information, they ponder the suitability of the different options at hand. As Lopes pointed out (2010: 79), one of the effects of this therapeutic pluralism has been to increase lay autonomy in the management of health resources. But while this autonomy may be emancipatory, it can also be the source of increased anxiety and insecurity.

Even though certain "pluralistic" health practices appear similar to "alternativist" ones when considered separately (vegetarianism, the consumption of healthy/organic food, the preference for the "natural" over the "chemical"), as a whole they differ in the degree of systematicity and internal coherence. Moreover, if we include vaccination choices (but we could also include, for example, choices regarding a more or less medicalized childbirth), the combinations are more open, varied, and unpredictable in the "pluralistic" variety: in one family every member is vegetarian, vaccinated, and "follows conventional medicine, but in a critical way" – as one mother put it; in another, children are not vaccinated, but dietary concerns are limited to the avoidance of "processed food, canned food and too much sugar. Otherwise, outside home we eat everything."

Diffuse Dissent: A Process

Moreover it is important to compare not only patterns, but also processes. Decision-making has been characterized as a processual and distributed phenomenon, that is, an ongoing event that evolves and is shaped through multiple encounters with medical and non-medical others, print media and Internet-based knowledge (Rapley 2008). In the case of vaccination choices, their meaning is best captured by taking into account not merely the decisions per se, but also a retrospective examination of the trajectory leading up to them. In other words, giving more consideration to the dynamics through which a decision takes shape, than reading into its affirmation as being grounded in a static or polarized position. This can be illustrated by the complex process that

preceded the decision made by Tiago and Maria (both artists, in their early fifties and mid-thirties respectively) against vaccinating their two daughters. They started to choose health care professionals, mainly doctors and paediatricians, as their first interlocutors.

We were abroad when our eldest daughter was born. And there were plenty of people that did not vaccinate (...). Then we read books and information and we began to question a little. But when we came back to Portugal it was hard. Not with the Dutch side of Maria's family. They took it the Dutch way: "if they studied the subject and reached a decision, then they know what they're doing". But the others... The doctors didn't give us any support and just wanted to wash their hands of the problem. We wanted to know things, ask questions. What if she catches measles? One of them said, "Well, you don't need to vaccinate against everything. I myself decided not to vaccinate my daughter. But it's different with me, I'm a doctor." We hesitated a long time, we had many doubts, but we were alone in this. The doctors only wanted to impose things upon us. We wanted to discuss things, but no. All they did was simply to scare us [instead of] explaining things. We are treated as minors. People have this attitude that the doctor always knows best. Doctors don't have a tradition of explaining their reasoning, their decisions.

Lay reflexivity may induce a higher insecurity. The self-management of information flows may expose individuals to potential contradictory messages stemming from different expert sources (Lopes 2010: 31). The autonomy it expresses is not self-sufficient, but relational and embedded in social relations (Rapley 2008: 434). Given its requirement of a co-production of understanding, the importance of the doctors' role was recognized by our interlocutors. They sought the advice of physicians in the first place.⁶ While some doctors (Helena's, one of Adriana's, as mentioned below) adopted a collaborative role typical of shared decision-making, that is, one that tried to combine patients' active questioning

with the promotion of decisions that refer to evidence-based and research-based knowledge (ibid.), other health care practitioners did not seem open to forming a consensus based on such a combination.⁷ Unable to find in health care professionals a communication channel capable of contextualizing, mediating, and assisting them in navigating the information they possessed, or to cope better with their questions and concerns, the parents above eventually looked for support on their own and they found it in the only channels left available to them: an anti-vaccination league based in Spain and a France-based vaccinophobic site. Thus, what had started as a *negotiated convergence* with one instance of biomedicine, ended up in a general alienation from it. Further on we will observe how this same pattern was reproduced in shaping parents' decisions about schooling and education.

Adriana, a 30-year-old school teacher, mother of two unvaccinated children, also uses the Internet as a source of vaccine information and a forum of discussion. But the way it impacts on her choices is mediated by networks of friends, peers, and health-care professionals.

