



2018

GENDER, SEXUALITY, AND CATEGORIES OF RISK: PHYSICIAN VIEWS OF CERVICAL CANCER IN BANGALORE, INDIA

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Digital Object Identifier: <https://doi.org/10.13023/etd.2018.278>

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GENDER, SEXUALITY, AND CATEGORIES OF RISK: PHYSICIAN VIEWS OF
CERVICAL CANCER IN BANGALORE, INDIA

THESIS

A thesis submitted in partial fulfillment of the requirements for the degree of Master of
the Arts in the College of Arts and Sciences at the University of Kentucky

By

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2018

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ABSTRACT OF THESIS

GENDER, SEXUALITY, AND CATEGORIES OF RISK: PHYSICIAN VIEWS OF CERVICAL CANCER IN BANGALORE, INDIA

India has one of the highest rates of cervical cancer morbidity and mortality globally. Despite this, there are no national or state-wide screening efforts for cervical cancer and its prevention in India. In an effort to understand the magnitude of cervical cancer in Bangalore, India, this research draws upon data collected in hospital contexts over a month-long period to explore the ways in which physician attitudes contribute to understandings of cervical cancer and its prevention in the growing urban context of Bangalore.

KEYWORDS: Cervical Cancer, Medical Anthropology, India, Gender, Reproductive Health

Emily G. Capilouto

July 10, 2018

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ACKNOWLEDGEMENTS

This work would not have been completed without help and support from a number of people. First, I am grateful to my advisor and Thesis Chair, Dr. Mary Anglin, whose intellectual challenges, academic instruction, and unyielding encouragement aided in the development of my perspective and work as a researcher, author, and person. Next, I wish to thank my Thesis Committee: Dr. Srimati Basu, Dr. Erin Koch, and Dr. Mark Whitaker. Each committee member provided invaluable feedback and guidance in the construction of this work. I would also like to thank Virginia Smith, Naomi Marshak, Daniel Ball, and Katie Zapel for their friendship, scholarly insights, and inspiration from beginning to end of the research and writing process. This work is truly the result of motivation from your continual support and love. Finally, I wish to thank my parents for challenging me to always ask tough questions, and for all of the help, support, and love they have shown me in my quest to find the answers for myself.

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Chapter One: Introduction

In Spring of 2016, I traveled to Bangalore, India to learn about the ways in which physicians viewed cervical cancer screening and prevention efforts. Informed by global statistics indicating India to be one of the countries most burdened by cervical cancer incidence and mortality, as well as informal data gathered during preliminary fieldwork, I set out to understand physician attitudes towards screening and prevention options available to women living in Bangalore and the peri-urban areas surrounding the city. In the course of a month, I conducted a total of seven interviews with physicians treating cervical cancer in the context of Bangalore and physicians leading cervical cancer prevention efforts in and around the city. This research draws upon data collected in hospital contexts in Bangalore over a month-long period to explore the ways in which physician attitudes contribute to understandings of cervical cancer and its prevention in Bangalore.

Fieldwork Context

Conducting this research in Bangalore, the capital city of Karnataka state and the third most populous city in India, allows for the examination of cervical cancer screening and prevention efforts in the context of a changing urban landscape. Bangalore exhibits a unique social structure comprised of differing linguistic, religious, geographical, caste, and class categories. This is due not only to its history but also its proximity to neighboring states, making it a center for migratory labor (Heitzman 2004; Shrinivas 2001). Bangalore is the third largest city in India, having doubled in population within the last fifteen years (CIA 2018). Current population estimates suggesting that 11.44 million people reside in Bangalore, and recent studies project that by 2020 the city will become

“the single largest IT cluster on the planet — overtaking Silicon Valley — with 2 million IT professionals, 6 million indirect IT jobs, and \$80 billion in IT exports” (CIA 2018; Magistad 2016). Thus, focusing research on cervical cancer screening in the context of Bangalore allows for an examination of screening and prevention efforts situated in urban and largely hospital-based contexts against the backdrop of rapid population growth particularly among young, educated professionals. My thesis research contributes to anthropological and public health literature focused on cervical cancer prevention and screening in India and South Asia more broadly.

Until the late 1980s, national and state governments formed the basis for economic growth. However, the coupling of new technology policies established in the 1980s with economic liberalization reforms in the 1990s led to the establishment of Bangalore as a space for private enterprise and transnational corporations (Heitzman 2004; Shrinivas 2001). In the past two decades, Bangalore has established itself as the information technology (IT) capital of India, earning the moniker of the “Silicon Valley of India” (Heitzman 2004; Shrinivas 2001). As anthropological research has demonstrated, this shift towards private enterprise and IT sector employment in recent decades has led to a change in workforce demographics, most notably the increasing inclusion of women in the IT sector (Patel 2010; Radhakrishnan 2011). This shift has given rise to what Fernandes terms a “politics of protection” in which claims made by the state in the name of the protection and purification of women’s sexuality have led to new forms of the surveillance of women’s movements and behaviors (Fernandes 2006; Patel 2010). Bangalore’s diverse and changing economic and social landscape, the city makes it a compelling site to explore questions about women’s lives, as well as the ways state

and private organizations deploy disciplinary practices to address new or growing health problems.

Cervical Cancer

Cervical cancer is a reproductive cancer that arises in the cervix. In initial stages of development, cervical cancer is asymptomatic; however, advanced disease is associated with vaginal bleeding, pelvic pain, and pain during sexual intercourse, among other symptoms. In many cases, cancer of the cervix can be detected by cytology-based screening methods such as the Papanicolaou test, also known as the Pap test or Pap smear, where the vaginal canal is opened using a speculum in order to collect cell samples from the cervix. Cervical cell samples are then examined under a microscope for abnormalities and to detect possible pre-cancerous changes at the cellular level. Cervical abnormalities that indicate possible pre-cancerous conditions can also be identified using visual inspection of the cervix after acetic acid (VIA) or Lugol's iodine (VILI) has been applied to the cervix, highlighting precancerous lesions in order to be viewed on the cervix without the assistance of laboratory tools such as microscopes (IRAC 2003). VIA and VILI methods can be used to identify pre-cancer of the cervix outside of a laboratory setting and require less training than cytological methods to accurately perform (Sreedevi et al. 2015).

Persistent infection with specific types of human papilloma virus (HPV) was identified in the 1990s as the necessary cause for the development of cervical cancer. There are over 100 known genotypes of HPV, over 40 of which have been demonstrated to infect the upper respiratory-digestive tracts and anogenital areas (Graham and Mishra 2011). Current estimates propose that over 99% of uterine and cervical cancers are

associated with persistent infection by HPV subtypes 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68 alone (Graham and Mishra 2011; Castellsague 2008). HPV is highly transmissible and is spread through skin-to-skin contact, making it the most common viral infection of the reproductive tract worldwide (WHO 2016). The Centers for Disease Control and Prevention (CDC) estimates that between 80-90% of sexually active individuals will acquire HPV in their lifetime (Graham and Mishra 2011; CDC 2013; Castellsague 2008). In most individuals, HPV infection is generally cleared organically or becomes undetectable, resulting in no disease development.

Early identification of pre-cancerous conditions such as cervical dysplasia makes it possible to monitor the development of or remove pre-cancerous, high risk lesions with cost effective, minimally invasive procedures such as the loop electrosurgical excision procedure (LEEP), cone biopsy, laser ablation, and cryotherapy. These procedures, which aim to remove atypical cervical tissue, are comparatively lower risk, more cost effective, and more efficient than treating cervical cancer once it has developed into malignancy.

Aside from early detection and treatment of pre-cancerous cervical conditions, primary methods of cervical cancer prevention include abstinence from sexual intercourse and routine cervical screening for those who are sexually active. Condoms are thought to protect against the development of cervical cancer due to their effectiveness against the transmission of other STD/STIs comorbidities associated with the development of cervical cancer. However, studies on the effectiveness of condoms in preventing the spread of HPV are inconclusive (Hariri and Warner 2013; Pierce Campbell et al. 2013; Winer et al. 2006; Manhart and Koutsky 2002). Given the strong association demonstrated between chronic HPV infection and cervical cancer

development, HPV vaccinations appear to present one possible way to address cervical cancer prevention.

Since its introduction to the American market in 2006, Merck's Gardasil vaccine has become a transnational, reproductive health commodity, sparking controversy in global and local contexts. After gaining fast-track approval from the Food and Drug Administration (FDA) Merck introduced Gardasil, an adjuvanted vaccine against HPV types 16, 18, 6 and 11, to the U.S. market in 2006. Gardasil is administered in a three-dose series through intramuscular administration at 0, 1- 2, and 6 months (Graham and Mishra 2011:1). Cervarix, approved in 2009, also protects against HPV types 16 and 18. More recently, the FDA approved Gardasil 9 in 2014, which adds protection against five additional HPV types—31, 33, 45, 52, and 58—which are believed to account for approximately 20% of cervical cancers not covered by previously approved vaccines, as well as vulvar, vaginal, anal, penile and certain types of head and neck cancers. When first introduced, the cost of Gardasil and Cervarix ranged USD \$150–\$190 per dose, making it one of the most expensive vaccines in history (Clendinen et al. 2016:5984).

Although both companies have reduced their costs for adoption in global vaccination programs such as Gavi, the global Vaccine Alliance, the vaccines remain unaffordable to countries without vaccine subsidies and are cost prohibitive to many individuals and families worldwide (Clendinen et al. 2016:5984). As prophylactic vaccines for the primary prevention of HPV types associated with the development of cervical cancer, HPV vaccines are most highly recommended for individuals prior to sexual debut and possible exposure to HPV.

Cervical Cancer in the Indian Context

Available data suggests that 122,844 women are diagnosed with cervical cancer and 67,477 die from the disease in India each year (Sreedevi et al. 2015). Population estimates indicate that India has 432.2 million women aged 15 years and older that are at risk for developing cervical cancer (Sreedevi et al. 2015). Despite this, India lacks a national screening program aimed at detecting pre-cancerous cervical conditions and treatment for preventing the development of cervical cancer. Thus, there are disparities in cervical cancer screening, treatment, and survival across the subcontinent.

Although there are no government supported national- or state-based screening programs for the early detection of cervical cancer and its precursors, the Indian government and global health organizations have utilized the potential benefits of HPV vaccines for the prevention of cervical cancer in ways that blur the lines between individual choice, coercion, and experimentation (Mattheij et al. 2012; Choudhury and John 2010; Sengupta et al. 2011; Towghi 2013; Tsu 2011). Early termination of two HPV vaccine ‘demonstration projects’ carried out by the Program for Appropriate Technology in Health (PATH) in two areas of rural India in 2010 became national news and raised the public’s suspicion regarding the safety of HPV vaccines and, indirectly, screenings for cervical cancer (Towghi 2013). These failed vaccine campaigns have led to increased politicization of HPV vaccines in India, further contributing to the the government’s apprehension regarding whether or not cervical cancer screening and prevention efforts at national, state, and local levels are feasible.

Although not discussed in depth here, the historical and coercive involvement of the Indian state in reproductive health and national population control efforts serves as a

backdrop to the examination of cervical cancer screening (Pande 2014; Towghi 2013; Hodges 2006; Van Hollen 1998, 2007, 2013). Furthermore, the changing landscape of cervical cancer prevention due to the identification of HPV warrants examination of the ways in which healthcare providers and program staff understand and implement cervical cancer prevention.

Indian Healthcare System

The state-sponsored Indian healthcare system follows a three-tiered, hierarchical structure and is constituted by primary health centers (PHCs) located in villages, district-based health centers (secondary care), and medical college hospitals (tertiary care) located in urban areas. Government regional specialty hospitals that function as clinical, teaching, and research facilities also exist across the country. Generally speaking, a patient's first point of access for care is usually determined by what level of care is available in their geographic area, such as PHCs for village residents, district-based health centers for peri-urban residents, and medical college or regional specialty hospitals for those located in urban areas (Gupta and Bhatia 2016). Patients may then be referred to hospitals within a state or neighboring states for specialized care depending on their diagnosis or medical needs (Gupta and Bhatia 2016). In addition to the state run healthcare system, similar hierarchical healthcare services exist in the private sector in the form of privatized clinics, regional hospitals, and premier specialty hospitals. Many nongovernmental organizations (NGOs) are also involved in the healthcare sector to meet population-specific health needs and interests.

The Constitution of India includes explicit language aimed at ensuring the public's health to be among the country's top concerns. In particular, Articles 39 and 47

of India's Constitution call for policy formulation in order to ensure the health of workers, raise the level of nutrition and the standard of living, and improve public health, while Article 38 calls for efforts to "minimize the inequalities in income, and endeavor to eliminate inequalities in status, facilities and opportunities, not only amongst individuals but also amongst groups of people residing in different areas or engaged in different vocations" (Const. of India, art. 38, 39, and 47). These provisions fall under Part IV of the Indian Constitution, the Directive Principles of State Policy, making "states primary responsibility for health service delivery, while mandating that the central government design national health programs" (Reddy 2015). In practice, healthcare quality, accessibility, and specialties as well as the availability of general social welfare programs vary across states (WHO 2011).

While in principle the coverage of the Indian healthcare system is available to all citizens under the tax-financed public healthcare system, poorly resourced public services have failed to meet the health needs of the existing and expanding population (Reddy 2015). Underperforming public services coupled with economic liberalization reforms of the 1990s, have given rise to the increasing privatization of healthcare in the Indian context. Recent published reports from the National Family Health Survey (NFHS-3) of India, conducted by the International Institute for Population Sciences (IIPS) headquartered in Mumbai, noted that "nearly two-thirds of all households (65 percent) in India generally seek health care from the private medical sector, while one-third of households use the public medical sector" (IIPS 2007). Furthermore, NFHS-3 data indicates, "forty-six percent of urban households and 36 percent of rural households go to a private doctor or private clinic for health care" (IIPS 2007). Such high rates of access

for private healthcare indicate the need for improved quality, availability, accessibility, and specialty in the public healthcare sector. Following private doctors or private clinics, public and private hospitals are the next most commonly accessed sources for healthcare, while community health centers are the least commonly accessed sources for care.

While privately purchased or employer-provided health insurance is available, it is only accessible to a small proportion of the population since “93% of the workforce comprises self-employed or contracted workers” and poverty levels are high (Agarwala 2009:330). NFHS-3 data indicates that, despite the emergence of a number of private health insurance programs since 2000, only five percent of households report that any member to be covered by any form of health insurance program (IIPS 2007). In urban areas, medical coverage is approximately five times more common than in rural areas (IIPS 2007). Thus, it is estimated that nearly 70% of Indian health care expenditures consist of out-of-pocket spending (Reddy 2015). In sum, such data indicates that the vast majority of Indian households, both in urban and rural settings, pays out of pocket for healthcare costs and relies heavily on the private healthcare sector in order to address health concerns regardless of geographic or financial background.

While travel for health purposes and treatments is not a new phenomenon, however, as anthropologists Andrea Whittaker, Lenore Manerson, and Elizabeth Cartwright point out, “the scale, extent of promotion, and organization of medical services for fee-paying patients, regardless of citizenship status, is new; so too is the ease of travel and the links with global corporate capital and networks” (Whittaker et al. 2010:337). As Whittaker et al. note, medical “consumption abroad” is supported not only by private, locally-based companies and multinational medical corporations, but also

national governments that view medical tourism as a significant economic opportunity that allows for both the ‘exporting’ of health services, and also “may involve governments making arrangements to ‘import’ tertiary treatments from other countries” (Whittaker et al.2010:338). Medical tourism is a growing sector., India is home to the second largest number of accredited facilities after Thailand, and regarded as one of the lowest cost and highest quality of all medical tourism destinations offering a wide variety of procedures at a significant reduction in cost in comparison to similar procedures in the United States (The Economic Times 2015; Chowdary 2017). The Indian medical tourism market at present has an estimated worth of USD 3 billion and is projected to grow to USD 8 billion by 2020 (Pollard 2017; The Economic Times 2015). India’s medical tourism market covers a variety of specialties, including but not limited to joint replacement surgeries, heart, liver and bone marrow transplants, spine and brain surgeries, cancer and kidney treatments, and in vitro fertilization (Chowdary 2017). Although Bangalore is not considered a leader in the medical tourism market within the context of India, a *Times of India* article published in 2016 suggested that at least 88,020 foreign patients have come to Bangalore since January 2014 for treatment (Chatterjee 2016). Thus, an exploration of the ways in which physician attitudes contribute to understandings of cervical cancer and its prevention in Bangalore must also be situated in the unique and diverse medical contexts within India more broadly

Overview of Theoretical Orientation

This research draws upon data collected in Bangalore over a month-long period through interviews with physicians that screen for and treat cervical cancer. In an effort to understand how the biomedical practices of screening and preventative treatment for

cervical cancer are contextualized in medical settings in Bangalore, this work employs a form of “hospital-based ethnography” where observations and interactions take place within a hospital setting. As anthropologist Julie Livingston explains, “ethnographers recognize that the hospital is an intensive space where critical moral, political, and social questions arise regularly with great urgency, and where broader political, social, and moral forces in society can be witnessed in a condensed fashion” (Livingston 2012:25). Thus, in this way, cervical cancer screening and preventative treatment can be examined as a “set of grounded practices occurring within a particular infrastructural, social, and epidemiological setting, rather than as a therapeutic ideal or model emerging out of cutting-edge research” (Livingston 2012:25). The ways in which physicians discuss the magnitude and characteristics of cervical cancer in the context of Bangalore, as well as their views regarding screening and prevention efforts, has the possibility to elucidate the cultural, gendered, and economic assumptions embedded in reproductive health screening in this context.

This research adopts a theoretical feminist anthropological approach in an effort to “document lived experience as it is impacted by gender, race, class, sexuality, and other aspects of participants’ lives” (Craven and Davis 2013:1). While ethnography is a qualitative research method that “centers on studying people and what they do and the contexts in which they live over time,” feminist ethnography additionally “attends to the dynamics of power in social interaction that starts from a gender analysis” (Davis and Craven 2016:9,10). An examination of gender and the ways in which gender intersects with race, class, experience, and human rights, can help to illuminate the ways in which individual’s everyday experiences are situated within uneven systems of power and can

allow for the examination of inequalities and power dynamics through gender and within it (Craven and Davis 2013:6; Davis and Craven 2016:9).

The theoretical foundation for this thesis is also based upon anthropological literature within the areas of global health, reproductive health, gender, and India.

Global Health

Anthropological and ethnographic studies of global health make possible examinations of the multitude of political, economic, and social relationships that underlie the production and circulation of biomedical knowledge and give way to the depoliticization, privatization, and individualization of healthcare on global and local scales (Biehl & Petryna 2013; Rylko-Bauer et al. 2009). Biomedicine is not homogeneous in practice or across geographical contexts. Biomedical categories and technologies for addressing health needs are themselves embedded in cultural values and understandings about the body and health.