I often look for advice with this doctor, she gives me lots of information, but I also look for information online, on sites from other countries, associations... I don't always identify with these sites because they have this very dichotomous way of putting things, either you're for or against vaccines. And if you're against, it's in a very radical way. I understand; it's a strong opposition because if something is blind, the reaction ends up being blind too. Sometimes in these blogs, it is as if vaccines were the devil. But things aren't so. I make up my mind in light of the information I have. I also have some friends with whom I discuss this. They belong to an older generation, they have kids. We support each other, we share the same concerns; we talk about it, influence one another: "Look, read what I found." Each shares the information they find. A couple of friends hadn't immunized their child, but now they have decided to give him the tetanus vaccine.

Given the strong reactions that non-vaccination choices tend to elicit, peers are also important in providing a supportive backdrop without which it would be difficult to avoid feelings of isolation or marginality. Yet Adriana, whose own parents had also decided not to vaccinate her and her brother, noted that attitudes had softened – an evolution equally pointed out by other parents in the changes occurred between their older and younger children:

Peer support is very important. Otherwise, we couldn't take the pressure. From other people, doctors... When the issue is vaccines, reactions are very strong, even from friends. People start fighting immediately – “Oh, but that'll kill them [these parents' children].”

Things are changing, though, in comparison to what my parents had to put up with. Lots of paediatricians refused to treat us. I remember me and my mother being expelled from a doctor's office – and he had been in medical school with my grandparents', who were physicians. They thought my parents were loonies. When one of my daughters almost had pneumonia, one doctor said “nobody will want to treat this child because she is not vaccinated, nobody will take the responsibility”. But today you can find doctors and people who support you ... Even healthcare officers have become more sensitive. Just the other day a woman from the health centre called to say that my daughters were not vaccinated yet and that she had to remind me that they had to be, otherwise they were unprotected. But she was very polite. Also at school, we are required to sign a standard statement, but it's nothing like what my parents went through. Every year they had to explain it to the school in writing. One year, the school was being especially punctilious, and my mother decided to say it was for religious reasons. It worked, they immediately stopped bothering her. There were no more problems, they accepted right away because religion is something untouchable.

The strategic use of the religious argument by Adri-

ana's mother was successful in that it did not challenge the reluctance and the suspicion against an expression of individuation typical of late modernity (Giddens 1991), that is, a greater autonomy vis-à-vis the tutelage of instituted forms of knowledge-power and values. In the case at hand, personal choices were not accepted – or even comprehended – while they were perceived as being assumed by an individual in a position of self-regulation. They were tolerated only from the moment they could be related to some tutoring system. Alluding to how attitudes towards vaccines can be socially stratified, a nurse speculated on the reaction adopted by health professionals in the face of vaccine refusal:

People think that those who do not vaccinate their children typically come from bottom of the [social] ladder, but no. Those worry a lot, as soon as the kid is 5 years old they come here right away to take the vaccine [necessary to enter school at 6]. Most of those who don't vaccinate are way up the ladder. It is they who study the subject, seek information. Except the extreme cases of total alienation, like drug addicts, those with less education comply, and spend huge amounts of money on vaccines that are not even included in the NPV. If necessary they don't eat in order to purchase those extra vaccines for their kids, they don't want to deprive them of anything. I usually don't bring them up because they are very expensive; if they're not in the NPV it's for some reason. And I try to assuage feelings of guilt expressed by parents for not being able to give these vaccines to their children.

Those who don't want any vaccine, well, I have learned to accept that. They refuse, OK, it's their right, they're entitled to their beliefs. We have to resist this habit of judging them: “you have to do it because I say so, I'm the one who knows what's best for you”.

This nurse is therefore also acknowledging the growing complexity of the relationship between parents and the health-care providers with regard to immunization decisions.

Frames of Communication

Using the concept of “biocommunicability” to describe the communication process of information about health – whose authority it is to assess this information, manage it, and speak about it – Charles Briggs (2010: 49) mentions different “cartographies of biocommunicability”. The biomedical cartography, which tends to organize practices of institutions and health professionals, is unidirectional. It is characterized by “a flow from specialized, knowledge-rich sectors to sectors lacking this information or possessing erroneous beliefs, undertaking inappropriate behaviours and misguided actions” (Briggs 2010: 49; see also Fainzang 2006; Ong et al. 1995). In contrast with the classic opposition “medical authority/patient passivity”, other cartographies centre on active patient-consumers and public-sphere citizen debates (Briggs 2010: 49). Like the middle-class subjects in Briggs’s study, who did not identify with the biomedical cartography in the same way as lower social strata did (for the Portuguese case see Cabral, Silva & Mendes 2002), our interlocutors also distance themselves from it and do not relate passively with biomedical authority. They actively tap multiple sources of information and they derive their own evidence from their personal experience – for example, like Briggs’s subjects, almost all parents spontaneously observed the absence of allergies in their unvaccinated children compared to others in their own immediate environment.