In the tradition of medical anthropological works, this research aims to investigate elite discourse production regarding the detection and prevention of cervical cancer development and challenge the hegemony of biostatistics employed in the detection and surveillance of reproductive illness. Statistical descriptions have historically been used in biomedicine to construct a seeming consensus on what clinically constitutes ‘normal’ or healthy body and, in turn, pathologizes variations from what constitutes ‘normal’ (Lock and Nguyen 2010:46). Medical anthropologists Margaret Lock and Vinh-Kim Nguyen argue that “biomedical interventions designed to ‘restore’ the ‘normal’ may go awry, because unexamined moral assumptions embedded in biomedicine often conflict with different culturally embedded visions of individual and collective wellbeing” (Lock and

Nguyen 2010:50). In this way, standardized approaches to the detection and treatment of cervical cancer and its precursors must be examined within a variety of fieldwork contexts in order to situate and understand the moral, cultural, and economic assumptions inherent in the adoption and use of global biotechnologies in local contexts.

Furthermore, this work aims to call in to question taken for granted assumptions about the magnitude, disease distribution, and burden of cervical cancer disease in the context of Bangalore, India by interrogating the authority of surveillance statistics. Exploring what populations are counted or overlooked in disease registries, what constitutes surveillance statistics, and who contributes to local, state, and national disease registries can help to illuminate health disparities and local power dynamics.

Reproductive Health

A focus on reproductive health can encompass health topics pertaining to reproductive function, ability, and agency at multiple stages of life. Anthropological work focusing on reproduction situates reproductive health at the intersecting interests of states and other powerful institutions in any given locality (Ginsburg and Rapp 1991; Browner and Sargent 2011). In particular, this analysis relies upon literature focusing on living with and access to treatment and preventive services for HIV/AIDS, access to screening and treatment for STD/STIs other than HPV, and gender identity and sexualities as they relate to HIV/AIDS transmission and prevention efforts (Boyce 2007; Lorway et al. 2009; Van Hollen 2013, 2010, 2007, 2003, 1998; Cohen and Solomon 2004). In particular, Van Hollen's work exploring the ways in which HIV positive women experience and access reproductive healthcare as well as her work discussing the experiences of women accessing maternal healthcare highlight the ways in which

provider attitudes impact gender-based health care in Southern India (Van Hollen 2011, 1998).

Additionally, this analysis is situated alongside anthropological literature exploring the proliferation of assisted reproductive technologies (ART) within the Indian context, including commercial surrogacy and in vitro fertilization (IVF). An anthropological study of ART regards such technologies as socio-technical products that are “shaped by human and non-human factors, including the technical features of the ARTs themselves, as well as by the economic, political, cultural, and moral environs in which they unfold” (Inhorn and Birenbaum-Carmeli 2008:178). Thus, technologies are culturally embedded and enmeshed within power relations, existing within the context of social relations, cultural norms, and knowledge systems (Inhorn and Birenbaum-Carmeli 2008:178). Anthropological works examining ART within the Indian context illuminate the ways in which reproductive health, gendered labor, sexuality and gender, and the State are intertwined and co-constitutive (Pande 2014, 2010; Deomampo 2013; Van Hollen 2007, 2010, 2013).

Anthropological literature in other geographical contexts, such as the United States and Brazil, has demonstrated the importance of ethnographic research examining healthcare providers’ and care seekers’ attitudes for understanding disparities in cervical cancer prevention and treatment (Chavez et al. 2011; Martinez et al. 1997; Gregg 2003). This research project adds to the study of reproductive health and reproductive health in India by adding to existing literature exploring healthcare providers’ understandings of cervical cancer and employing cervical cancer as a lens through which broader questions about gender, class, geography and their intersections can be explored.

Gender in India

Anthropological work demonstrates a changing landscape of gender for women in the Indian context. This includes a reinterpretation of historical and cultural understandings of gender varying across class, caste, religious, and geographical backgrounds (Forbes 2007; Ganguly-Scrase 2003; Wilson 2013). New configurations of dating, courting, and marriage norms have emerged with the increase of the IT sector, non-traditional employment opportunities for women (Patel 2010; Radhakrishnan 2011). In particular, scholars have noted general shifts towards later marriage, changing trends in dating and courting, and/or longer participation in the formal workforce in many urban settings and among middle-class populations (Scrase 2006; Radhakrishnan 2011; Fernandes 2006; Dickey 2012). Expectations in regards to being married, having a family, and following appropriate career and educational aspirations are still vastly different among men and women. Despite gains in employment opportunities or middle class mobility among young women, women lack gender equity in regards to opportunities for employment, gender-based expectations, and safety for women in the Indian context, regardless of class background (Patel 2010; Radhakrishnan 2011). Since gender and female identity is not homogeneous at global or local levels, there is need for further work examining the ways in which notions of gender are understood and/or changing (Dickey 2012; Fernandes 2006; Kapur 2006; Liechty 2002; Radhakrishnan 2011; Wilson 2013). In particular, research is needed on the healthcare access and delivery options available to women wanting to address reproductive health issues, such as access to asymptomatic screenings.

It is important to note here that this work does not include an analysis of caste. This is not due to a lack of importance of caste in the historical or contemporary context of India, nor due to a lack of anthropological literature exploring the significance of cast in the lives of Indians. It can be argued that within the context of India, caste, class, and gender are inseparably linked and constitute and reinforce each other. In fact, some scholars argue that women are and have historically been viewed as the gatekeepers of caste as marriage, purity, and women's ability to reproduce create and reinforce hierarchy and patriarchy that constitute the underlying basis for caste (Dumont 1972; Rege 2013; Chakravarti 1993). Instead, an analysis of caste is not included in this work as no one directly invoked caste in any of the interviews I conducted. In an effort to avoid problematic social mapping as a non-Indian white scholar, as well being careful not to replicate colonial structures of analysis, I have not directly provided an analysis of caste in this work. Rather, I highlight ways in which interviewees possibly circumvented discussions of caste by employing a coded language of class and emphasizing an urban-rural divide. Similarly, as I met only with physicians and conducted observation in common areas in hospitals rather than speaking directly with patients, I cannot speak to the ways in which race, gender, class, and caste intersect within the limited time I observed within hospital settings. Further work pertaining to physicians' attitudes of cervical cancer screening and preventative treatment and/or women's experiences of such screening and prevention efforts in this context must include questions about race and caste in an effort to understand the ways in which the intersections of race, gender, class, and caste impact patient care in this setting.

Methodology

All data collection and in-country research for this study was collected in February 2016 in Bangalore, India, and peri-urban areas surrounding the city. In person semi-structured interviews constituted the primary method of data collection for this study. A total of seven interviews were conducted with physicians treating cervical cancer or leading cervical cancer prevention efforts in and around the city of Bangalore.

Interviews

In an effort to interview health care providers from a variety of health care settings in Bangalore, I sought out physicians working in government, private, and NGO sectors for interviews. Initial contact was made with interviewees through email introducing myself and outlining the study's purpose as well as informed consent protocols in line with the study's IRB approval. Signed informed consent forms were collected prior to the beginning of each interview, and interviewees were made aware that they could withdrawal consent and stop participation at any time. All interviews were audio recorded, and hand written notes were taken during the course of the interview as well. I spoke with one physician from the region's government-funded cancer specialty hospital, two physicians from private teaching hospitals, two physicians from private hospitals, and two physicians working with charitable organizations that regularly conduct cervical cancer screening camps in peri-urban areas surrounding the city of Bangalore.

Language

Although it is difficult to find reliable, current data with which to map language distribution in Bangalore, depending on which part of the city one is in and the types of

transactions involved, Kannada, Tamil, Telugu, Malayalam, Gujarati, Marwari, Hindi, and English are commonly spoken languages in Bangalore (Chandra 2017). While many signs are written in a variety of local languages, it is not uncommon to hear English spoken within the city center and I found it was routine for vendors to speak English. In this way, while speaking English is still a marker of status and education, English is spoken not only among the elite and is employed to meet Bangalore's changing migration and tourist patterns. Unlike my previous trip to Bangalore in 2009, I did not find it difficult to navigate the city alone as an English speaker in subsequent visits in 2015 and 2016. In my experience, English was also regularly spoken within the hospital context between patients, healthcare providers, and hospital workers. All correspondence and interviews were conducted in English, as it was routine in this setting for physicians or healthcare workers to speak English.

Observation

Interactions in hospital settings were also observed in an effort to better understand healthcare delivery systems and provision. In an effort to respect patients' privacy, observational data is limited to common areas in hospitals and physicians' offices rather than exam rooms or hospital wards that housed patients.

Anonymity

All data from this study has been anonymized and interviewees have been given pseudonyms in an effort to protect any identifying information of participants. Handwritten notes from this study do not contain participants' names, and transcribed interviews have pseudonyms in place of interviewees' names.

Coding

Transcribed interviews and notes have been coded using line-by-line categorization in an effort to systematically analyze the ethnographic data (Emerson, Fretz, and Shaw 2011:174). This approach makes it possible to identify re-occurring themes across the data for further analysis and discussion.

Chapter Two: Contextualizing Cervical Cancer

India accounts for a significant proportion of the global burden of disease and eighteen percent of global deaths, due in part to its large population (Balarajan, et al. 2011:505). Historically, communicable diseases have accounted for the majority of morbidity and mortality in India, but NGO and government sponsored childhood vaccination efforts have helped to reduce mortality from infectious disease significantly in the past twenty-five years. Recent estimates suggest that while thirty-six percent of deaths in the subcontinent are attributable to communicable diseases, perinatal and maternal conditions, and nutritional deficiencies, chronic diseases now account for roughly fifty-three percent of deaths (Balarajan, et al. 2011:505). Data available from the World Health Organization (WHO) from 2012 lists ischemic heart disease, chronic obstructive pulmonary disease, stroke, diarrheal disease, lower respiratory infections, preterm birth complications, tuberculosis, self-harm, falls, and road injuries to be the top ten causes of death countrywide (WHO 2015). While such data indicate a protracted epidemiological shift, health outcomes continue to vary starkly across caste, class, geography, and gender.