However, unlike Briggs and Hallin (2007), who consider these new cartographies as “neo-liberal” expressions of an “active consumerist orientation”, we contend that the form of agency tried out by both our Portuguese and French interlocutors is more adequately characterized by situating them not as “consumers”, but rather as “political subjects” (see also Fainzang 2011). Likewise, it is not to be equated with “healthism”, a phenomenon Greenhalgh and Wessely (2004) associated with “Western middle-classes” and stereotyped as “demanding and manipulative behaviour by individuals for whom ‘health for me’ takes precedence over any notions of equity, fairness or citizenship” (ibid.: 207). Al-

though some characteristics are similar (health-awareness, information-seeking, self-reflection), our interlocutors’ conduct bears little resemblance to the “conspicuous consumption” orientation aligned with “healthism” (e.g., escalating demands for unnecessary tests, referrals and treatments). It tends to be rather the opposite (see Lopes 2010). In the specific case of vaccines, as the nurse above suggests, a consumerist orientation going well beyond NPV vaccines tends instead to be a characteristic of low-income, less-educated users. In terms of citizenship, the political orientation also far from matches the 1980s and 1990s free-market ideologies and the “cult of the individual” that defined the historical context out of which “healthism” arose (Crawford in Greenhalgh & Wessely 2004: 200). Firstly, the political ideological alignments of these interviewees are as heterogeneous as their lifestyles;⁸ secondly, and despite this ideological heterogeneity, political agency often converges into forms of neo-cooperativism and neo-mutualism that transcend the usual dichotomy between the public and the market provision of services; thirdly, it does not break with the wide consensus existing in Portugal around the importance of the welfare State.⁹

We will return to this point later on. In any event, the issue in bio-communicability in some cases does not even pose itself as the opportunity to discuss information flowing from knowledge-rich professionals to a presumably all ignorant public, but as the possibility of actually obtaining from the former *any* kind of information at all, like the following mother (Helena, 36 years old) implies:

We have been really lucky with our doctors, they explain everything to us. But we react badly to doctors who don’t. We don’t accept that they treat us like we’re idiots. They provide an essential service, it is our health. But people accept it as if it were a divine thing. We’re all human, we cannot relate to people as if they were infallible. We can only do our best and we have to trust them, but doctors should not feel upset by our questions. Both sides are responsible for this.

One might say that these parents relate to the NVP in the same way they relate to doctors, that is, as active, vocal interlocutors who do not delegate the power of decision over their bodies to higher authorities without critical scrutiny. They thus expect to be informed of the medical options adopted. Likewise, they relate to vaccines and vaccination in the same way as they relate to medication. The acceptability of vaccines shares many features with, and is accompanied by, the kind of compliance they express regarding medication and prescribed drugs. In this sense, the “biocommunicability” mentioned by Briggs (2010) is indeed a central dimension of self-regulation, that is, of the way individuals structure self-surveillance of health and the body – as the following mother exemplifies:

I usually discuss a lot with doctors. [My daughter] is prone to ear infections, they want to give her antibiotics. But I know that if it's a virus, antibiotics won't help. They don't tell you that, this is something I know. They say, ah, but it's OK, it's a preventive measure (...) I don't want to do self-medication, I want to follow what doctors say, because I'm aware that they know more than me. And it's much easier to trust and go home without thinking about it anymore. But at the same time I also know that this doesn't give you any guarantee, because doctors have different opinions, and there are things that they don't know either.

With children this is more difficult to manage, what to decide, because it is what you hold dearest. Take fever, for instance. When do we take the child to the hospital? Where do you draw the line? Sometimes it's not good to go there with the sick child. I rely on intuition, but intuition is something you train, it's an educated guess. To wait, to evaluate, to see if it comes down or not, whether it's constant or has cycles, whether the kid's behaviour is normal or not, but act. There's always this anxiety. When she had pneumonia, I saw immediately that something was wrong, I didn't even wait. I have no problems with antibiotics. Bless them when they're needed; But not in every

situation. But dialogue with the doctors is very difficult. They deal with people as if they were ignorant, they often do not even bother to explain.

However, as far as these parents are concerned, their conduct seems to be less about defying the official cartographies of communication than about repositioning themselves as subjects within them and ceasing to be “interpellated” in the subject positions that they project. We use the notion of interpellation as proposed by Briggs (2010: 48), that is, as “the act of assuming the social position in which one is located by virtue of being designated as the ‘receiver’ of a particular discursive act”. By disturbing the expected categories, subjectivities, and discursive relations of classic schemes of communication, this repositioning may generate a series of misunderstandings. The following example involves attempts reported by Adriana to escape what she considered to be an excessive medicalization of childbirth.

Medicine is so hyper-preventive these days... It wants so much to control everything and to interfere with natural processes that it becomes aggressive. I had a hard time with doctors just because I wanted a natural childbirth. I didn't want them to induce it according to a pre-defined schedule; I didn't want an epidural (...). One of them said, “How can one possibly want to give birth in pain in the twentieth century? That is totally outdated.” But this is not a matter of masochism. The epidural also anesthetizes the baby (...). With my youngest, the head nurse said “So, you don't want the epidural? But what is that, some kind of cult? Is it your husband who won't let you?” They really humiliate you, because they think you're ignorant.

After the dilation, she comes in with a syringe this size [makes a gesture] to burst the water bag, which is an absurd procedure, totally outdated. It was used in the nineteenth century to speed up deliveries, but it's no longer done. So we were there arguing, I said I wouldn't let her do it. And she said: “But do you believe the baby will be born with the bag intact?” They don't give you any credit whatsoever.

The misunderstandings surrounding this interaction seem to stem from the fact that the social position presupposed by healthcare professionals within a traditional scheme of biocommunication no longer matches the one this mother assumes and identifies with. In a disagreement where both parties mutually locate themselves in an evolutionary scale of progress and end up relegating each other to “the past” (the nineteenth century), the misunderstanding is even more pronounced when a position that is presumed to be backward in the eyes of one party, is considered advanced by the other.

This negative experience took place in a private clinic, after which Adriana decided to “never go back to a private hospital again”. Benefiting from health insurance,¹⁰ she tried this option for the first time not because she found it more trustworthy in terms of medical competence and quality, but because she presumed she would find an environment more attentive to her preferences in what she deemed to be a special moment for her – only to find herself trapped in a cartography of communication even more rigid than the ones she sought to avoid.¹¹ Indeed the type of doctor–patient communication schemes is not so much contingent upon the division public vs. private sector as upon other factors, such as health care professionals’ perception of patients’ autonomy/dependency, and changing social attitudes towards the medical profession and authority in general (cf. note 11).

Diffuse Dissent: Patterns

It is important to stress that the trend expressed by these parents is not necessarily articulated in terms of health and disease. It would be too limiting to try to make sense of it within the frame of particular therapeutic ideologies or lifestyles. It is rather an instance of dissent whose form and meaning are better captured when put in a wider framework, together with claims of control over the body and the person in other spheres besides health. It includes negotiations of power vis-à-vis the State, authority, and the workings of institutions regarding processes and decisions that concern critical areas of life, citizenry, and individual identity. In the same way that these

parents actively confront biomedical power in order to have more bearing on child delivery (a more or less medicalized childbirth, with or without an epidural, at home or at the hospital), they confront state bureaucracy – and they challenge it in court, if necessary – to have more freedom of choice over naming their children. In Portugal, the choice of names is strongly regulated by the State. These have to be selected from an official list of authorized first names. Since name is deeply constitutive of the person and of individual identity,¹² the ability to decide on this matter is not experienced as trivial. Two couples report their naming experience as follows:

We had a problem with [the first daughter’s] name, they wouldn’t allow it because they said it was a male name [it is gender neutral]. Then with the [second daughter] they wouldn’t allow her name either because it was not on the list of approved names. We have a lawsuit running so that we could register the name officially. I searched on the Internet and found an article by a professor who claimed that this [limitation] is a problem, that favouring mostly the legitimacy of religious names as traditionally Portuguese was a creation of Salazar’s dictatorship. He [i.e., the professor] said that there was no basis for denying parents the liberty to choose, because there are thousands of exceptions anyway and today there is a big cultural mix, so it no longer makes sense in a multicultural society. I felt oppressed by not being able to make decisions about the small important things in our life, which concern us, not others.