For example, one-fifth of maternal deaths and one-quarter of child deaths in the world occur in India (Balarajan, et al. 2011:505). Maternal mortality is often used as a general indicator of overall population health, the status of women in society, and of the functioning of a health system. Thus, high rates of maternal mortality can serve as markers of wider problems of health status, gender inequalities, and health services in a country (WHO 2016; MEASURE Evaluation 2018). It is in this context that cervical

cancer can serve as a case study by which to examine health disparities in India and Bangalore more specifically.

In an effort to understand physician attitudes towards screening and prevention options available to women living in Bangalore and the peri-urban areas surrounding the city, I spoke with physicians treating, researching, and teaching about cervical cancer, including gynecological oncologists and gynecologists, as well as those involved in screening outreach efforts. My fieldwork took me to overcrowded government-run hospitals, spa-like corporate hospitals, and expansive teaching and research hospitals. Speaking with those who treat cervical cancer in these varied settings helped me to understand how physicians view the magnitude of cervical cancer in India and Bangalore more specifically, who is most affected by cervical cancer, and where those most at risk are located.

Although all of my interactions with doctors resulted from cold-emailing physicians that I had identified via internet research, the possibility that their willingness to speak with me was in part due to my university affiliation and credentials included in my email signature cannot be discounted. It is highly likely that the physicians I spoke with were willing to meet with me due to my self-identified positionality as a graduate student and my Masters in Public Health background in epidemiology.

I found it relatively easy to access hospital spaces as well as the transportation necessary to get to hospital locations, which would likely not be typical for many patients accessing care at government hospitals, for example. Additionally, the fact that I am white certainly played a role in how easily I could access spaces unknown to me and how

often I was offered assistance in hospitals in finding the correct offices and the physicians with whom I had appointments.

Many times during our interviews physicians treated our conversations as two professionals speaking with one another, possibly making them more comfortable to speak their mind. It was not uncommon for physicians to ask me questions about cervical cancer screening and treatment efforts in the context of the U.S. or to ask my opinion on controversial topics such as the HPV-vaccine. Thus, my experience interviewing physicians for the purposes of this research cannot be separated from my situationality as a MPH, medical anthropology graduate student, and Caucasian in this context.

Disparities in Surveillance

When I asked the healthcare providers I spoke with if cervical cancer is a large health issue for women, they unequivocally agreed that cervical cancer has and continues to present one of the most significant health issues facing women in India. When asked if it was the largest health concern facing women, however, I was told cervical cancer is only one of many health issues disproportionately faced by women, and is generally not a woman's largest health concern. This discrepancy suggests that although available health statistics indicate cervical cancer to be one of the largest health issues facing women in India, women face many other health challenges in their daily lives. Although cervical cancer will occur at a rate of approximately 1 in 53 Indian women during their lifetime, a myriad of pressing health issues face women in India at staggeringly higher rates when compared to women worldwide (Krishnan et al. 2013:1285).

Dr. 5 is a consulting oncologist specializing in gynecological oncology at Manipal Hospital in Bangalore, one of a fifteen-hospital network that comprises the third largest

healthcare group in the country. Manipal Hospital has five locations in Bangalore alone that provide multispecialty preventative and therapeutic care. Although Dr. 5 and I corresponded by phone and email prior to our meeting, it took me three visits to the hospital before we were able to speak. Once past the registration desk, Manipal's oncology suite housed eleven offices where physicians would consult patients. The waiting room had a handful of seats that were always occupied, with waiting patients spilling out into the hallway lined up at the doors of their doctors. A flat screen television in the corner of the waiting area shuffled through a PowerPoint advertising Manipal's state of the art robotic surgical treatments. The patients in Manipal's oncology waiting room were a diverse group in terms of age and ethnic background, with African immigrants and families conversing in Arabic amongst the crowd. Female patients dressed in a mixture of saris, shalwar kameez, and Western dress, while the men wore slacks and button down shirts. Aside from similarly enduring long waits to see their respective physicians, the patients in the waiting room all shared one distinct feature: each had with them a file of their medical history and corresponding papers of record.

In between meetings with patients, Dr. 5 squeezed me in for a brief interview. He explains that, while the incidence of cervical cancer appears to be coming down, published estimates are likely deflated in comparison to the true magnitude of cervical cancer in Bangalore and India more widely. "See, the reported incidence was in excess of 32 per 100,000 and is now less than 28 per 100,000," Dr. 5 explains. "What I can say is, five years back, it was far more than 32, although that is what was reported."

Dr. 5 points out that the national cancer based registry is made up of a population based cancer registry (PCBR) operating out of major cities across India and a hospital

based cancer registry (HBCR) that coordinates data gathered from hospitals countrywide. Staff from the National Cancer Registry Programme (NCRP), a countrywide surveillance effort of the Indian Council of Medical Research (ICMR) that began in 1981, visit “hospitals, pathology laboratories and all other sources of registration of cancer cases on a routine basis” and gather data from death certificates where cancer has been labeled as cause of death (NCRP 2017). Thus, national cancer estimates tend to over-represent cases that present to hospitals in urban centers and under-represent rural areas where care is provided to patients in rural clinics. Dr. 5 explained that since cervical cancer is seen in predominately rural, low socioeconomic strata, and only one PCBR in India is situated in a rural area, that cervical cancer rates “must have been in excess of 40 per 100,000, which was reported as 30 to 32 per 100,000.” Nonetheless, epidemiological studies suggest that cervical cancer rates appear to have come down in recent years while breast cancer rates are on the increase. “I used to see for every one breast cancer case, two cases of cervical cancer. Now, for every four cases of breast cancer I see, I only see one [cervical cancer case].”

Dr. 5 attributes this decreasing trend in cervical cancer to increased cancer awareness and improved education, in turn leading to improved standards of living. As he explains:

Education of the people in our villages, the low socioeconomic people, the cleanliness level is totally better now. The villages have toilets now and multiple pregnancies and deliveries are not like before and so deliveries happen in a small hospital, a village PNC [postnatal center], and they are monitored by something called an auxiliary nurse midwife worker which is part of a government organization. No longer do village ladies have ten children, they have one or two, and their nutritional status is good, their education and awareness is good, so because of this the incidence has come down.

Thus, Dr. 5 notes that improvement in health infrastructure, such as access to PNCs and auxiliary nurse midwife workers as well as increased sanitation through access to toilets may account for a decrease in cervical cancer. However, it is unclear to me how these improvements, as well as lower parity among women, directly accounts for or attributes to a lower incidence of cervical cancer.

Clinical gynecologist and professor of gynecology at St. John's Medical College Hospital, a tertiary medical service hospital and teaching hospital that is home to twenty-four departments providing specialty and super specialty care to patients in Bangalore, Dr. 7 cautions against accepting the data that suggests cervical cancer is on the decline in Bangalore and India more broadly: "If you take what the urban registries are showing it shows that there is a decrease in the number [of cervical cancer cases]. But, you also have to consider what is the accessibility of the urban people for healthcare. That is something which has to be questioned because the number who are really able to access healthcare are picked up. But there will be a number of women who will not access healthcare, so the fact that the urban registries are showing falling numbers...some of us question as a fallacy." When asked what other explanations could possibly account for the decrease in cervical cancer cases seen in recent years, Dr. 7 responded, "I couldn't explain that. Even if you take the registries...a disease like cervical cancer doesn't just decrease without an intervention. So it would only mean that there is something wrong with the documentation."

Class and Health Inequities

Although many of the doctors I interviewed attributed the declining trends seen in the reported number of cervical cancer cases to general and ambiguous 'improved

standards of living' across the country, during our conversation, Dr. 7 stated in no uncertain terms that those women for whom cervical cancer is the greatest risk are impoverished women. The largest barrier to access to screening and treatment she states simply are "Money. Money and poverty." Dr. 7 explains that, whether or not women are diagnosed or treated "really depends on whether they have the money [for healthcare] or not. If they have the money they will end up in [medical] centers. If they don't have the money, they will die where they are." Thus, Dr. 7 suggests that cervical cancer rates are closely tied to class.

India lacks a national cervical cancer screening program so there is uneven screening coverage for pre-cancerous and cancerous cervical conditions. Women with private health insurance and access to primary care are more likely to undergo asymptomatic screenings for cervical cancer than women who rely on government health services for care. Thus, screenings for cervical cancer for those without private health insurance are usually conducted by private organizations as a form of public health outreach. Generally speaking, these cervical cancer screening efforts are conducted by physicians and medical students that volunteer their time and travel to villages and rural areas to conduct 'health camps' and educational outreach. Samples are usually collected in villages and must be transported back to hospitals equipped with laboratories and technicians to process the samples and read the cytology. Follow up with patients can be difficult due to significant distance between laboratories and rural areas as well as long periods of time between screenings and reporting findings back to patients. Dr. 5 explains that such screening initiatives are "basically only opportunistic screenings, so there is

usually no follow up. It's only those who can afford some kind of treatment who will come forward for treatment.”

This disparity was clearly demonstrated during my visit to Apollo Hospitals Bangalore. The Apollo Hospitals Group is one of the largest healthcare groups in Asia and is made up of fifty hospitals in India, Bangladesh, Kuwait and Qatar. Apollo Hospitals Bangalore serves as a tertiary care flagship unit of the Apollo Hospitals Group. When my cab pulls up to the hospital's drop-off area I am surprised to see people lounging on the building's front lawn, an activity usually reserved for park spaces as grass is scarce in the urban area. Once I pass through a metal detector – an experience unique to this hospital in comparison to the others I visit – I am greeted by an usher who helps me find my way to the oncology wing. Rather than wait in the waiting room that is flanked by cascading water fixtures and furnished with padded chairs, I am directed down a corridor decorated by a wall to ceiling collage of photos possibly meant to demonstrate ‘wellness’ to the office suites. Mixed in among the soccer balls, apples, and close-ups of grass are stock photos of white people being active and Indian doctors in white coats talking with patients.