There were problems with the names of the two [children]. But we were lucky because they were born abroad, so we used that to name them as we wanted. When we came back to Portugal, we had to register them, and then another problem was the hyphen in the family name. We wanted to join the surname of the mother and father. We had no problem with that abroad, but here we had to make a request because it was not considered part of the Portuguese tradition.

A similar pattern arises in choices regarding schooling and the education of children. Again, these parents actively confront what they experience and perceive as rigid, opaque, and impermeable institutions, unable to respond adequately to parents' requests. If their attempts to have a stronger participation in school processes, or simply become better informed of them, are not reasonably satisfied, they may give rise to innovate varieties of informal education and care.

I wanted to see the public school in my area of residence. I wanted to speak with the school principal, but there was no way to get to her, they told me that it was not usual to receive parents. I asked to speak with the coordinator. No use, I was always told that they didn't know for sure when she would be there. I asked to see the school, but they said it was impossible; I had to make a written request first. Then I asked whether they thought it was normal not being able to see the school where I was considering putting my daughter. I asked if it was a high security prison: you cannot see it, cannot speak to anybody. (34-year-old mother of two)

It was in the aftermath of this unfruitful attempt, while searching for other options, that this mother discovered not only another type of school, but also places where unvaccinated children were easily accepted. Like some of our other interlocutors, she took part in new schooling experiences. This process is not to be equated with a typical elite trajectory that buys its way out of public schools into private ones. Some of these parents (regardless of whether they could afford that trajectory or not) associate in informal "horizontal" structures that work as an alternative to both – in fact receiving children who were previously registered in public or private sector structures. They create small-scale trustful child-care environments and schools through mutualistic, non-profitable grass-root structures, associations or cooperatives.¹³ They aim to have a higher degree of participation and choice regarding methods, pedagogy, diet, activities, and guidelines. Not incidentally, these are also schools where non vaccinated

children are accepted without a medical certificate, or exempt parents from that requirement.

We asked the parents involved in these schools how they dealt with the daily co-existence of children with different immunization statuses. Those with (totally or partially) unvaccinated children answered along the same lines as a founding member of one of the schools. That is, parents who had chosen to vaccinate their offspring took certain precautions in order not to endanger non-immunized children.

Some parents initially raised the issue of unvaccinated children, whether they could represent a risk to others. We explained that if there was a risk, it would be the other way around: it's those who are not vaccinated that would be at risk, the others are protected. We also warn parents not to bring kids to school for some time in case they are immunized with active viruses, because there could be a risk to others.

My son had the polio vaccine when it was still given with the active virus. I didn't take him to school for a week because I knew there were unvaccinated children, they could become infected.

In weighing individual immunization choices, the issue of co-existence may arise for these parents on three specific levels. Firstly, it is considered (by vaccine-acceptors, vaccine-decliners and vaccine-undecided or partly decliners) in terms of concrete collectivities, such as the schools attended by their children. As the excerpts above suggest, co-existence is negotiated (in some cases with the mediation of school boards) by reversing the subject positions of danger: it is not unimmunized children who are a potential threat to immunized ones, but the other way round. Secondly, it is considered at the level of public health, weighing notions of personal freedom and the security of others in terms of concrete individuals. The following reasoning in connection to social responsibility exemplifies this:

Nowadays there are vaccines for such trivial problems, things we all caught when we were children

– chickenpox, whatever – that one really wonders. But then on the other hand... Sometimes it is a question of social responsibility... For example, rubella. We have a neighbour who is pregnant. If an unvaccinated kid was to be around, and if she got it... If I were pregnant, I wouldn't like that either, to have a kid next to me with rubella... Damned... That was one of the things that made us change our mind and to eventually vaccinate our kids. (Mother, 36, two children)

Thirdly, also at the level of public health, the principles of individual freedom and collective security are considered in wider and more abstract terms. However, as shown by the following two couples, who opted for non-vaccination, the social narratives of risk in which those two principles come to play are diverse; moreover, even at this level the negotiation of such principles remains for these parents context specific, dependent on circumstances such as exceptional disease outbreaks or the evolution of herd immunity. The parents we interviewed are used to be confronted with the “free ride” argument (others vaccinating give them the possibility to enjoy herd immunity and avoid personal risks). But they present their option as innocuous for others while not risk-free for themselves in the present; also, they present it as reversible in the future, as an ongoing negotiation with collective circumstances.

There was a doctor who told us, “Yeah, you benefit from the umbrella of others’ [children], who protect yours”. Another guy told us: “But yours endanger others.” ... Then we said it's not like that, on the contrary. Others are immunized; it's ours who may catch something.

In case of epidemics, then of course we must see things differently. Because this option of not vaccinating is only viable as long as other children are. So you cannot be against vaccines unconditionally or indefinitely. This has to be a dynamic thing. But people should not be required to vaccinate themselves in all circumstances. If suddenly it is necessary for public health reasons, then OK.

Overall, most of the interviewees who were vaccine-decliners and partial vaccine-decliners held less polarized and more provisional views on vaccine issues than the “alternativist” ones such as Isabel's. They seemed more open to reconsider them on the basis of collective changing circumstances, in the same way they seemed more open to advice from individual health professionals consulted in the first place. Vaccinating for the benefit of society, however, is not a primary driver of such reconsideration, any more than it is a driver of uptake for vaccine acceptors (Brown et al. 2010). Moral judgements and imputations of selfishness are therefore not only misplaced as promoters of vaccine acceptance, but are actually counterproductive in that they may induce or crystallize a defensive anti-vaccine stance. This potential counterproductive effect runs parallel to the authoritarian frames of communication we have identified, alienating rather than fostering parents' trust.

Concluding Remarks

Focusing on the variation of practices and perceptions that shape vaccine acceptability, we have addressed a tendency whose form and meaning are best described when put in the wider context of contemporary social and cultural transformations. This tendency is not confined to a particular social scene, nor circumscribable to a bounded system of ideas, an “alternativist” lifestyle or a “healthist” orientation. Unlike what has been reported for other countries (see Poltorak, Leach & Fairhead 2004), it is also not constituted specifically in relation to concrete vaccine controversies or vaccine issues – that is, the vicissitudes, uncertainties, and risks that this technique may entail for specific bodies with specific health biographies. Moreover, although this tendency is part of the current reconfiguration taking place within the lay management of health and the body, as well as an aspect of the eclectic reshaping and pluralization of therapeutic worlds that have created more leeway for personal autonomy (Lopes 2010), it may not even be articulated strictly in terms of risk, health and disease. Health and the body are but one of the realms in which a same pattern arises. This common pattern does more than simply provide the

background or set the context for understanding the meaning and the form of the diffuse tendency we have approached here. Rather, it is at its very core and it is precisely what makes *this variant* of vaccine acceptability specific in relation to others. It would therefore be misleading to frame its analysis within the narrow limits of health and risk management.

In this case, it is by positioning these parents as political subjects that the views, conducts, and practices sketched out by them can be captured more accurately, whether relatively to health, education, care, or pertaining to the very idea of person, like naming issues. In several domains, they feature a more active agency vis-à-vis bureaucratic authorities, experts systems, and instituted cartographies of communication. They thus try out a different political participatory framework. The relationship with biomedical institutions is but one of these domains. And the relationship with vaccination is but one aspect of this pattern within the biomedical domain.

Changing engagements with immunization in Portugal are thus coherent and tend to go hand in hand with emergent forms of assertive citizenry that challenge what is experienced as a distant, opaque, and overbearing state regulatory power over the person and the body. However, this should not be confused with neo-liberal claims implying for example State withdrawal from health or education. On the contrary, there is no ideological stake on the private sector and more often than not these parents are actively engaged in confronting state institutions with inadequacies and insufficiencies which they thereby seek to attenuate. Public services in health and education are prized and would, by rule, be a first choice. What is claimed instead is more leeway for individual choice, agency, and participation *within* the state-regulated realm. When “opting out” occurs (which does not preclude the co-existence with, or the return to that engagement), it tends to take the form of a pragmatic neo-cooperativism that creates horizontal varieties of solidarity and interdependence.