In speaking with Dr. 3, a consulting oncologist in surgical gynecological oncology at Apollo Hospitals Bangalore, cervical cancer was framed as an illness whose distribution falls squarely along class lines. Dr. 3 explained:

See in India, [cervical cancer] is highly variable. The healthcare system, distribution, and patient population is all highly variable. What you should probably understand is that this is a corporate hospital which caters to maybe the higher section of the Indian society. Now, if you go to a government cancer hospital like Kidwai...the number of cervical cancer per se that we see here is far less. You do see it, but it is far lesser than what a government hospital will see, because we cater to a higher socioeconomic strata of patients in India. There is

even the city to village distinct variation. Bangalore being more urban, the incidence is lesser. It is by and large...see, I have been both in...I did my residency and training in a government district, so the number of cases that would come in a government cancer center would be far higher than what we would see [here].

When asked why a hospital like Apollo sees less cases of cervical cancer than the government hospitals, Dr. 3 pointed to the available government reimbursement schemes for treating cancer:

See, the whole thing is that there are different states in India. The Southern states are considered social welfare states compared to the Northern [states] - Karnataka, Tamil Nadu, Andhra Pradesh - so what these states have done...there is universal health insurance, at least in Karnataka, for cancer cases and serious neurological problems. This [universal health insurance] is supposed to be for patients that fall below the poverty line, so patients come with a card, what we call a BPL card - below poverty line medical card - and he gets free access to cancer care. What happens is that there are different hospitals and the hospitals have to take approval to take treatment from the government, and then the government pays a sum of money for every cancer case which is treated. A place like Apollo normally doesn't [participate in these programs] because the costing [sic] is much higher than what the government pays. So we have not taken approval for these schemes because there will be a conflict between the type of patient we see here and the type of patients with this [BPL card].

Since Apollo is a corporate hospital that caters to individuals with private health insurance or those that can pay out of pocket for their care, Dr. 3 explains, they do not see individuals that he believes to be most at risk for cervical cancer. He continues:

You can call it a sort of racism, but the particular reality is if we start taking [patients with BPL cards], we may get a good number of patients but they will not suit...we cannot take them with our regular patients because there would be a hygiene issue, they would be poorly dressed. A hospital like this would start losing its other clientele if it starts that.

Given this explanation, the reason why hospitals like Apollo see less patients with cervical cancer is directly related to class, and in turn, one's ability to access preventative

healthcare. Dr. 3 directly equates the development of cervical cancer to class, with which he also highlights markers of hygiene and dress to be associated, and furthermore notes that catering to such individual most at risk would not be on-brand for Apollo.

Geography and Access to Care

Health disparities in India are stratified across multiple geographies, including across regions, among states, and within states and cities. One of the major reoccurring themes I encountered in nearly all of my interviews was that of the urban-rural divide. The healthcare providers I spoke with explained that in rural, village areas, meeting basic health needs was a pressing issue due to lack of infrastructure and low socioeconomic status. As Dr. 1 explained, preventing cervical cancer is not a priority in India “because the basic needs are not met. Especially in the slums and small towns. In the small towns reliable healthcare is not available. Sanitation and [access to] clean drinking water must be priorities there.”

Dr. 1 has spent the last twenty-six years of his career as a clinician and professor in gynecological oncology at Kidwai Memorial Institute of Oncology, the largest state-run cancer center in Southern India. Kidwai is an exclusive tertiary care center for patients that also serves as an academic research and teaching institute for physicians and healthcare providers. Without fail, I was told in every visit with corporate hospitals or private organizations that conducted cervical cancer screenings that if I really wanted to understand cervical cancer care in Bangalore then I needed to visit Kidwai.

Right off of a major and busy roadway, the compound on which Kidwai is housed is expansive. In addition to the primary hospital, there are dorms for patients and their families to stay, a cafeteria, and free-standing pharmacy building. Auto-rickshaws appear

to be the most common form of transportation to the hospital, followed by the bus regularly comes to the stop out front of the compound. The air is thick and heavy upon entering the main hospital building, and many of the lights are out as I make my way through the long halls to Dr. 1's office. Before entering the oncology suite, a sign in English, Hindi, Tamil, and a script I do not recognize asks for visitors to remove their shoes before entering. Patients in saris and lungis sit on wooden benches on each side of the narrow hallway waiting for meetings with doctors or in-between treatments. When I enter the suite, an office assistant offers me tea while wait – a customary gesture of hospitality that has not been extended to me in other hospitals settings.

“People come from far off places to here, to Bangalore [for care],” Dr. 1 explained. “We have people from all over. From other states also, because this is the biggest cancer hospital in South India. We have people coming from all of the states, not just Karnataka.” He notes that over his career the incidence of cervical cancer has decreased countrywide, as well as in Bangalore, likely due to improved living standards overall. “Improvements in sanitation, education, living standards – everything has improved,” Dr. 1 sates. He was quick to clarify, however, that such living improvements did not reduce the disparities seen in the incidence of cervical cancer across the urban-rural divide. Dr. 1 explained that many of the women most at risk for developing cervical cancer only had access to local health centers that could not necessarily meet their needs regarding cervical cancer detection and treatment. “Many working [at local health centers] are not trained in screening,” Dr. 1 said, “they do not know the pap smear and they lack technicians that can read the smear.”

For many patients who need subsequent care, transportation to the city for hospital examinations and time off from work or family duties can be cost prohibitive even if medical treatments are covered by the government. Thus, by the time most women present for care at a hospital they have advanced cancer symptoms. Dr. 1 explained that while some of the patients he sees have been directly referred to him after their initial screenings, others usually are not aware they have cancer. He estimates that “maybe 5% are stage 1 and 90% are stage 2 or 3” by the time they come to Kidawi for treatment. “Many have symptoms,” he explains. “Maybe they think it’s some kind of infection, but they know it is something. Probably they have gone to a doctor and have been prescribed medicine for an infection, because that is where you go when there is an infection. But by the time they realize is it not an infection it’s too late” he explains, as many are experiencing symptoms due to being in the advanced stages of cancer and metastasis.

Competing Priorities

Many of the healthcare providers I interviewed related that a main reason cervical cancer persisted as a significant public health issue facing women was because it was simply not a government priority in terms of pressing health needs to be addressed as there are many competing population-based health needs. Daily life in India, many doctors pointed out, continues to be colored by infectious disease and high rates of infant mortality and maternal mortality. Dr 2., a gynecologist with a private foundation whose work focuses on preventative health and cancer screenings and one of the only female physicians I was able to speak with explained that cervical cancer is not a current priority for the government due to other competing health needs at the population level:

I wouldn't blame [the government]...maternal mortality and infant mortality rates are still so high so they are still trying to battle with that. So all of the focus is on that and however much you may argue that chronic diseases right now are responsible for more deaths than maternal and child deaths, in principle it is just wrong that mother or child should die at birth, a normal physiological process. So that becomes the primary call of the governments. And then you have infectious diseases like malaria and tuberculosis and those are things they need to control because unless they control it it becomes an epidemic and they can't let that happen. So it's just that the focus right now is just mainly on that and venturing into something new for them is just more difficult.

When asked what made cervical cancer screenings particularly difficult to implement from the government's perspective Dr. 2 stated: "More than the monetary resources I think it's the human resources that are hard to utilize for [cancer screening] programs." Thus, the government is faced with competing priorities when it comes to addressing population-based health needs, and holes in the current healthcare infrastructure make it difficult from the government's perspective to address all the significant health needs facing India's vast and diverse population. Within this context, preventative screening for an asymptomatic, slow growing cancer is not viewed as feasible.

"Cervical cancer is not a priority [in India]," Dr. 1 explained. "There are other pressing problems. Sanitation, infections, malaria, tuberculosis...also drinking water is a problem. For example, here in Bangalore you get drinking water, tap water, only twice a day, so you must store water. So basic water is not available. And people get used to it so we don't think about it. You go to small towns and they don't even get drinking water. Clean water is a big issue."

When asked what the major health concerns facing women are, Dr. 5 responded that infant mortality and maternal mortality are an Indian woman's largest health concerns, followed by infectious disease. "And next, possibly, is cervical cancer. Not before that." Although as an oncologist Dr. 5 believes the burden of cervical cancer in

India is significant, especially when compared to incidence rates other countries, his responses indicated that women disproportionately face so many health issues and that cervical cancer – known to be slow growing and asymptomatic for the majority of its development – is not viewed by many as the most pressing and immediate health concerns that women must face.

Dr. 3 explained that, for oncologists, cervical cancer remains a large concern due to the magnitude of incidence in the country, but that is not a concern for the government: “That is because the government is still concerned with infectious disease and pediatric vaccination, so these are the things that are the priority – and rightly so from the government’s point of view.” He noted that in the last five years the government has included cancer treatment for those with the BPL card, allowing qualified patients that fall below the poverty line to get free treatments in various hospitals across the state. “Typically before this,” he explained, “most [with cancer] would not have taken treatment, especially since the females are not [income] earning members [of the family]. So if the husband could not afford it then I don’t think they would have taken treatments. At least what this scheme has done, because it covers the treatment the billing, [cancer treatment] can be given without putting the family in poverty.”