For this reason, just as we have avoided positioning these parents as “consumers” in order to underline instead the specific *political* character of their

agency, we also prefer to avoid the current ambiguity contained in the notion of “empowerment” and the instrumental connotations within its semantic scope. Although this notion was initially shaped in the context of civil movements and civic struggles for citizens’ rights and emancipation, its extension to health has increasingly connected it with a discourse imparting – if not altogether transferring – health responsibilities to citizens themselves. Within this discourse, the increased power that results from possessing more information is to be promoted insofar as it potentiates personal control over the factors that influence health and a healthy lifestyle (Nogueira & Remoaldo 2010: 27). As follows from the description above, the notion of power that is at play in the conduct of our interlocutors has a wider scope and cannot be reduced to this instrumental aspect.

If indeed vaccination is deeply anchored in relations of power and authority between the State, science, and citizens, then this form of dissent is entirely coherent with predominant forms of consent in Portugal (see Saavedra 2011) in that it is built along the same lines, but as a symmetrical opposite. The consensus around vaccination is based not so much on a pro-active adherence and commitment to its principle, than on tight instruments of control, registration and monitoring dispersed through society. Moreover, the users over whom medical power and disciplinary action are exerted more fully and authoritatively in healthcare institutions are those more deprived of educational and economic capital, and positioned more unfavourably in the class structure. These are the ones who express a more passive acceptance of the norm and its administering agents. As Saavedra (2011) showed, hegemony in such consensus is dynamic and incomplete in that it does not imply a total homogenization of practical compliant behaviour. It hides a myriad of nuances, meanings, motivations, conveniences and personal priorities. The fact that these users juggle with the NPV schedule according to their daily priorities, and to how they assess their children’s contextual vulnerability, expresses a practical negotiation of the limits of hegemony and of institutional power.

Yet, even if the concrete modalities, schedules, and circumstances in which vaccination occurs may be challenged, such irregularities in immunization practices are not articulated as a critique, nor cease to express a passive acquiescence before vaccination in its biomedical definition.

In the case of our interlocutors, they may contest vaccination not because they are more “enlightened” than the users above, or because they are in possession of more or better information from the outset. It is rather because they actively question themselves about vaccines and, in doing so, they do not find in healthcare institutions an environment that is receptive to such questioning, or willing to help them navigate other information they have obtained by themselves. Likewise, it is not necessarily because they have endorsed an alternative lifestyle beforehand that their children are sent to schools outside official circles. Instead, it is because such official circles were not open to their attempts at greater participation and were impervious to them. Dissent is thus more a point of arrival than a point of departure, more a process than a stance, more the result of a relationship than the expression of an individual trajectory. This is crucial for any attempt at understanding the production of contemporary forms of dissent.

At a wide analytical level, resistance or hesitation in relation to vaccination can therefore be considered as the reverse of consent. This is so even if consent, when considered at a more specific level, may reveal a variety, irregularity, and inequality, which also characterize dissent. Be that as it may, in their forms and meanings the production of consent and that of dissent seem to stand in relation to one another as two sides of the same coin. This is not without implications for policy. Despite the highly complexified landscape both in vaccine science and vaccine public acceptability, the case for routine vaccination has not ceased to be strong from an epidemiological point of view, as it has been historically. Declining vaccination rates have consequences, even in the absence of the major epidemics of the past.¹⁴ But, precisely because of this importance and complexification, it is crucial not to presume that a con-

sensus around vaccination may stand indefinitely on passive and unquestioning forms of citizenry. That consensus is now more fragile and uncertain. A renewed candid approach to dissent (e.g., Willrich 2011) in its diffuse contemporary variety may be a way to foster it.