Chapter Three: Gendering Blame

In an effort to understand the landscape of cervical cancer screening and treatment in the context of Bangalore, I set out to speak with clinicians in a variety of hospital settings, ranging from private, corporate hospitals to the largest government-run cancer specialty hospital in South India. The two private hospitals I visited were about seven miles outside of the city center in opposite directions, but both shared similarities with one another. In both, the waiting rooms had only a few people and patients checked in for their appointments with one of several secretaries before taking a seat to wait. Before being seen by a physician, patients were directed to even smaller waiting areas outside of their physicians' offices before their physician would greet them and invite them inside their office. While both top-tier private hospitals I visited had a spa-like quality to them reminiscent of high-end outpatient specialty clinics in the U.S., I was surprised when I learned that one of the hospitals was located in a shared compound with the World Trade Center and an enormous shopping mall housing stores that included Western fast-fashion brands like Zara and Forever 21.

The two teaching hospitals I visited had a distinctly different feel than the personalized, leisurely atmosphere cultivated by the corporate hospitals. Upon entering both, I was greeted by a hectic waiting room in which patients and their families carried their healthcare paperwork with them from one specialist appointment to the next. Patients waiting to be seen spilled over into the hospital hallways and took to congregating outside of their physician's office in order to be seen. Wait times were long and it sometimes took multiple hours before patients were escorted to their doctors' offices by healthcare workers.

Both the private and teaching hospitals, however, had vastly different atmospheres than Kidawi Memorial Institute of Oncology, the government-run cancer specialty hospital. Kidawi is a regional cancer specialty center that provides cancer care to Karnataka and surrounding states and sits only three miles south of Bangalore's city center. As such, it is in a well-trafficked area and is a sprawling operation with multiple buildings for patient care as well as dormitories for patients and their families who have traveled to Bangalore for long-term treatment. Windows provided the only light in common patient waiting areas, and healthcare workers were stationed at folding tables near the entrance to help direct patients to the correct building or floor of their doctor's office. On my first visit to Kidwai, I became turned around upon entering the main hospital building and wandered around lost in the massive, dimly lit hospital for over thirty minutes. Unlike at the teaching and corporate hospitals, there were very few signs at Kidwai in English, and almost no artwork to help differentiate one floor or specialty wing from the next. I finally found my way to the gynecological cancers wing, which was flanked by patients waiting on benches along the hallway to be ushered into the doctor's suite for consultations. Unlike at private hospitals, patients removed their shoes before entering specialists' office suites, which I had found to be customary when entering a private residence but had not observed outside of homes. Regardless, I was never instructed to remove my shoes when visiting Kidwai.

While all of these hospitals were vastly different from one another in a number of ways, physicians across across all the healthcare settings shared similar ideas about who was most at risk for and most affected by cervical cancer. While all the physicians I spoke with acknowledged significant, practical barriers for women to access cervical

cancer screenings and preventative treatment such as cost, lack of transportation, and lack of healthcare infrastructure, it felt like an underlying sentiment in many of the interviews I conducted with specialists was that women simply did not access screenings and treatment when opportunities to do so were presented. Many explanations for the magnitude of cervical cancer in Bangalore included that women waited to seek care even if they had been experiencing symptoms such as foul vaginal discharge, pain during sex, or chronic bleeding due to a lack of education and low socioeconomic status. As many physicians explained, many women simply did not know when they needed to access healthcare.

Often, specialists identified lack of sanitation and poor personal hygiene as significant risk factors for the development of cervical cancer in the same conversations in which they would implicate HPV infection as the necessary cause of cancer of the cervix and identify the HPV vaccine as the most promising method for population level prevention of the development of cervical cancer. Specialists would commonly acknowledge that infection with the HPV virus was the culprit of cervical cancer, but would instead frame behavioral factors as the explanation for cervical cancer development. While one doctor explained that proper genital hygiene was important in order to prevent general vaginal infections, no other doctors discussed the ways in which poor personal hygiene and cancer of the cervix were correlated despite having noted it as a significant risk factor. Although it was unclear to me what was considered to constitute good genital hygiene, poor genital hygiene in this context implied that women did not buy commercial menstruation products and had to wash and reuse their sanitary napkins.

The majority of doctors I spoke with stated that having multiple sexual partners also increased a woman's risk for developing cervical cancer. As Dr. 3, a consulting oncologist in surgical gynecological oncology at one of Bangalore's top-tier private hospitals, Apollo Hospitals Bangalore, stated:

In India [cervical cancer is a problem] in the villages. It's in the lower socioeconomic strata so that is it. So in that, of course, there are risk factors at play - like multiple sexual partners - all of that applies in India.

Dr. 3's response conflates socioeconomic status and promiscuity, both of which he situates in the rural context. He continues:

In a city you will never get the real picture. You have to visit the periphery... So I know of a gynecologist who used to go there and conduct mass screening on a regular basis [in a peri-urban area]. She goes regularly back and forth conducting specifically cervical cancer screening camps for the last 10 years. So you will get the real picture there, which you will never get in any hospital here or high end hospitals in Bangalore. [Cervical cancer] is a very big problem in rural areas. Last time I met with the doctor she was attributing the rise in cervical cancer to the human trafficking, which happens in these peri-urban places. See, what happens sometimes in these areas is these young females are sent into prostitution and sometimes even go to the Middle East where they are exposed to multiple sexual partners...and when they do come back they are already exposed to this thing. So the doctor was telling me, the gynecologist, was telling me that she used to see lots of such problems in the peri-urban.

When asked about what he believes accounts for the decline in cervical cancer incidence in Bangalore and the surrounding areas in recent years, Dr. 3 explained that while it is likely due in part to an increased awareness of cervical cancer and screening options, the decline could mainly be attributed to an improvement in "overall livelihood" because "[urban women] don't have to resort to prostitution like before." While I do not have other data to cross-reference Dr. 3's claims that rural women experience human trafficking at a high rate or that there has been a significant decline in prostitution in

urban areas, I did not hear these specific claims made by any of the other physicians I spoke with, including those that conduct screenings in rural areas.

Dr. 3's response implicates human trafficking as the cause for high rates of cervical cancer in peri-urban areas. However, Svati Shah, a gender, women, and sexuality studies scholar, explicitly argues against equating sexual commerce and human trafficking in the Indian context (Shah 2014:11). She argues that such a conflation serves as a way to undermine women's sexual autonomy and overlooks sexual commerce as one of many livelihood strategies among women in this context (Shah 2014:40). Dr. 3's mention of human trafficking as a possible explanation for high rates of cervical cancer in Bangalore's peri-urban areas does not mention the role men play in the transmission of HPV or sexual commerce, further serving to place the burden of responsibility upon women for the prevention, detection, and treatment of cervical cancer.

Dr. 1, a clinician and professor in gynecological oncology at Kidwai noted, however, that while the most significant risk factor for development of cervical cancer was sexually transmitted HPV infection, "The most important factor here in India would be early age at marriage. [Rural women] get married really early here, at 13, 14 years. These marriages are very common in rural areas. In urban areas this is not so common." Dr. 1 did not elaborate on how early marriage particularly put women at greater risk for the development of cervical cancer, or why the burden of this practice fell onto women and impacted their health adversely. Thus, it was unclear to me how early marriage itself could be implicated as a risk factor for HPV acquisition in women when abstinence until marriage and monogamy are traditionally regarded as common cultural practices and expectations for women in this context.

Many of the physicians I spoke with highlighted a difference in the incidence of cervical cancer along an urban-rural divide, emphasizing that cervical cancer was mostly a health issue in rural areas rather in urban settings. When asked what they believed could have contributed to the purported decline in cervical cancer cases in recent years, many specialists responded that higher standards of living accounted for the decline in incidence.

Dr. 7, a clinician and professor of gynecology in the department of medicine at a Bangalore-based Catholic university and teaching hospital and of the only females I spoke with, did not agree with her colleagues' assessments of a rural-urban disparity in terms of cervical cancer incidence, and instead suggested that a lack of urban surveillance could account for any perceived difference in number of cases detected. She explained:

I don't see any differences, but you will see that the urban registries will continue to not pick up diseases of the low-socioeconomic status, people of the low-socioeconomic status because they will not access treatment. They will die without being cited in the statistics... It is here in Bangalore. It will be a disease of the urban poor. That can happen also in the United States, among Blacks, Puerto Ricans, other minority groups. Those poor are most at risk for being ignored and uncounted.

Thus, it is possible that the continual framing of cervical cancer as a disease primarily affecting rural women serves to further disenfranchise women in urban settings from accessing care. Lack of low-cost screening efforts and widespread awareness campaigns in the urban context likely add to the difficulty of women being screened in urban areas.

My fieldwork aimed to capture the clinical landscape of screening and preventative treatment for cervical cancer in Bangalore, but I quickly found that I needed to widen my research context to include the peri-urban areas surrounding Bangalore as these were the areas in which screening camps were regularly conducted and the areas in

which clinicians felt cervical cancer to be a significant issue. I was able to arrange a meeting with the Biocon Foundation, the healthcare outreach arm of the India's largest biopharmaceutical company Biocon Limited. The foundation's focus, as described by the company's promotional literature, is to deliver affordable healthcare, improve civic infrastructure, and provide educational opportunities for the "less-privileged" in rural and urban sectors of India (Biocon 2018). As the group's website explains, the foundation aims to empower underserved communities "by establishing primary healthcare centers, actively creating awareness about disease prevention, public health and sanitation, building civic infrastructure and initiating education programs" (Biocon 2018). The Biocon Foundation regularly conducts preventative health screenings aimed to address tobacco cessation and oral cancer detection, early detection and management of diabetes and hypertension, testing and prevention of anemia, malnutrition management, and cervical cancer screening and referral for treatment for cervical pre-cancer and cancer. Currently, they have ongoing cervical screenings and reproductive health education programs in eight rural and peri-urban areas surrounding Bangalore.

The Biocon Limited campus, located only twelve miles outside of Bangalore in an area known as Electronic City, is a well-guarded compound home to multiple office and laboratory buildings. Tall shrubbery shields a view of campus from the road, and security gates communicate clearly that only authorized vehicles can enter. After making my way to the security station and presenting verification credentials for my appointment, I was met by a female gynecologist, Dr. 2, and led to a conference room where a projector and laptop were set up with a presentation. Dr. 2 and her female nursing assistant then walked me through a thorough presentation that covered the ways in which the Biocon

Foundation partners with local health clinics in rural areas and trains women from the communities in which they conduct screenings to be health workers in an effort to have more effective and culturally appropriate clinical and educational interactions with community members. Currently, the Biocon Foundation conducts cervical screening and awareness camps for women aged 21 and over or women who have been married for at least three years. Although cervical cancer is a slow growing cancer tends to develop later on in life, Dr. 2 explained that this age group was chosen so women would have earlier and more frequent opportunities to address reproductive health issues. She explains:

Here we don't talk about promiscuity because it's not socially acceptable to talk about it so it is unlikely that a girl would come up to us and say 'I am not married but I have had had sexual contact for the last three years and I'm above 21 years'. So we set the parameter of married for more than three years to include younger women and about the age of 21 for women who may not be married but are sexually active. Although we haven't found any significant cancers or pre-cancers in this age group, we found a lot of reproductive infections. That, I feel, just goes to show that these women probably later would develop other problems of the reproductive tract so it's good to see them early and try to explain the importance of treating these conditions and the importance of having regular examinations.

Although premarital sex may not be something that is culturally acceptable for women to discuss, the reality is that many people may have multiple sexual partners – willingly and unwillingly – during and outside of the context of marriage. By setting the screening parameters to include women married prior to the age of 21 or women over the age of 21 in general, Dr. 2 explained, Biocon's screening camps aim to include all women that are sexually active without putting the onus on women to disclose their sexual history.

Since Biocon Limited is a large pharmaceutical company that is notably one of the top three producers of insulin globally, I came prepared for a meeting in which healthcare providers would likely stick to the script in terms of what information they

were willing to share with me regarding their patients' and target audience's experiences.

I was surprised, however, that Dr. 2 was willing to speak directly about the ways in which men played a role in the major health issues facing women. Dr. 2 identified domestic violence to be one of the common health issues experienced by women who came to the screening camps. As she explains:

Another thing that came up when doing cervical cancer screenings, especially in the rural areas, is that women experience domestic violence. It may not be physical, but a lot of financial, a lot of social abuse...like she may not be able to go to the doctor with the permission of her husband. So that is a social vice because you cannot prevent someone from seeking healthcare.

Dr. 2 explained that educating health workers who are members of the community about the various forms of domestic violence that women can experience was paramount in order to misunderstandings about what constitutes abuse. Dr. 2 continues:

Since a lot of our staff are from within the community you will find that they sometimes agree that since he's the husband and she's the wife, it's his money, his time, and she needs to first take care of his home and his needs and his children before she takes care of her needs. So we did this whole workshop with [the community health workers] about domestic violence and how earlier domestic violence was thought to be just things like hitting, beating, and marital rape...but even things like marital rape they felt was alright because they think why else are they getting married. Like, 'you should know that's part of it. So you cannot say that the husband is able to rape his wife'. So with all of these things in their mind we try to teach them a very structured understanding of violence, where violence stems, what it is, where it is and how we should respond to it.

Dr. 2 stated that the need to address the health issue of domestic violence was important because health care workers and clinicians kept encountering women experiencing various forms of domestic abuse:

As healthcare workers we are exposed to it the maximum. We actually come across this with our patients the most and to pick up these little signs you can get from women is important because maybe just that one interaction when we are talking in general about how to take care of yourself and how it's not ok for anyone to harm you mentally or physically, it may change her perspective and force her to stand up for herself once in a while if required.

When I asked her to explain some of the ways that domestic violence is identified during a cervical cancer screening, she shared the story of a 28-year-old woman who presented with a vaginal abscess but did not report any pain to the clinicians. “She had a huge abscess and she’d had it for like a really long time,” Dr. 2 stated, “and she's been having intercourse with pain and not complaining about it. And she felt that that was ok. She is obviously in a lot of pain and she is still having sex,” Dr. 2 continued, “and that is like a violation of a basic right because she is in pain and not well and that's a human need. But she is unable to speak up to her husband about it, or he doesn't care. And that's abuse.” Addressing what may be viewed as social issues such as domestic violence, Dr. 2 explained, is important “because [women's health] does depend on the relationship between the man and the woman because if there is violence of any sort then reproductive health cannot be good.”

When asked what the biggest challenges facing women who are at most need for cervical cancer screening and treatment, Dr. 2 again discussed the role men play in women accessing healthcare. Dr. 2 responded:

I think it's the kind of cooperation that they require from their husbands. The men, the men are the biggest challenge. Any program related to women, especially in rural areas where there is so much of a dependence on male acceptability of everything.

She went on to explain that the need husbands' approval in order for many women to be screened did alter the ways in which health information was tailored to women participating in screening and reproductive education programs.

They husbands are really curious about what's happening. Even in our education we have to be very careful about what we tell women, because if we tell them 'hey you are getting this because of your husband' that would be ok for some women but if certain women were to discuss that with their husbands, especially

when you talk about multiple partners and things like that, that wouldn't go down well with the men because you are basically filling the wives' ears with thoughts that shouldn't be there or whatever.

So that is one of the main takeaways from any STD education that you would want to give, that to get the receptivity and cooperation of the husbands is important so you should put it in a more subtle way and it shouldn't be done directly on the face. So we made it very clear that our primary goal was to screen women for cervical cancer. Though we would like to prevent all STDs, our primary goal is simply that we wanted as many women coming in [for screenings] as possible so we did tweak the education subject so we don't directly make accusations against the men.

Dr. 7, the only other female physician I was able to speak with, shared similar sentiments regarding the ways in which men impact women's access to cervical cancer screening and care. When discussing why there appears to be more breast cancer awareness campaigns and screening efforts in comparison to that of cervical cancer, Dr. 7 explained:

I think [cervical cancer awareness] is a difficult conversation and in that, see, in breast cancer it is not indicated that a cause is multiple sexual partners, so the male is not held responsible. But in cervical cancer the male will be held responsible. Otherwise she is termed as a whore, to put it very plainly. So then overall [cervical cancer awareness] becomes very difficult to address. I don't think there is a discussion of the male role [in cervical cancer development] at all. It is not done.

Thus, Dr. 7's response echoes that of Dr. 2's regarding how reproductive health information pertaining to the behavioral risk factors for HPV acquisition and cervical cancer development is tailored in order to avoid discussions about the ways in which men can contribute to the spread of HPV and expose their partners to the virus. Rather husbands are viewed by program planners as the gatekeeper women must get past in order to access healthcare and thus messages highlighting men's contributing roles in the development of cervical cancer in women are omitted from educational reproductive health programs.

When asked whether or not cervical cancer was regarded as a large health concern for women in India, Dr. 7 responded simply, “No, it’s not a large concern.” When I asked her why she felt that to be the case she offered:

Because I think this country, it's a patriarchal country, it's basically male oriented. So if you look at what happens in these cancer centers, they will look after the male child, then they will look after the male member of the family, then they will look after the girl child, and then comes the woman.

Dr. 2 added that infertility currently seems to be one of women’s major health concerns.

Lately, we have been seeing a lot of infertility and we don't know if that's because women are willing to talk about it. But again there is always that idea that it's the lady's fault. So that's another issue that needs to be dealt with because it's a social evil in the sense that a man gets married to a lady and they don't have a child, they just assume that it's the girls fault so he can get married to someone else and leave her, and that's a social evil. And that's something that people need to talk about as well.

Dr. 2’s response brings to light the ways in which women’s healthcare decisions and health challenges, such as infertility, have potentially large social implications.

Discussions with both Dr. 2 and Dr. 7 offer a different perspective regarding the contributing factors in women’s healthcare decision making. Namely, unlike discussions with male healthcare practitioners, both Dr. 2 and Dr. 7 highlighted the ways in which men play a large role in women’s health outcomes and, for many women, whether or not they will seek care. Although many of the male physicians I spoke with indicated that education for women was central to improving women’s health outcomes, many did not elaborate on how or why they felt education would directly improve women’s health, or specifically what types of education would be most useful for women. Interestingly, when Drs. 2 and 7 were asked what they felt was central to improving women’s health outcomes, both pointed out that the role of men in women’s lives interpersonally and culturally needed to be addressed in order to improve women’s health and that women

and community members needed to be better educated about what constitutes violence against women and how to address domestic violence. Drs. 2 and 7 also noted that it was necessary to tailor educational information regarding HPV and other STIs in an effort to avoid implicating men in the spread of sexually transmitted diseases. Thus, although all doctors indicated that some form of ‘education’ would positively impact women’s health outcomes, there was an observed difference between male and female physicians regarding what the subjects of such education should be.

Discussions with physicians regarding what the constitutes challenges to accessing care and major health concerns for women in Bangalore and its peri-urban areas highlights the way in which blame is gendered in this medical context. Male physicians were quick to point out behaviors of women that are viewed as risk factors for the development of cervical cancer, such as lack of personal hygiene, while the female physicians I spoke with noted the ways in which cultural expectations of women, such as the place of women in the home hierarchy, were significant contributing factors to the development of cancer of the cervix and other reproductive health issues. The male physicians I spoke with also tended to frame cervical cancer as an issue disproportionately affecting rural women, while the female physicians were skeptical of the perceived lower incidence rate of cervical cancer in urban areas. Unlike their male counterparts, Drs. 2 and 7 felt that cervical cancer was likely just as large of an issue in terms of incidence in urban Bangalore, but noted that cases are likely undercounted and underreported due to a lack of screening efforts in urban areas. Thus, the ways in which physicians spoke about factors that contributed to the development of cervical cancer in Indian differed greatly

across gender lines, and reflected the ways in which a woman's class, caste, and geography impacted physicians' views and explanations of cervical cancer development.