Notes

- 1 This paper is based on the research project Vaccination: Society and Body Management (PTDC/HAH/71637/2006), FCT / “Vacinação e cuidado, poder e incerteza”, CRIA; PEst-OE/SADG/UI4038/2011. We are grateful for the insightful comments of two anonymous reviewers.
- 2 Research has nevertheless shown that resistance is often less to vaccines than to vaccinators or to vaccination processes (e.g., Pereira 2002; Greenough 1995).
- 3 In French bookstores, the shelves with non-professional medical science books hold titles divided for the most part between two themes: the main one is ageing and dying (with many books on palliative care), and the other group deals with the dangers of vaccination.
- 4 Together with Spain, Portugal is the European country with the greatest job insecurity in the 25–49 age group (Oliveira & Carvalho 2008).
- 5 The vaccines mentioned by this mother are part of the Portuguese NPV.
- 6 As Brown et al. (2010) have suggested, personal advice from health professionals may be more powerful than generic information materials, thus the importance of a trusting relationship with parents.
- 7 A recent national study on compliance (Cabral & Silva 2010) showed that well beyond a “gratitude bias”, Portuguese doctors inspire in patients high levels of trust and satisfaction in terms of prescribed treatment and “technical” competence. However, satisfaction is much lower in other aspects, such as doctors’ ability to take patients’ opinion into account, to present them with therapeutic alternatives, and to make room for them to ask questions and to express themselves. On the other hand, most patients show low levels of autonomy and tend to adopt a passive attitude during consultations, abstaining from dialogue and leaving the initiative to doctors. This pattern of communication is thus co-constructed; it does not arise out of the doctor’s conduct only. Moreover, it has to be put in the wider context of Portuguese history. The very idea of health as a right pertains to a welfare state that saw its inception only after the democratic revolution of 1974. The long authoritarian regime to which this revolution put an end was not without leaving its marks on the political culture of everyday citizenry (Cabral 2000). Question-

- ing (medical) authority – and accommodating that questioning – is also part of changes in that culture.
- 8 These alignments range from right-wing conservatism to the socialist and radical left.
 - 9 According to the last European Social Survey (2008), Portuguese widely value the welfare State; they are among the less neo-liberal Europeans in this regard (Carreira da Silva, forthcoming).
 - 10 Health care in Portugal stands on three systems: public (National Healthcare Service, NHS), parapublic (e.g., for civil workers, military, bank employees), and private. The overwhelming majority of the population is covered by the NHS (circa 85%), followed by parapublic services (circa 12%–13%), and a residual minority by private health insurance (Cabral, Silva & Mendes 2002; Cabral & Silva 2009). Private services are mostly used as a complement to public ones, and in specific situations (mainly for ophthalmic and dental care).
 - 11 In a compared assessment of public perceptions about both sectors, surveys (Cabral, Silva & Mendes 2002; Cabral & Silva 2009) have shown that private services are deemed to be more attentive, better organized and provide faster access; however, irrespective of the demographic and socio-economic characteristics of respondents, public services are considered to offer high quality and better prepared health care professionals. This perception is reinforced among middle-class respondents and those with a higher education degree: they deem the quality of human and technical resources in the public sector higher than in the private one – a counter intuitive survey result in the light of often media vilified public services.
 - 12 For the nominative resonances, emotional implications, and references involved in the choice of names, see Pina Cabral (2008).
 - 13 Officially, parents may declare their children to be home-schooled when such establishments are not legally recognized as schools. These informal neo-cooperativist arrangements differ from some of the forms that preceded them in the 1960s and 1970s in that they are not informed by a coherent philosophy or alternative ideology (Cunha 2006).
 - 14 See for example Mieszkowski (2010).

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Manuela Cunha holds a Ph.D. in anthropology and is a member of CRIA-UM (Portugal) as well as IDEMEC (France). She is a professor at the University of Minho. Her research interests centre on prisons, total institutions, and moral economies, on informal processes, the compared structure of drug markets, and on intersection between crime, gender and ethnicity. Together with Jean-Yves Durand she edited *Razões de Saúde. Poder e Administração do Corpo: Vacinas, Alimentos, Medicamentos* [Health Reasons. Power and the Body: Vaccines, Foodways, and Medication] (Lisbon: Fim de Século). (micunha@ics.uminho.pt)

Jean-Yves Durand holds a Ph.D. in anthropology and is a member of CRIA-UM (Portugal) as well as IDEMEC (France). He is the Director of the ethnographic museum Museu da Terra de Miranda in northern Portugal. He is interested in various types of “knowledges” (water-dowsing, ethnobotany, traditional handicrafts, immunology) and in objects associated to techniques of mobility (traffic-circles, GPS). Together with Manuela Cunha he edited *Razões de Saúde. Poder e Administração do Corpo: Vacinas, Alimentos, Medicamentos* [Health Reasons. Power and the Body: Vaccines, Foodways, and Medication] (Lisbon: Fim de Século). (jydurand@yahoo.com)