Chapter Four: Conclusion

On June 22, 2018 the World Health Organization published a tweet from their official Twitter account that read “Vaccine-preventable diseases include:” and proceeded to list eighteen vaccine-preventable diseases, among which cervical cancer was included (@WHO 2018). However, as this thesis contends, , HPV vaccines are politically fraught and socially complicated medicines. Additionally, they are prohibitively expensive for those who must pay out of pocket for medical care. While it could be argued that HPV vaccines could be the most promising population-based approach to widespread prevention of cervical cancer development, they donot appear feasible - for the majority of the world’s population. Thus, even with the advent of new medicines and technologies aimed at reducing the morbidity and mortality of cervical cancer, the people at greatest risk for developing cervical cancer and dying due to cervical-cancer attributable causes continue to be those most underserved.

Sociologist Johan Galtung defines structural violence as violence that is “built into the structure and shows up as unequal power consequently as unequal life chances” (Galtung 1969:171). As a form of embedded inequality and systematic bias, it leads to disparities seen across the life cycle, as individuals are situated in privileged or disadvantaged positions from the start. Such structural violence accounts for the uneven distribution of resources, “as when income distributions are heavily skewed, literacy/education unevenly distributed, medical services existent in some districts and for some groups only” (Galtung 1969:171). Most importantly, Galtung argues, power to decide over resource distribution is, itself, unevenly distributed, leaving many poor and low income women unable to exercise autonomy over their lives and material needs

(Galtung 1969:171). These inequalities, manifest in differential mortality and morbidity rates among subsets of society, as they result from the accumulation of inequalities across the life course (Galtung 1969:177). Paul Farmer adds to this definition that violence “is structured and *structuring*,” explaining that it “constricts the agency of its victims,” by determining which resources can be allocated to and experienced by its victims” (Farmer 2004:315). Given the significant difficulties women must overcome in order to access cervical cancer screening and preventative treatment in this context, the development of cervical cancer and the high morbidity associated with it in this context can be viewed as a failure of the medical establishment and the product of structural violence faced by women.

Further Work

Initially, the research that contributed to this thesis was undertaken as part of larger dissertation project. As such, speaking with physicians and clinicians providing cervical cancer screenings and preventative treatment was planned in conjunction with the intention to speak with women in general about this topic as well as with women in healthcare centers or screening camps to better understand their experiences in the realm of cervical cancer screening and preventative treatment. In order to more fully unpack and assess the myriad power dynamics that form the attitudes and experiences that constitute undertaking cervical cancer screenings and preventative treatment, it is imperative that future work in this area includes women’s accounts. Furthermore, I believe there is merit in further exploring the ways in which physicians’ attitudes regarding reproductive health and particularly reproductive cancers possibly differ across gender lines.

Examining access to care and the experience of women and healthcare practitioners in the context of cervical cancer screenings and preventative treatment can be an avenue through which gender is explored through an illumination of “how the management of reproductive health serves to both reaffirm pre-existing gender norms and provide a space for their potential transformation” (Van Hollen 2016). An examination of attitudes and agency in the management of reproductive healthcare can help to draw attention to reproduction as a “potentially transformative space” (Van Hollen 2016). Women’s decision making within the context of reproductive health can serve as a space in which women are able to push back against gender-, class-, and caste-based forms of discrimination (Van Hollen 2016). Thus, undertaking research in the area of women’s reproductive health examining screenings and early treatment for cervical cancer can help to highlight important experiences of how gender is constructed and reinforced within in healthcare settings and clinical interactions.

Forthcoming works, such as Rebecca G. Martinez’s text *Marked Women: The Cultural Politics of Cervical Cancer in Venezuela* (Stanford University Press, June 2018) and Cecilia Van Hollen’s in-progress article "Cancer and the Kali Yuga: The biopolitics of cancer causality in reproductive cancer screening in South India" (*BioSocieties* for Special Issue on "Cancer and the South"), presumably explore the topics of cervical cancer screening in India and the global South and add to the growing body of literature situating cervical cancer as a site for analysis in medical anthropology and gender studies. Further research in the area of cervical cancer screening and preventative treatment is imperative in order to center patients within the delivery of reproductive healthcare and services through policy or programmatic changes, and is important for understanding the

ways in which gender, class, race, and ethnicity intersect and impact healthcare experiences.

Additionally, further work examining cervical cancer and screening and treatment for reproductive health issues in the Indian context is important to situate gendered experiences of healthcare within culturally specific contexts across India. In November 2016, the Indian government was slated to begin a mandatory national screening program for commonly occurring cancers, such as breast, oral, and cervical cancer; however, it is unclear the extent to which cervical cancer screenings have been implemented nationally under this effort at this point in time (Bagechi 2016). In speaking with doctors and healthcare providers during my fieldwork, it is likely that widespread implementation of cervical cancer screenings will take many years.

In the meantime, much controversy still surrounds cervical cancer screening efforts as an 18-yearlong study in Mumbai purportedly aimed at evaluating the effectiveness of VIA/VILI screening as an alternative to Pap testing was recently ended due to ethical concerns (Piller 2017). Researchers involved in the study have been accused of withholding effective standard-of-care screening methods from study participants and of falsifying data to support claims of earlier detection of cancers (Piller 2017). Against this backdrop of longstanding controversy surrounding reproductive health screening and treatment efforts across India, the government will be tasked with shaping a national dialogue encouraging women to receive screening and treatment for reproductive cancers and will have to work closely with local and state level governments that have diverse needs in order to implement an effective and mandatory screening program.

Personal Reflection

Since conducting this fieldwork in 2016, my relationship with the subject matter of cervical cancer screenings and preventative treatment has become more personal as I now have first-hand experience with managing pre-cancerous cervical conditions. A few months after my fieldwork concluded I underwent my first colposcopy and cervical biopsies in an effort to determine the severity of cervical dysplasia indicated by a previous Pap smear. Although I understood the procedure from an academic and clinical standpoint, I was very nervous about the procedure, what the results could potentially mean for my health, and how invasive and painful the procedure could be. While I am extremely fortunate to have been under the care of a OBGYN that I felt was knowledgeable and whose office went out of their way to answer any questions I had and explain in detail the procedure in advance of my treatment, I am most grateful to my friends and peers who had undergone this procedure for sharing their experiences with me and providing me with the recommendation that one should not, in fact, go right back to work immediately after the procedure despite what the doctor's office reassured me. The colposcopy, which included a VIA/VILI inspection and cervical punch biopsy, was a painful and anxiety inducing procedure even though I had a wonderful clinical care experience and had a strong support system of family and friends.

Subsequently, I have had two more colposcopies with biopsies and recently underwent a LEEP procedure to remove two-thirds of my cervix in an effort to prevent my pre-cancerous condition progressing to cervical cancer. The procedure was not easy, despite being fully prepared with knowledge of the procedure and its necessity for my health as well as being put at ease by my doctor. A lidocaine injection was used to

manage my pain and an ephedrine injection was necessary to control my excessive bleeding during the procedure. Although cauterization of the site was successful, I was advised to be on bedrest for two weeks after the surgery due to being a high bleeding risk. In comparison to the cervical biopsies, the LEEP was less physically painful – most likely due to the medications used for pain during the procedure – but was more invasive and emotionally difficult. I was surprised by how violating I found the surgery to be in the face of my thorough grasp of the procedural aspects of the treatment.

For almost three years now I have received preventative treatment of a pre-cancerous cervical condition, and I will continue to receive follow up care and monitoring in an effort to prevent the development of cervical cancer. In between colposcopies, biopsies, and the LEEP, I have had a number of follow up Pap smears at Planned Parenthood locations in multiple cities in the U.S. with the cooperation of OBGYN's office in Lexington, KY. Had it been necessary for me to undergo Pap smears anywhere other than Planned Parenthood clinics, I would have had to wait longer than the suggested six-month follow up time and would have been required to re-establish care with an OBGYN office every time I moved to a new city. The frustration and difficulties I have encountered in trying to proactively manage a pre-cancerous cervical condition have been an exhausting and anxiety-inducing journey, even while having health insurance. My personal experience, however, has helped me to better understand the reasons why women may be unable or reluctant to receive screening or preventative treatment despite governmental, programmatic, or personal efforts to address barriers to accessing care. I now understand that procedures I once viewed simplistically as 'cost effective', 'minimally invasive', and 'highly effective' in the face of the alternative of

cancer diagnosis and treatment can, simultaneously, be violating, emotionally and physically difficult, and time-consuming procedures.

I also came to better understand that while reproductive health education is necessary for women to understand their bodies and make well-informed and autonomous decisions about their health, reproductive health education alone does not necessarily serve to assuage one's anxieties about reproductive health screenings or preventative treatment. Rather, empathetic clinical and social support is necessary, in addition to reproductive health education, for women undergoing reproductive health screenings and preventative treatment. This support is vital, no matter how 'minimally invasive' or programmatically simple such procedures may be to perform.

While my research in the area of reproductive health has always been motivated by the desire to address gendered health disparities and improve healthcare outcomes and experiences for women, my recent experience personally accessing and receiving treatment has strengthened this commitment and highlighted opportunities for further work in the context of the Southern U.S. as well.

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